FINANCE FUNCTIONS OF THE ALABAMA EXCHANGE

ALABAMA DEPARTMENT OF INSURANCE

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Contents

Figures

Table

Finance Functions of the Alabama Exchange

The Patient Protection and Affordable Care Act (ACA) requires state Health Insurance Exchanges to comply with provisions regarding financial management and program integrity. The Alabama Exchange will have a range of financial obligations and responsibilities and will interact with market partners and affiliates, such as health insurers, producers, navigators, state agencies, and consumers. If the Exchange performs services on behalf of Medicaid or ALL Kids, it should develop a cost allocation method to enable the state to access additional federal funds. By the end of calendar year 2014, the Exchange will need to have a financing mechanism in place to support its operations when federal funds are no longer available. The Exchange will also be subject to annual Department of Health and Human Services (HHS) audits, as well as state audits and operational reviews.

As an entity responsible for implementing a complex law affecting nearly all Alabamians, the Exchange will need to demonstrate transparency, competency, and integrity. Accordingly, it will need to establish a system of internal controls and program integrity measures that reflect public and private-sector best practices.

INTERNAL CONTROLS AND FINANCIAL MANAGEMENT

The Alabama Exchange will need to prepare a comprehensive financial management plan to manage its funds, including federal funds and any assessments or user fees it collects to finance its operations. As required by the ACA and further defined by proposed federal rules,[1] the Exchange must have adequate financial management systems and efficiently and effectively account for and control all property, funds, assets, and federal grants and cooperative agreements.

The Exchange will need to establish and execute financial controls and audit protocols to ensure the validity and appropriateness of all financial transactions. Financial information, in summary form, will need to be made publicly available, as part of a series of reports the Exchange will need to produce pertaining to its finances and operations. Alabama's Exchange must account for all activities, receipts, and expenditures; provide an annual report to the HHS Secretary; and comply with annual federal audits. In addition to strong accounting and financial management systems, the Exchange will need to be self-sustaining beginning in 2015, which likely means it will need to assess and collect an assessment or user fee.[2]

[1] ACA, Public Law 111-148 § 1313.

[2] An upcoming (November 2011) LMI report will detail financing options for Alabama's Exchange.

The Exchange is required to publish the costs of licensing, regulatory fees, and any other payments used to support its operations. Data warehousing will be necessary to manage these financial functions and to generate reports and receipts. Outsourcing and vendor-management functions will also be needed. At least monthly, the Exchange will need to reconcile billing and collections with qualified health plan (QHP) issuers and possibly with the US Treasury.

The Exchange will need to hire a chief financial officer or finance director, along with a finance support staff, who will be responsible for establishing a financial management structure that will

- develop or purchase accounting and financial reporting systems,
- set up a general ledger,
- obtain a Tax ID number,
- establish the entity with the Internal Revenue Service and appropriate state agencies, and
- develop the necessary banking relationships to operate the Exchange.

An off-the-shelf software program will likely be sufficient to meet the Exchange's short-term needs. These programs are easy to install and have the necessary functionality to allow the Exchange to reflect basic cash, receivables, and payable transactions.

In the longer term, the Exchange will need to comprehensively assess its financial management needs. Given the many people who may enroll in Alabama's Exchange and the need to manage multiple revenue streams—such as carrier assessments, federal and state grants, and member premiums—the Exchange will quickly outgrow a basic accounting package. One key decision will be whether to purchase and implement an enterprise resource planning (ERP) system with extensive features and functionality (along with correspondingly complex installation and use) or a more modest software package commonly used by small businesses with limited functionality.

The extent to which the Exchange will be directly involved in premium billing, collection, and remittance, as well as the manner by which it is financed, will influence its need for a complex, comprehensive accounting and internal controls system. As discussed below, outsourcing premium billing may minimize the need for a sophisticated financial control and accounting system. Decisions regarding the financing of the Exchange will also affect the complexity and comprehensiveness of its financial reporting. Regardless of these decisions, Alabama's Exchange will need a robust financial management and reporting system to support its operations and meet the statutory and regulatory reporting requirements.

PREMIUM BILLING, COLLECTION, AND REMITTANCE

A key early decision for Alabama involves the extent to which the Exchange will be directly involved in premium billing, collection, and remittance. The Exchange, either directly or indirectly, will need to generate bills, process electronic funds transfers or credit card payments, and generate receipts, all with appropriate security protocols in place. Uniform policies will need to be established across carriers with regard to enrollment, billing cycles, collections, late payments, and termination for non-payment. Many of these requirements are set forth in the law—and further defined in the Notice of Proposed Rulemaking (NPRM) issued by the Centers for Medicare and Medicaid Services (CMS)[3]—and will need to be addressed by Alabama's Exchange.

The complexity of the billing and collections of funds—and the extent to which the Alabama Exchange handles this responsibility—will differ for the individual market Exchange vis-à-vis the Small Business Health Options Program (SHOP) Exchange. Alabama's Exchange may choose not to assume responsibility for the management of these financial transactions in the individual market, but will, at a minimum, need to aggregate premiums for employers that purchase coverage through the SHOP Exchange.

Billing individual purchasers is a relatively straightforward, one-to-one relationship (the individual or family receives a monthly invoice and remits the full payment to the insurer). However, for individuals eligible for an advance premium tax credit (subsidy), the federal government will pay a portion of the premium, and the Exchange or QHP issuers will need to develop a process to bill enrollees for their share of the monthly premium and the US Treasury for the federal government's share.

In the SHOP Exchange, billing may be a many-to-many reconciliation (many employees enrolled in health plans offered by different health insurers). Under the employee choice model required by law and defined further in the proposed federal regulations,[4] employees will be allowed to select from a number of QHPs offered by the health insurers that participate in the Alabama Exchange.

With employees able to select from a number of QHPs offered by different health insurers, without a centralized and coordinated premium billing system, an employer would face the prospect of receiving monthly invoices from the different health insurers selected by their employees and needing to establish relationships with each of the QHP issuers. An employer, particularly a small employer, is unlikely to opt for these additional administrative requirements.

[3] HHS, 45 Code of Federal Regulation Parts 155 and 156, "Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans," Proposed Rule, July 15, 2011.

[4] "(c) *Payment by qualified employers.* The Exchange must accept payment of an aggregate premium by a qualified employer pursuant to § 155.705(b)(4)." *Federal Register*, Vol. 76, No. 135, Proposed Rules, "Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans," July 15, 2011, p. 41916.

As a result, the Exchange will need to administer premium billing, collection, and remittance on behalf of the employers and the health insurers. The "SHOP Exchange" section below describes the employee choice model and the need for the Exchange to handle monthly financial and administrative transactions.

Individual Market Exchange

The individual market Exchange has three basic options with regard to its role in billing, collecting, and remitting premiums. It can

- provide information to the health insurers on the enrollment of an individual or family, as well the applicable advance premium tax credit and cost sharing reduction, but otherwise take no part in the actual billing and collection process;
- facilitate the payment of premiums by creating an electronic pass-through; or
- bill enrollees, collect premiums, and remit payments to the carriers.

At a minimum, the Exchange will need to provide QHP issuers with information on enrollees' eligibility for, and level of, advance premium tax credits and reduced cost sharing.

If the Exchange acts as a conduit for premium payment transactions—including processing and tracking payments, applying premium tax credits, and managing premiums in the individual market—the Exchange will also need to track delinquent payments and could be responsible for administering the advance premium tax credits that will be provided by the federal government. The Exchange could coordinate the distribution of advance premium tax credits with the federal government, thereby alleviating the need for the health insurers to set up an interface with the federal government. The Exchange would need to collect payments from two sources (the federal government and the enrollee) for one subscriber (the individual or family) and remit the applicable full premium to the QHP issuer.

Although the law directs the Secretary of the Treasury to make advance premium payments to the issuers of QHPs, having the Exchange set up a centralized premium payment process for all QHP issuers (in lieu of having each health insurer establish an interface with the federal government) may save administrative effort and cost. This issue should be explored further with the carriers that may offer coverage through Alabama's Exchange.

Regardless of the premium billing, collection, and reconciliation process established by Alabama's Exchange, the law and the proposed regulations require Exchanges to allow enrollees to pay their share of premiums directly to the QHP

issuer, if they choose.[5] This requirement may mean that two payment options will be available to individual purchasers—direct to the QHP issuer or through the Exchange.

SHOP Exchange

In contrast to the options in the individual market Exchange—and the possibility that Alabama's individual market Exchange will not be actively involved in premium billing, collection, and remittance—the CMS regulations require the SHOP Exchanges to serve a central role as premium aggregator on behalf of employers and health insurers. This is primarily due to the requirement that the SHOP Exchange offer employers the option of allowing their employees to select from a number of QHPs offered by multiple insurers.

The SHOP Exchange allows small employers to offer employees health plans from different health insurers, in much the same way that large employers offer their employees different health plan choices. In the current market, small employers that provide employer-sponsored insurance are generally not allowed—by insurers—to offer more than one health carrier to their employees. In addition, most employers offer their employees only one health plan.

Under the employee choice model, an employer will be allowed to select a benefit tier (Platinum, Gold, Silver, or Bronze), establish the amount of premium contribution for individual and family coverage, and facilitate having its employees choose a QHP from the insurers participating in the SHOP Exchange. Under this purchasing model, employees may be enrolled in plans offered by different QHP issuers. As displayed in Figure 1, without a centralized premium billing, collection, and reconciliation system, an employer would receive monthly invoices from each of the health insurers selected by the employees.

Small employers will not be allowed to purchase high deductible health plans (HDHP) through the Exchange, nor will they be allowed to purchase HDHPs outside the Exchange. The law limits the maximum upfront deductible for health plans purchased by small employers, and small group health plans may not have an upfront deductible that exceeds $2,000 for single coverage and $4,000 for family coverage.[6] These limits do not apply to the individual market, although the 60 percent actuarial value minimum for Bronze level plans will effectively cap the amount of upfront deductible that may apply to individual HDHPs sold through the Exchange. With the exception of the amount of the upfront deductible, the Bronze level plans will be of comparable actuarial value to an HDHP.

To minimize the administrative burden of employers needing to pay more than one insurer, as well as the administrative requirements of insurers needing to bill

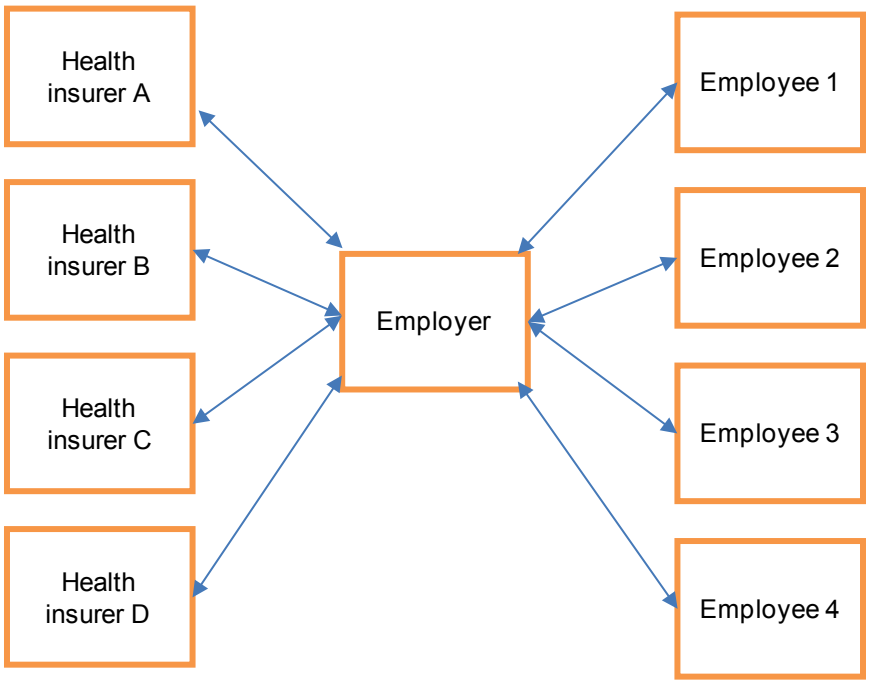
[5] ACA, Public Law 111-148 § 1312(b), and *Federal Register*, Vol. 76, No. 135, section 155.240, paragraph (a), July 15, 2011, p. 41916.

[6] ACA, Public Law 111-148 § 1302(c)(2)(A)(i)(ii).

employers for a subset of employees, the Exchange will be responsible for developing a consolidated bill, collecting premiums from the employers, and distributing premiums to the appropriate QHP issuers. The Exchange will need to

- develop a single monthly bill for all of the QHPs in which an employer's employees are enrolled;
- prepare and submit a single invoice for an employer, which reflects the employees' health plan choices;
- facilitate the collection of premiums from the employer; and
- distribute premiums to the appropriate QHP issuers.

Figure 1. Monthly Premium Billing, Collection, and Remittance without Exchange

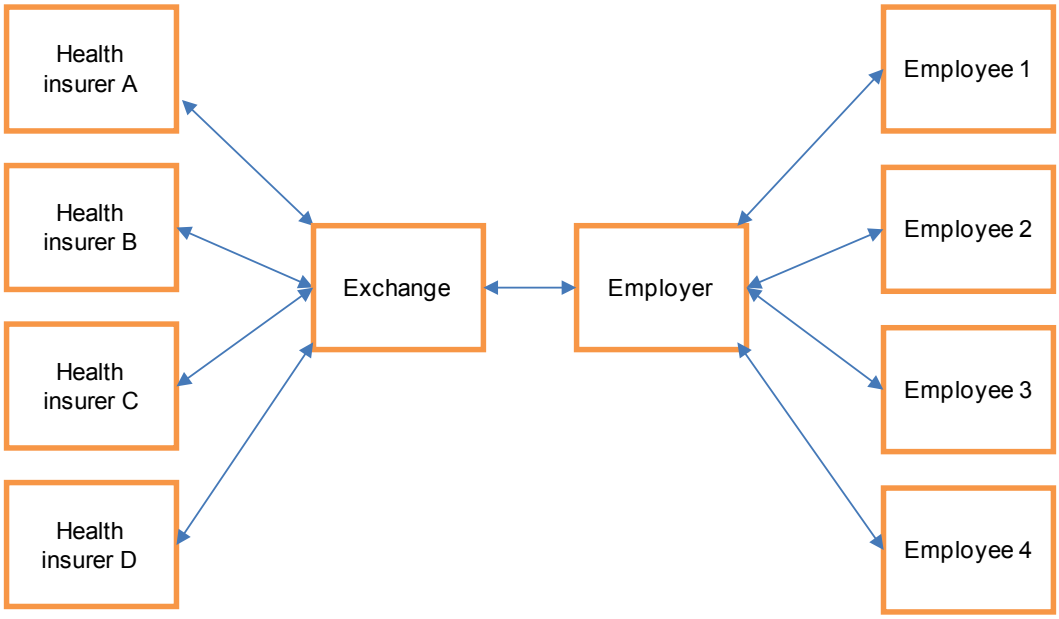


From an employer's perspective, the prospect of paying multiple insurers would greatly diminish the attractiveness and potential value of purchasing coverage through the Exchange. In addition to receiving multiple invoices and issuing multiple checks for employee coverage, if premium billing and other administrative functions are not centralized within the Exchange, the employer would need to deal with different carriers to handle midyear changes in employment (such as new employees eligible for coverage and employees that leave the firm), off-cycle changes in status for existing employees (such as marriage, divorce, or the birth of a child), and other administrative tasks now handled by the insurer or a producer.

As displayed in Figure 2, the Exchange will need a system sophisticated enough to aggregate employer payments, report and collect amounts due to multiple carriers, bundle the payments by carrier across multiple employers, and reconcile the payments due to the carriers for multiple employees and employers.

Private-sector vendors provide this service in many markets, and vendors are developing billing solutions that the Exchange may leverage. However, some customization will be required for billing multiple sources and tracking the flow of premiums, such as those between Treasury and QHP issuers, individuals and the Exchange or QHP issuer, and employers and the Exchange. Billing and collection capabilities can either be built by Alabama's Exchange or outsourced to one of several vendors in the market.

Figure 2. Monthly Premium Billing, Collection, and Remittance with Exchange



The Exchange will have responsibility for facilitating and coordinating premium payments in the SHOP Exchange, and may choose to centralize premium payments in the individual market Exchange, but it will not be liable for payment. The preamble to the July 15, 2011, NPRM includes the following qualifier with regard to financial liability of the Exchange if it facilitates the payment of premiums: "We clarify that premium collection by the Exchange does not make the Exchange liable for payment. For example, if an individual is late making a payment or misses a premium payment, the Exchange would not have to make a payment on behalf of an individual."[7]

Employers with lower-wage workers that offer employer-sponsored insurance may be eligible for premium tax credits for up to 50 percent of the employers' share of the premium for up to 2 years. This tax credit will be available to small

[7] *Federal Register*, Vol. 76, No. 135, July 15, 2011, p. 41879.

businesses with fewer than 25 employees and average wages below $50,000. To be eligible for the credits, small employers must purchase their employer health plan through the SHOP Exchange. Unlike the advance tax credits provided to individual purchasers, the employer tax credits will be provided to the employer at the time they file their taxes. Because the tax credits will not be provided in advance, the Exchange will not be responsible for informing the Internal Revenue Service or other federal agencies of delinquent payments by employers.

NAVIGATORS

Pursuant to the requirements of the ACA, the Exchange will need to contract with outside entities that can assist individuals, and possibly small employers, with eligibility and enrollment. The law requires the Exchange to award grants to navigators, which will be responsible for informing people of their health coverage options and helping individuals enroll in a health plan or in other publicly subsidized health coverage programs.

Navigators are entities such as trade, industry, and professional associations; chambers of commerce; community-based nonprofit groups; and other groups that have established or can readily establish relationships with employers, employees, consumers, or self-employed individuals.

Navigators will be responsible for the following:

- Conducting public education activities to raise awareness of the availability of QHPs through the Exchange
- Distributing "fair and impartial" information concerning enrollment and the availability of premium subsidies and cost-sharing reductions
- Facilitating enrollment in QHPs
- Referring people to the appropriate agency or agencies if they have questions, complaints, or grievances
- Providing information in a culturally and linguistically appropriate manner.

The ACA prohibits health insurers from serving as navigators and navigators from receiving "direct or indirect payments" in connection with the enrollment of an individual or an employee in a QHP.[8] This latter exclusion may affect whether producers (insurance agents or brokers) can effectively serve as navigators.

The Exchange will need to establish a selection process for awarding grants to navigators. Most important, under the current law and proposed regulations, federal funds may not be used to fund the navigators program. This prohibition is

[8] ACA, Public Law 111-148 § 1311(i)(4)(A)(iii).

complicated by the requirement under the NPRM that navigators assist people during the initial open enrollment period, which will begin 3 months before coverage is in effect (open enrollment will begin October 1, 2013, for coverage effective January 1, 2014).[9]

Exchanges are expected to use their operating revenues to fund the navigators program. Because the Exchange may not be able to assess fees and collect revenues before people are enrolled in coverage, funding navigators prior to enrollment will be a challenge and may require the state to advance the funds necessary to support this function before the Exchange collects fees to fund the navigators program. With state revenues already stretched thin, relying on Alabama's general fund to support the Exchange's navigators program may be problematic. Regardless of the source of revenue, the Exchange will need to set up a process for selecting and funding navigators, possibly by establishing standards and certification criteria. The navigators will receive grants, and the Exchange will need to facilitate the payment and monitor the activities and uses of these funds.

Finally, if Alabama chooses to permit or require navigators to provide information and support for Medicaid and ALL Kids outreach, education, and enrollment, it will be able to leverage federal funding for a share of these expenditures. The agreement or contract with the navigators will need to include a means for identifying costs or attributing expenditures to Medicaid and ALL Kids in order for the state to claim federal matching funds.[10]

PRODUCERS

Many, if not most, of the people purchasing coverage through the Alabama Exchange will be new health insurance consumers. In light of this fact, it will be critical for the Exchange to provide people with well-informed assistance as they go about selecting a health plan that works for themselves and their family. Health insurance producers may be important front-line agents in filling this role and providing Exchange consumers with advice and assistance in enrolling in a qualified health plan.

The role of producers in Alabama is somewhat complicated by the fact that the dominant insurer in the state, Blue Cross Blue Shield of Alabama, uses in-house agents and does not use the services of producers. If Alabama's Exchange decides to leverage the expertise and experience of producers to help individuals and employers enroll in coverage, it may need to establish a policy—and may need to establish a commission schedule—that allows producers to sell all of the QHPs offered by the Exchange and to be compensated equitably across all QHP issuers.

[9] The NPRM states that CMS "is considering a requirement that the Exchanges ensure that the navigator program is operational with services available to consumers no later than the first day of the initial open enrollment period." *Federal Register*, Vol. 76, No. 135, July 15, 2011, p. 41878.

[10] *Federal Register*, Vol. 76, No. 135, July 15, 2011, p. 41878.

If the Exchange is to succeed in promoting competition and encouraging more health insurers to enter the Alabama market, an objective noted by the Governor in his establishment of the Alabama Exchange Study Commission, it will need to ensure that consumers are provided information on all of the QHPs available. Leveling the playing field with regard to producer compensation should mitigate any incentive to enroll a consumer in a QHP offered by a particular health insurer.

In addition to the questions of whether and how to use producers, the Alabama Exchange may need to compensate producers at reasonable commission rates while maintaining a low administrative cost structure. Whether to have commission parity inside and outside the Exchange will be an important policy decision.

The manner by which the two existing "public" Exchanges use and compensate brokers and agents (i.e., producers) may be informative. In Utah, brokers are paid $37 per subscriber for enrolling people in coverage through that Exchange, while in Massachusetts brokers are paid 2.5 percent of the monthly premium for each policy sold through the Commonwealth's Exchange. The Utah Exchange's broker fee is reportedly marginally higher than the prevailing market rate in that state, while the Massachusetts Connector's broker fee is slightly below the market rate in the Commonwealth.

In the individual market, enrollees eligible for advance premium tax credits cannot receive these subsidies unless they purchase coverage through the Exchange. However, for higher-income people not eligible for subsidies, premiums will be the same inside and outside the Exchange, and if producer compensation is materially different inside the Exchange, a producer could steer the consumer to purchase coverage either inside or outside the Exchange, depending on the producer compensation schedule.

In the small employer market, employers eligible for premium tax credits in 2014 and beyond will only have access to these tax credits if coverage is purchased through the Exchange. This financial incentive may drive some employers to the Exchange, perhaps regardless of the producer compensation arrangement. These employer tax credits are provided to employers—not employees—that purchase coverage through the Exchange, and will be limited to 2 years of coverage.

A secondary concern if producer compensation is lower inside is that the Exchange could become susceptible to "street underwriting," where producers direct higher-risk enrollees to the Exchange and send healthier enrollees to carriers outside the Exchange, where commission levels may be greater. This could result in adverse selection and higher cost in the Exchange compared with the outside market. This may be particularly problematic if some carriers do not participate in the Exchange and operate only in the non-Exchange market.

Such activities by producers allegedly contributed to the downfall of previous Exchanges, including California's PacAdvantage, which ceased operations in 2006. However, PacAdvantage differs from the Exchanges under the ACA in that

PacAdvantage's enrollees constituted a separate risk pool. Because Exchange enrollees will be part of each carrier's overall individual or small group market risk pools, the adverse selection issues between the Exchange and non-Exchange markets are largely addressed.

In summary, the Exchange will need producers to help consumers, many of whom will be new to the purchase of health insurance and will need assistance in selecting a health plan. In structuring a compensation arrangement for products, the Exchange will need to be cognizant of the fees paid to brokers for health plans sold outside the Exchange and structure a compensation schedule that reflects the broader health insurance market and the valued role of producers in the Alabama market.

COST ALLOCATION

As noted above with regard to navigators, for Exchange services and functions that support or otherwise involve Medicaid or ALL Kids, the state may be able to leverage federal matching funds for a portion of the costs. For example, if the eligibility system used to determine eligibility for the Exchange is also used for Medicaid and ALL Kids, Alabama should be able to claim federal funding for some of these expenses. If the state chooses to establish a single call center to handle eligibility or enrollment for all publicly subsidized health coverage programs, it will want to establish a cost allocation method to draw down applicable federal funding. As Alabama maps out the implementation and operations plan for the Exchange, it should identify services and functions that may be shared by state-federal programs to leverage federal funding to help defray the expenses that would otherwise be borne by Alabamians.

FINANCIAL SUSTAINABILITY

Pursuant to the ACA, the Exchange will need to be financially self-sustaining by calendar year 2015. Alabama will need to establish a means to support Exchange operations once federal funding ends at the close of the first year of operations (December 31, 2014).[11]

SUMMARY

Table 1 summarizes the major functions and corresponding responsibilities, resources, and estimated costs associated with these functions.

[11] See Note 2.

Table 1. Exchange Finance Functions

Responsibilities	Resources	Cost estimates
Internal controls and financial management		
• Develop financial management plan. • Establish and execute financial controls and audit protocols. • Account for all activities, receipts, and expenditures. • Prepare an annual report to the HHS Secretary. • Comply with annual federal audits. • Publish the costs of licensing, regulatory fees, and other payments.	• Exchange staff with finance and accounting expertise. • Financial management and accounting software or system.	• Exchange Staff costs range from $2,500,000–$3,000,000 depending on number and expertise. • Financial management and accounting software costs from hundreds of dollars for off-the-shelf products to tens of thousands of dollars for ERP systems.
Premium billing, collection, and remittance		
Individual market		
• Generate bills, process electronic funds transfers or credit card payments, and provide receipts.	• Provide information to the health insurers on the enrollment of an individual or family, as well the applicable advance premium tax credit and cost sharing reduction, but otherwise take no part in the actual billing and collection process. • Facilitate the payment of premiums by creating an electronic pass-through. • Bill enrollees, collect premiums, and remit payments to the carriers.	• Dependent on whether the Exchange plays an active role in premium billing, collection, and remittance. • Minimal cost if the Exchange opts not to take part in billing and collection process. • As much as $6 to $10 per enrollee per month if the Exchange assumes responsibility for premium billing, collection, and remittance.
Small group market		
• Aggregate premium on behalf of employers and health insurers. • Develop a single monthly bill for all QHPs in which an employer's employees are enrolled. • Prepare and submit a single invoice for an employer, which reflects the employees' health plan choices. • Facilitate the collection of premiums from the employer. • Distribute premiums to the appropriate QHP issuers.	• Bill employers, collect premiums, and remit to the appropriate health insurer.	• Dependent on enrollment volume. • Estimated $6 to $10 per enrollee per month.

Table 1. Exchange Finance Functions

Responsibilities	Resources	Cost estimates
Outreach and marketing		
• Conduct public education activities. • Distribute information on enrollment and availability of premium subsidies and cost-sharing reductions. • Facilitate enrollment in qualified health plans. • Refer people to the appropriate agency or agencies if they have questions, complaints, or grievances.	• Develop selection process and navigator certification or licensing standards. • Grants manager and overseer/ coordinator of navigator activities.	• Exchange staff to establish and monitor navigators program: $75,000–100,000 (amount included above is under staff cost estimates). • Grants ranging from $250,000 to $750,000, depending on the preference of the Alabama Exchange.
Producers		
• Help individuals, employers, and employees compare plans and enroll in coverage.	• Leverage existing system of health plan distribution and allow health insurers to pay producers directly. • Establish role for producers across all QHP issuers and determine fee schedule.	• Dependent on role of producers and compensation schedule.
Cost allocation		
• Identify services and functions that may be shared by state-federal programs, which can be used to leverage federal funding.	• Update state's cost allocation plan to account for Exchange services that may support Medicaid and ALL Kids programs.	• $10,000–15,000.
Financial sustainability		
• Establish a means to support Exchange operations once federal funding ends at the close of the first year of operations (December 31, 2014).	• A more detailed analysis is available in the *Financial Sustainability of the Alabama Exchange* report.	• Annual ongoing budget estimated between $34.0 to $49.6 million.

The ACA requires states to comply with many provisions regarding financial management and program integrity. However, it does allow states flexibility and autonomy when determining how to meet these obligations. Alabama must decide to which extent the Exchange responds to these responsibilities. While the federal government will fund the Exchange through December 31, 2014, the state of Alabama must sustain these functions from January 1, 2015. The costs of many of these functions, coupled with existing state budget constraints should motivate Alabama to seek cost efficiencies in many of these functions. This would include automating many of these functions in the early years, as well as leveraging the capabilities of other state agencies. Most important, the state should capitalize on existing experience in relevant areas. Many of these functions, particularly related to program integrity are performed across many state agencies. Using lessons learned and even methodology from other agencies will allow Alabama to meet these Exchange requirements in a cost-effective way.