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Health Benefit Exchange
Design Options for Safety Net Plans

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Executive Summary

Ingenix Consulting was retained by the Association for Community Affiliated Plans (ACAP) to draft a paper that discusses the top key areas that states will consider as they design and implement their Health Benefit Exchanges ("Exchanges"). The key factors discussed in this paper were narrowed to focus on those that will have the greatest potential impact on ACAP's members, which are primarily safety net health plans that serve Medicaid and other low income populations.

As of the date of the paper, the Department of Health and Human Services (DHHS) has not published draft regulations for implementing Exchanges; therefore, there are many unknowns as to how prescriptive the federal regulations will be with respect to the design of Exchanges. However, the Patient Protection and Accountable Care Act (ACA) language does provide flexibility to states in a variety of areas such as the method of how a state Exchange will qualify plans to offer products in the Exchanges and what role the Exchange will play in regulating its market.

Because each state has a unique health care landscape, there is no right or wrong answer with regard to Exchange design; therefore, this paper is intended to identify potential key issues regarding the design of Exchanges that impact safety net plans and to highlight options to address the issues. In recognition that there is no "one size fits all approach," ACAP adopted a set of guiding principals when addressing Exchange design issues with policy makers:

- Provide options that offer the best value for low income and vulnerable populations.
- Avoid barriers to participation that would disproportionately impact the ability of Medicaid managed care plans, including safety net health plans, to participate in Exchanges.
- Encourage and support continuity of coverage for individuals and families that may shift between the Exchange and other sources of coverage, e.g., Medicaid/Children's Health Insurance Program (CHIP).
- Look to build on existing Medicaid/CHIP systems, processes and policies, which are familiar to consumers who will be interacting with the Exchange.
- Establish a robust process for stakeholder input that will allow for the design of a highly efficient Exchange that connects individuals with the most appropriate coverage.

Approach

The ACAP executive staff and Ingenix Consulting took several steps to identify the key Exchange design topics and to identify the issues that are included in this paper:

- Ingenix Consulting staff interviewed individuals from health plans in Massachusetts to get their perspective on offering products within the Commonwealth Connector. Ingenix Consulting staff also interviewed California health plans to learn more about the background of the recent California Exchange — enabling legislation that was recently signed into law. Former leadership of the California PacAdvantage program was also interviewed to learn about real-world lessons learned in Exchange design.
- ACAP staff surveyed its executive committee members on their opinions regarding the key design issues. This survey was followed up with a teleconference that included broader ACAP members to get additional feedback on the top areas identified by the executive committee.
- The top issues were presented at the fall 2010 ACAP meeting during which there was interactive dialog among the health plans to further refine the issues and options.

NOTE: All legislative footnote references refer to sections in the ACA as signed on March 23, 2010.

The following list provides a brief description of each of the state Exchange design areas that ACAP members identified as most important to safety net plans.

Key Exchange Design Areas

1. Structure and Role of the Exchange

The first decision a state must make regarding the implementation of the Exchange is whether the state itself wants to administer it, or does the state want to defer that responsibility to the federal government? That decision will be based on a variety of factors, including state budget pressures, appetite for administering a complex program and desire to cede local control to the federal government. If the state administers the Exchange, then the next decision is 1) will they operate both an American Health Benefits Exchange for individuals and a separate Small Business Health Options Program (SHOP) Exchange, or 2) will the state administer one Exchange for both individuals and small businesses? A secondary consideration to the decision to administer a single Exchange is whether the individual and small group pools should be merged into a single pool, or should they remain separate.

Once the state decides to administer the Exchange and how to structure the risk pools, then it must address the role of the Exchange. Will the Exchange be structured as a passive clearing house for health insurance products, or will the state assume a more active role in selecting the qualified health plans and regulating the Exchange benefits? In addition to the degree of involvement in regulating the market, the Exchange can assume collective administrative functions on behalf of the qualified plans, such as premium and subsidy collections. Will it take on additional functions, and if so, how will it be compensated for those responsibilities? The answers to all of these questions will determine the degree of the barriers that the Exchange design will present to safety net plans.

2. Achieving Continuity of Care

A high percentage of individuals who will be eligible for premium subsidies in the Exchange will have had Medicaid, or will have touched the Medicaid or CHIP programs through their children. Lower income populations tend to churn in and out of Medicaid. Therefore, in order to achieve continuity of care, safety net plans may want to consider offering a continuum of products designed for the low income populations who may have children in CHIP and who may churn on or off of Medicaid.

3. Benefit Design Standardization

Administrators of the Exchanges will have the option to restrict the number of products offered through the Exchanges and within each of the five designated benefit levels (bronze, silver, gold, platinum and catastrophic). Commercial insurers have a long history of designing multiple products in order to manage the risk of the population. Safety net plans do not have that experience and may be adversely selected as a result. Limiting the number of products within a benefit level will offer a more level playing field with respect to consumer transparency as well as risk selection by individuals — especially since the premium subsidy benchmark is the second lowest priced product in the silver benefits level.

4. Accreditation/Deeming

The type of accreditation required to become a qualified plan is unknown as of the date of this paper. However, in order to ensure there are no barriers to participation by a health plan that otherwise meets all the other qualification standards, a phased in approach to accreditation may be a reasonable approach to qualification and is permissible under the ACA.

5. Licensure and Reserves

Safety net plans may not have available resources or sources of funding to meet required financial reserves to be licensed and in good standing with their state regulatory authority. States may consider

taking a similar approach to reserving requirements as with accreditation: allowing a multi- year phased-in approach, which would permit plans to build upon required reserves.

6. Risk Adjustment

The ACA that states establish a risk adjustment methodology. The goal of the risk adjustment is to smooth the risk of the health plans. This will mean that plans that are paid a premium in excess of a certain baseline risk plus margin will rebate a portion of the premium back to the regulating body. The regulating body, in turn, will take those rebates and reimburse health plans with losses that exceed the baseline risk. There are multiple methodologies for risk adjustment, and states should take an approach that creates a level playing field.

7. Plan Ratings — Quality and Price

There is evidence from the Medicare Advantage program Stars rating system to suggest that health plans serving larger proportions of low income beneficiaries will have lower performance ratings. It can be expected that based upon this experience, health plans in the Exchange that have a large share of the subsidized individual Exchange population can expect similar outcomes. In addition to the population mix, safety net plans may have higher cost products due to the requirement that Federally Qualified Health Centers (FQHCs) and their look-alikes are reimbursed at the prospective payment system; therefore, price may not be comparable due to differences in network.

8. Basic Health Plan Option

The ACA provides for an alternative to the Exchange for individuals with incomes from 134 percent to 200 percent of the federal poverty level (FPL). The basic health plan option will be attractive to State Medicaid programs and to health plans who currently serve this population through waivers or who are interested in capturing this cohort within the premium subsidized Exchange population because of their mission fit and risk characteristics, and because they will churn in and out of their Medicaid programs.

Introduction

On March 23, 2010, President Obama signed the Patient Protection and Affordable Care Act of 2010 (ACA).[1] A central component of reforming the health insurance market is the establishment of Exchanges in each state and the District of Columbia. The goal of the Exchanges is to provide an array of affordable health insurance options to U.S. citizens and legal residents.

The ACA provides states with flexibility on some aspects of the structure of the Exchanges. Like health plans will do for insurance coverage outside the Exchange, states may implement two general risk pools — one for all individuals who are eligible to purchase health care coverage through the Exchange and another for small groups. The latter is offered through the SHOP. States have the flexibility to combine the two pools into a single risk pool.

Low income individuals will only be able to receive premium subsidies to purchase health insurance through the Exchanges. Exhibit 1 shows the federal poverty levels that make an individual eligible for subsidies, the approximate household income for a family of four associated with the income level and the percentage of the amount of the premiums that the individuals will pay after the subsidy is applied.

Exhibit 1: Premium Subsidies within the Exchange

Federal Poverty Percentage	Average Income for a Family of Four	Individual Premium Responsibility
Up to 133%	$22K–29K	2.0%
133–150%	$29K–33K	3.0–4.0%
150–200%	$33K–44K	4.0–6.3%
200–250%	$44K–55K	6.3–8.05%
250–300%	$55K–66K	8.05–9.50%

Through expanded eligibility and premium subsidy programs, many safety net plans are currently serving individuals who will be eligible for subsidized health insurance through the Exchanges.

The Exchanges will be fully operational beginning in 2014; however, to be operational by that date, state and federal planning must begin far before 2014. In fact, a number of states began taking action in 2010. No later than January 1, 2013, the DHHS will determine whether or not a state will be prepared to operate the Exchange by 2014 and whether the federal government will be required to operate the Exchange in lieu of the state — either directly or though a contract with a non-profit agency.

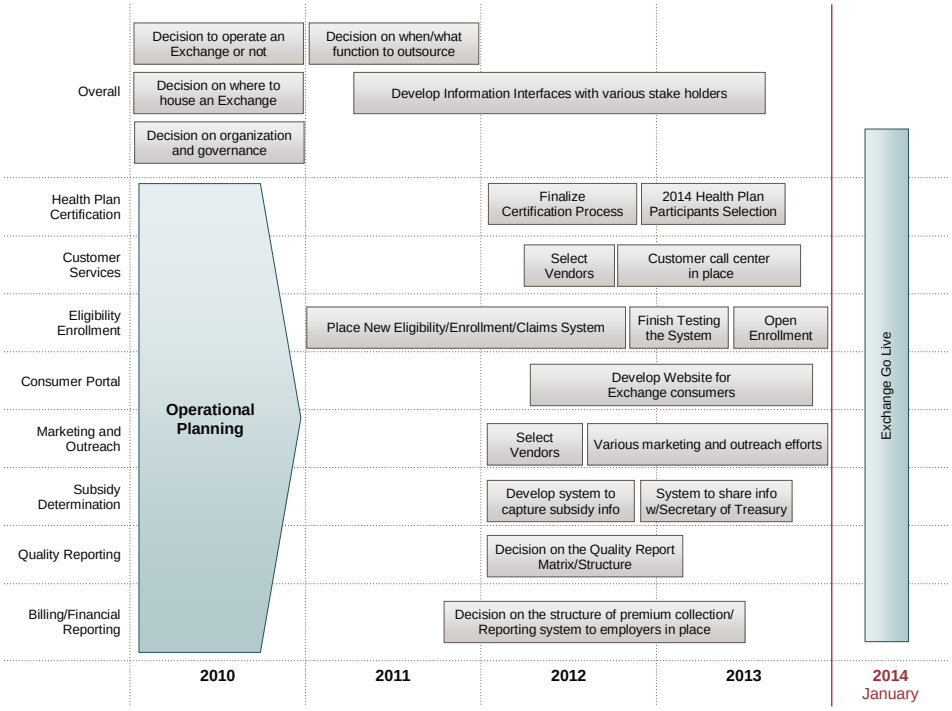
States are also permitted to form compacts with other states to create regional/multi-state Exchanges.[2] States may require a health plan to be licensed in each of the compact states or be licensed in its domiciled state and have other compact states develop means for accepting other states' licensure for deeming purposes.

[1] PPACA, P.L 111–148, as amended by P.L. 111–152.
[2] §1333

While the multi-year state Exchange planning process will be guided by federal regulation, states are beginning to make key decisions prior to their issuance. Exhibit 2 presents a high-level timeline for state Exchange implementation activities.

Exhibit 2: Exchange Implementation Timeline

To become operational by 2014, states need to be prepared to meet key milestones.



Exchanges may only contract with qualified health plans. The ACA identifies the following types of organizations that will be eligible to seek qualification:

- Private and pubic health plans[3]
- Consumer operated and oriented plans[4]
- Multi-state health plans[5]
- Primary care medical home plans[6]
- Child-only health plans[7]

[3] §1301(a)(1)(C)
[4] §1301(a)(2)
[5] §1334
[6] §1301(a)(3)
[7] §1302(f)

Health plans must meet a number of criteria to qualify for participation in the Exchange.

- A health plan is certified by the Exchange. The certification may include a seal or other indication of approval, showing that the health plan meets the certification criteria. There are several requirements for a plan to be certified. The following is a minimum list of certification criteria.[8] A health plan must:
  - Meet marketing requirements and not employ marketing practices or benefit designs that have the effect of discouraging enrollment by individuals with significant health needs
  - Ensure a sufficient choice of providers, meet adequacy standards and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers
  - Include safety net providers (where available) that serve predominantly low-income, medically underserved individuals within health insurance plan networks
  - Be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set® (HEDIS®) and patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey. Also be accredited with consumer access, utilization management, quality assurance, provider credentialing, complaints/appeals, network adequacy, network access and patient information programs. Must be accredited by any entity recognized by the secretary for the accreditation of health insurance issuers or plans (as long as any such entity has transparent and rigorous methodological scoring criteria) or receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans
  - Implement a quality improvement strategy
  - Utilize a uniform enrollment form that qualified individuals and qualified employers may use (either electronically or on paper) when enrolling in qualified health plans offered through such Exchange
  - Utilize the standard format established for presenting health benefit plan options
  - Provide information to enrollees, prospective enrollees and to each Exchange in which the plan is offered on any quality measures for health plan performance
  - Report to the secretary (on a minimum of an annual basis) and in such a manner as the secretary shall require. Pediatric quality reporting measures must be consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act
- A health plan must provide the essential health benefits package described below:[9]
  - Ambulatory patient services
  - Emergency services
  - Hospitalizations
  - Maternity and newborn care
  - Mental health and substance use disorder services
  - Prescription drugs
  - Rehabilitative services and devices
  - Laboratory services
  - Preventive and wellness services
  - Chronic disease management
  - Pediatric services (including oral and vision care)

[8] § 1311(c)
[9] § 1302

- A health plan must be licensed and in good standing to offer health insurance coverage in each state in which such issuer offers health insurance coverage under this title
- A health plan must agree to offer at least one qualified health plan in the silver level and at least one plan in the gold level in each Exchange
- A health plan must charge the same premium rate for each qualified health plan without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent
- A health plan must comply with all regulations and requirements the Exchange may establish

None of the Exchange requirements are insurmountable for safety net plans. In fact, many health plans may already be in substantial compliance with these requirements, and therefore, are advantaged in Exchange participation because many are similar to Medicaid managed care requirements. Thus, every safety net plan should take a strategic look at their current business and future opportunities that may be present with the implementation of the ACA.

Health Benefit Exchange Market Considerations

The first step to evaluating Exchange participation is to understand the likely impact of expanded insurance coverage and the shifts and changes in existing coverage with full implementation of ACA in 2016.[10] The landscape of health insurance coverage will change dramatically for many Americans. Exhibit 3 is the national data output of the Lewin Health Benefit Simulation Model (HSBM). The HSBM shows the current sources of health care coverage (projected 2011 populations) and the shifts in population cohorts to future sources of health care coverage.[11]

Exhibit 3: Health Benefits Simulation Model

Change in sources of coverage under the PPACA assuming full implementation in 2014 (millions)

Current Source of Coverage		Private Coverage Through Exchange			Private Coverage out of Exchange		Medicaid & CHIP (excl duals)	Medicare, TRICARE & Other	Uninsured
		Employer	Individual		Employer	Individual			
			With Subsidy	Without Subsidy					
Employer Workers and Dependents	154.4	6.8	8.6	3.9	130.5	0	3.7	0	1.0
Non-Group	14.3	0.4	3.5	0.6	2.1	6.7	0.7	0	0.2
Employer Retiree	3.7	0	0	0	3.7	0	0	0	0
TRICARE	6.1	0	0	0	0	0	0	6.1	0
Medicare	33.2	0	0	0	0	0	0	33.2	0
Medicare Dual Eligible	6.8	0	0	0	0	0	0	6.8	0
Medicaid/CHIP	41.7	0.6	0.4	0.1	1.4	0	39.2	0	0
Uninsured	49.2	2.4	7.6	2.2	7.6	0	11.0	0	18.5
Total	**309.5**	**10.1**	**20.1**	**6.8**	**145.3**	**6.7**	**54.9**	**46.2**	**19.7**

The HSBM provides data on projected changes in coverage that is compelling for safety net plans as they consider participation in the Exchanges:

- An estimated 23 million people currently covered through an employer group will be covered through the Exchange or through Medicaid
- A projected increase of 13 million for Medicaid-eligible individuals

[10] Modeling full implementation is extended to 2016 for insurance enrollment take-up rates.
[11] See Appendix 1: Lewin Health Benefits Simulation Model.

- An anticipated decrease of 30 million in the number of uninsured individuals
- An estimated 12 million of those currently uninsured will receive their coverage through the Exchange. Another 11 million will become Medicaid-eligible while the remainder will receive coverage through an employer
- An estimated 37 million will receive their insurance coverage through the Exchange. Of this 37 million, 20 million will be eligible for premium subsidies

These shifts in coverage will impact the current market share of payers with Medicaid and commercial lines of business. It is also expected that traditional Medicaid Managed Care Organizations (MCOs) and pure commercial carriers will look to expand into this new line of business, potentially resulting in an array of competitors. The increase for Medicaid eligibility to 133 percent FPL means that there will be greater interplay between Medicaid and commercial enrollment, especially with the subsidized individual Exchange products. This results in a natural fit with, or extension of, the mission of safety net plans and the subsidized individual Exchange consumers.

The Safety Net Plan Mission and Exchanges

Safety net health plans have traditionally served low-income populations. They are often sponsored by providers that have served the poor, such as community health centers and safety net hospitals. They are closely connected to their communities and frequently offer a wider array of services than just health care in order to help with the overall well-being of the consumers they serve. Because of the role that safety net plans have in serving the poor, they will have a natural and important role in the design and implementation of the Exchange. This is especially true in the areas of coordination between the Exchange, Medicaid and CHIP as well as designing products for the subsidized individual consumers, many of whom may have multiple touch points with the Medicaid and CHIP programs.

It is estimated that 20 million individuals will be eligible for subsidies through the Exchange.[12] Medicaid MCOs will have an interest in the individual subsidized Exchange population, which may have been Medicaid-eligible prior to the Exchange, may have had family members enrolled into the Medicaid or CHIP plan, or may have had similar health risks as the expanded Medicaid population. This is especially true for plans in states that have previously expanded health care coverage to low income, non-categorical adults and families through Medicaid 1115 Waivers[13] and state-only funded programs.[14]

It is plausible that these expansion and subsidy programs will be subsumed by a combination of the Medicaid expansion to 133 percent FPL and the implementation of the Exchanges in 2014. Safety net plans that have served these populations may want to offer an Exchange product to retain the members with incomes that exceed 133 percent FPL rather than lose enrollment.

In addition to the population shifts from low income programs into Exchanges, there will likely be an increased blending of Medicaid, CHIP and individual subsidized Exchange populations. States will be required to streamline Medicaid/CHIP/Exchange subsidy and eligibility determinations, which may mean single enrollment applications and eligibility determinations. Experience with the CHIP program shows that there is always a certain amount of Medicaid woodwork when determining eligibility for low income populations. A Medicaid MCO will want to have the opportunity to be selected or retained by an individual who is applying for an individual Exchange policy, but is Medicaid-eligible. Therefore, insurers may benefit from offering both Medicaid and Exchange products.

Given the volatility of employment, it can be expected that enrollment of low income populations will move between the Medicaid program and the Exchange. Having both Medicaid and Exchange offerings will help ensure continuity of care and possibly result in a more stabilized risk profile across the plan's membership.

Another example of the blurring of Medicaid/CHIP/Exchange is the family whose income is 185 percent FPL. The children will be CHIP-eligible and the parents will be eligible for subsidies in the Exchange. Many families will want to enroll in a single health plan; therefore, a plan that does not have both CHIP and Exchange products runs the risk of losing potential enrollment.

Safety net plans currently operate in highly regulated environments and as Medicaid MCOs are subject to the Balanced Budget Act (BBA) of 1997's managed care regulations.[15] The ACA requirements for plan certification are largely parallel to the BBA Medicaid managed care regulations. This framework plays to the strengths of safety net plans and provides them with an advantage over health plans that have not operated within such a highly regulated framework. Another advantage for safety net plans is that they generally operate at relatively low margins, often with Medical Loss Ratios (MLR) of at least

[12] Lewin Health Benefits Simulation Model.
[13] Examples include Indiana (Healthy Indiana Program), New Mexico (State Coverage Insurance), Vermont (Catamount), New York, (Parents with incomes up to 150% FPL), Minnesota (Minnesota Care) and Massachusetts (Commonwealth Care).
[14] Examples include Montana (Insure Montana) and New York (Healthy New York).
[15] 42 C.F.R. Part 438

85 percent because Medicaid plan payment rates are structured to provide low margins. Some states recoup a portion of capitation payments if the MLR is less than a certain percentage, such as 85 percent.

Participating in the Exchange can also be seen as a defensive move by safety net plans because at the same time the Exchange becomes operational, Medicaid eligibility will be expanded to 133 percent FPL. This will mean increased competition from new health plans wanting to enter the market. Preserving market share may necessitate Exchange participation.

Key Themes for Safety Net Plans…

…and how the Exchange should be structured

Many safety net plans have expressed an interest in potentially participating in the Exchange due to the mission fit, the population shifts in coverage and as a means of increasing and/or preserving market share. Currently, there are many unknowns regarding how the Exchange will operate. Federal regulations have not been issued and the full degree of state flexibility is not known. Not all states have decided whether they will even establish an Exchange or if they will relinquish the authority to the federal government. In spite of this uncertainty, and possibly because of it, there are opportunities for safety net plans as well as other insurers to advocate with their states' political structures for legislation, policy and the operational design of the Exchange and its products. At a minimum, safety net plans need to ensure that they are not disadvantaged and that there are no fundamental barriers to their participation in the Exchange. Safety net plans may also look to leverage some of their unique attributes to create opportunities.

The following are seven key areas for which safety net plans should develop a position and advocate to their legislators and policy makers. There is an eighth topic, The Basic Benefit Plan, that will also be discussed because, while not an Exchange product, whether or not to implement the Basic Benefit Plan will be part of the Exchange's design. The topics are:

1. Structure and Role of the Exchange
    a. Who should administer the Exchange — state or federal government?
    b. Should the state assume a passive or active role in qualifying health plans for the Exchange?
    c. Which common administrative functions should the Exchange operate?
    d. Should the state have one Exchange or two? If one, should the risk pools be integrated?
2. Achieving Continuity of Care
3. Benefit Design Standardization
4. Accreditation/Deeming
5. Licensure and Reserves
6. Risk Adjustment
7. Plan Ratings — Quality and Price
8. Basic Health Plan Option

The remainder of this section will address each of these nine areas separately. Individual states have different market dynamics from different baseline Medicaid and other safety net programs, different employer bases and different socio-economic profiles. As such, there is no single right answer for many of the issues addressed within the following topics. Different perspectives will be outlined for consideration by ACAP members as they strategically evaluate each perspective within the context of their individual states and local markets. If there is a clear recommendation that is applicable and universal across all safety net plans, it will be highlighted as such.

1. Structure and Role of the Exchange

The first area that safety net plans need to consider is the development of the overall Exchange model, including its roles and functions, as many of the other areas of importance will be determined by how the Exchange is structured. There are four primary topic areas that will be addressed:

a. Who should administer the Exchange — the state or federal government?

b. Should the Exchange assume a passive or active role in qualifying health plans?

c. What common administrative functions should the Exchange operate?

d. Should there be one or two risk pools?

a. Who should administer the Exchange — state or federal government?

ACA Provisions

ACA establishes a decentralized, state-based framework for the development of the Exchange.[16] However, the law does not mandate that states implement the Exchange. If a state does not elect to implement an Exchange or if DHHS determines that a state will not be capable of implementing an Exchange by January 1, 2014, then DHHS will establish an Exchange and operate it either directly or through a non-profit agency.[17]

Safety Net Plan Issues

In the current highly polarized and political environment surrounding the ACA, some states may elect to opt out of administering the Exchange at the state level. Some states may determine that operating an Exchange is not financially feasible. Although states technically have until January 1, 2013, to inform the federal government of their decision to opt out, in reality, a state will need to make the decision far earlier to avail itself of the federal planning and implementation grants and to develop the infrastructure to operate an Exchange. As of September 2010, The National Governors Association reported that, based on a recent blinded survey of their membership, 26 states indicated their intent to move forward with establishing an Exchange, two states indicated that they have elected not to establish an Exchange and the remaining states are undecided.[18]

The ACA provides the federal government with two options regarding the structure of a federally operated Exchange. They may establish a national Exchange or contract with a non-profit organization to administer the Exchange at the state level. In either case, they are not required to contract with local entities or an individual state. Assuming that the federal government will be required to operate Exchanges for multiple states, it is likely that that they would establish uniform rules under which the federal Exchanges would operate and these would be standard across the states. Uniformity will mean that safety net plans will have greater difficulty in influencing how the Exchange will be structured.

In the event that the federal government is required to operate an Exchange, it may elect to approach contracting at a national level with the multi-state plans. This approach would limit the federal government's burden of selecting, accrediting and rating plan performance by selecting health plans that operate across multiple states. In comparison, safety net plans are state and local market specific. Most do not operate in multiple states. They are often more integrated into the fabric of their community social service infrastructure and provide a community focus and connection to services that are needed by the lower income subsidized Exchange population.

A state-operated Exchange is potentially better positioned to factor in the needs of the various Exchange populations from language to culture to the role of safety net providers and safety net health plans.

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[16] §1311
[17] §1321(c)
[18] September 2010 AHIP Meeting for Medicare and Medicaid.

A state-based Exchange would likely provide safety net plans with a greater ability to participate in the Exchanges because of being local and closer to the needs of the community.

Options to Consider

Regionally based safety net plans are generally closely linked with and integrated into their local communities. They are largely not-for-profit organizations with missions directed at meeting the needs of their members and communities. Based on the Exchange's actual design, safety net plans will be better positioned to participate in the Exchanges if the state operates it rather than the federal government because the federal government may take a "one size fits all" approach.

Recommendation: In states where it appears that the state leadership is considering opting out and allowing a federally administered Exchange, safety net plans should work to influence state legislators to pursue the development of a state-operated Exchange. In states where the federal government will definitely operate the Exchanges, safety net plans should work with the federal government to ensure that there are no participation barriers in the federal Exchange. It is in the interest of the federal government to leverage their current, successful public/private partnerships with safety net plans in the Medicaid and Medicare Advantage programs.

Recommendation: States will need to demonstrate to the federal government by January 1, 2013, that they will be ready to operate an Exchange on January 1, 2104. In order to be ready, state-planning should start as soon as possible. Part of that planning should be a state-led steering committee or work group that develops a road map for Exchange implementation. It is important that the steering committee solicit input from all stakeholders, including top state policy makers, on the numerous options that the structure of the Exchange may take. Safety net plans should endeavor to participate in all types of stakeholder meetings including "behind the scenes" efforts where many decisions are often made. Safety net plans should also engage their state legislators as they draft Exchange-enabling legislation to ensure that there are no barriers to safety net plan participation.

b. Should the state assume a passive or active role in the Exchange's qualifying health plans?

ACA Provisions

The ACA requires that the Exchange conduct the following activities:[19]

- Qualify health plans for Exchange participation
- Certify, recertify and decertify health plans
- Operate a toll-free hotline
- Maintain a website where enrollees obtain comparative information on health plans
- Assign a rating to each qualified health plan offered through the Exchange —according to the DHHS criteria
- Utilize a standard format to present benefits
- Refer individuals to Medicaid or CHIP if they meet eligibility criteria
- Make a cost of coverage calculator available
- Verify individual claims of eligibility to participate in the Exchange
- Transfer list of individuals who are eligible for the tax credit to the Secretary of the Treasury
- Inform employers when an employee terminates coverage

[19] See Appendix A for a full list of the required activities for state Exchanges.

- Award grants to Navigators

The five items from the above list that most significantly impact safety net plans are the following:

- Qualify health plans for Exchange participation
- Certify, recertify and decertify health plans
- Assign a rating to each qualified health plan offered through the Exchange
- Refer individuals to Medicaid or CHIP if they meet eligibility criteria
- Award grants to Navigators

The ACA provides little guidance on how these activities will be conducted. Because of the statute's lack of specificity, there is considerable flexibility in how the federal regulations will be drafted. The DHHS released a Request for Comment on August 3, 2010, to solicit input on how the federal regulations should be drafted. Many of the questions specifically address the state's degree of flexibility.

Although there will be flexibility at the state level in many areas, this section will address the role of Exchanges in qualifying health plans. While the ACA is silent on many details of Exchange required activities, it provides specific flexibility on its ability to limit the number of participating health plans:

"…the Exchange 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[20]*…"*

Given this provision, it is expected that there will be a continued level of involvement that Exchanges have in regulating qualified health plans. At one end of the continuum is a passive Exchange that functions like a "Travelocity" for health care that facilitates enrollment into qualified plans, making market forces drive consumer choice. Health care coverage will become a pure commodity in this model. Any health plan is qualified to participate in the Exchange based upon a set of criteria that is lightly regulated.

At the other end of the continuum is an active Exchange. In this model, the Exchange takes on a robust regulatory role — like states with Medicaid managed care programs. There is competitive bidding, robust regulation of certification criteria, benefit design, pricing and quality. Active Exchanges set strict standards for qualifying plans and may limit the number of participating plans. In this model, health care is not merely a commodity, but a complex set of products and services that will have varying value and therefore, varying prices.

Current Exchange models including the Utah Health Exchange, the Commonwealth Connector and the proposed California Exchange enabled in AB 1602 all fall somewhere within the continuum of passive versus active Exchanges described above. Exhibit 4 summarizes key Exchange activities of current models.

[20] §1311(e)(1)(B)

Exhibit 4: Current Exchange Models Selected Activities

	Utah Health Exchange	Commonwealth Choice[21]	California AB 1602	Commonwealth Care
Selective Contracting		x	x	x
Greatly Restricts the Number of Qualified Plans				x
Enrollment Responsibility	x	x	x	x
Collects Subsidies			x	x
Regulates Benefits and Price		x	x	x

Safety Net Plan Issues

One of the most critical issues for safety net plans is the need to ensure that there are no barriers to their participation with the Exchanges. As California lawmakers crafted the Exchange legislation, there were concerted lobbying efforts on the part of a large commercial insurer and the California Hospital Association to exclude Medi-Cal plans from participation. The large commercial insurer recognized the opportunity for potential future market growth and larger shares in the subsidized individual market and wanted to exclude the safety net plans in order to reduce competition in the subsidized market. Commercial insurers will likely pursue similar strategies in other states.

The California Hospital Association expressed concerns that their members would be required to accept Medi-Cal rates from the Exchange's insurers. It is likely that providers in other states will pursue positions to limit or prevent Medicaid health plan participation if there is a perceived risk that they would be required to accept Medicaid payment rates, which are generally lower than both Medicare and commercial fee schedules.

Many safety net plans have regional service delivery areas and may wish to continue to serve beneficiaries only in their current catchment. States may have the flexibility in selective contracting to limit the service areas rather than require statewide offerings in the Exchange. Limiting service delivery areas may result in greater safety net plan interest in participation in an Exchange.

Options to Consider

Current, past and proposed Exchange models have roles that span the continuum of passive involvement with active involvement. Closer to the passive end of the continuum is the Utah Health Exchange.[22] The Utah Health Exchange model is considered a passive Exchange and does not regulate the health plans in any manner. When fully operational, the Utah Health Exchange will provide businesses with a Web portal that links consumers to both private and government health care programs. Health plan participation in the Exchange is optional and the Exchange facilitates enrollment only into participating health plans.

[21] The Commonwealth Connector has two separate "Exchanges." The Commonwealth Choice program is a single pool for small group and individuals who are not subsidized. The Commonwealth Care program is an 1115 Waiver program that provides subsidized health care to a Medicaid adult expansion population.
[22] http://www.exchange.utah.gov/report1.html

The Utah Web portal will contain comparative information on participating health plans including provider network, claim payment timeliness, benefits, cost sharing, adverse events and Department of Insurance (DOI) solvency ratings. The Utah Health Exchange is also required to develop a private sector solution for collecting premiums from multiple sources.

This option is desirable in markets where safety net plans have an opportunity for large future captive Exchange enrollment. With solid brand recognition, particularly with individuals currently connected to Medicaid either as an eligible person or with eligible family members, a "come one, come all" approach may present limited risk to safety net plans. This would especially be true in large Medicaid managed care markets.

At the other end of the continuum is an Exchange that actively regulates and selectively contracts its participating health plans. Within the Commonwealth Connector[23] is an example of this model, the Commonwealth Care program, which selects participating health plans through a competitive bidding process.

In between the Utah Health Exchange and the Commonwealth Care models is the method the Commonwealth Connector uses to administer the Commonwealth Choice program that serves a non-subsidized commercial population. The Commonwealth Choice model selectively contracts with health plans and regulates benefits, prices and awards a Seal of Approval for benefit plans according to price and quality. Like the Utah Health Exchange, there is comparative data on participating health plans.

A more active Exchange model would be favored by safety net plans in markets vulnerable to new entrants for both Medicaid and Exchanges. An active Exchange that selectively contracts will be more likely to limit the number of participating plans that should favor incumbents.

Finally, states may have the flexibility to limit the numbers of regions that health plans are required to offer Exchange products. Limiting the service delivery areas — similar to many Medicaid programs, will encourage more safety net plan interest in participating with the Exchange. Safety net plans that want to remain regional in scope should advocate for selective contracting and selective service delivery areas — especially if the state has an interest in ensuring safety net plan participation.

Recommendation: From the beginning, there should be no limits on the type of health plans that enter the Exchange market — even if there are limits on the number of plans. Safety net plans will add value to the options for coverage for many consumers who currently access their health care through these plans. It is important that safety net plans be included in available options.

c. What common administrative functions should the Exchange operate?

ACA Provisions

The ACA lists the minimum requirements for Exchange operations that a state must administer:

- Operate a toll-free hotline
- Maintain a website where enrollees obtain comparative information on health plans
- Utilize a standard format for the presentation of benefits
- Refer individuals to Medicaid or CHIP if they meet eligibility criteria
- Make a cost of coverage calculator available
- Verify individual claims of eligibility to participate in the Exchange

[23] https://www.mahealthconnector.org/portal/site/connector/

- Transfer a list of individuals who are eligible for the tax credit to the Secretary of the Treasury
- Inform employers when an employee terminates coverage

The ACA requires health plans to be able to accept premium subsidy payments from the Treasury Department.[24] The Treasury Department will make an advanced payment to the health plans on a monthly basis. The health plan will be required to meet the following with respect to premium subsidies:

- Subtract the amount of the advance subsidy payment from the amount of the premium prior to billing the enrollee
- Notify the Exchange and Treasury Department about the premium reduction
- Include the amount of the premium reduction in the billing statement
- When an enrollee does not pay his/her premium, notify the Treasury Department and allow for a three-month grace period of non-payment prior to dis-enrolling the individual

In addition to collecting subsidy payments and reducing premiums, health plans will be required to track the out-of-pocket (OOP) expenses for limited cost sharing for individuals with incomes from 100–250% FPL and limit the amount of OOP expenses for individuals with incomes from 100–400% FPL.[25] The Treasury Department will reimburse the health plan for the actual amount or may capitate the plan for this estimated amount.

Safety Net Plan Issues

Commercial insurers currently collect premiums, subsidies and track copayment amounts. In comparison, some of ACAP's member safety net plans do not currently have the capabilities to perform these functions. These functions would be an additional component of required system remediation. Plans may have the option to contract with a third party administrator. However, this also brings administrative complexities and administrative costs. The cost to either buy or build these functionalities may be better used to meet state reserving requirements, to purchase clinical and financial analytic tools, or to increase staffing or improve existing system capabilities in anticipation of new enrollment such as call centers or care management systems, etc.

In addition to premiums, subsidies, cost sharing and OOP collection and tracking, many safety net plans do not perform enrollment activities. State Medicaid programs directly, or through enrollment brokers, conduct outreach, application and enrollment activities. The state or broker sends files to health plans informing them of their membership, including demographic information, contact information and ID numbers. In order to eliminate as many possible barriers to participation, Exchanges could perform all of these functions.

Other safety net plans currently have systems with these functionalities. Of greater concern than the health plan IT capabilities is the ability of the Exchange to interface with Medicaid eligibility systems, many of which are legacy systems that may not be able to be modified to meet the interface requirements. Upgrading or replacing these systems to meet the requirements will be costly during a time when state budgets are stretched beyond capacity and there no additional federal funding to offset state costs. There is general skepticism that Medicaid systems will be upgraded to take on new capacity needs including aligning Medicaid eligibility with Exchange premium subsidy eligibility processes in advance of the Exchange go-live data in January 2014.

[24] §1412(c)(2
[25] §1402(c)

Options to Consider

For health plans without the system's functionalities to track premiums, subsidies and copays, one option is for the Exchange to perform many administrative activities in addition to those listed in the ACA. These administrative functions include collecting premiums from consumers, subsidies and cost sharing reduction amounts from the Treasury Department, marketing, enrolling and dis-enrolling consumers. There is precedence for some or all of these functions within the Utah Health Exchange, Commonwealth Connector and the California AB1602 Exchange enabling legislation.

Exchanges are positioned to provide a structure for administrative standardization and efficiencies. An administratively efficient Exchange will help reduce the overall costs of providing health care within the Exchange environment which will help reduce the price of premiums for consumers as well as provide consumer friendly information with respect to the available options. However, all of this comes with a cost, and Exchanges must be self-sufficient. The ACA permits Exchanges to assess fees on qualified plans[26]. Indeed, the California AB 1602 has such a provision to pay for the Exchange operations. However, states might design a fee structure that does not create a barrier to safety net plan participation, such as a percentage of revenues rather than a flat per member per month assessment that is the same for all size of plans.

d. Should the state have one Exchange or two Exchanges? If the states have one Exchange, should the risk pools be integrated?

ACA Provisions

The ACA establishes two Exchanges, an individual Exchange, the only vehicle through which subsidies are available and SHOP. States are permitted to integrate the administration of the two Exchanges. Exchanges are also permitted to merge the two risk pools or maintain them separately.

Safety Net Plan Issues

From the perspective of state cost and administrative efficiency, states will benefit from operating a single Exchange rather than two separate ones. However, if administered as one Exchange, it would be a challenge for some safety net plans if they were required to participate in both the individual and small group markets. These are very different markets and require different marketing and support services. There are no provisions in the ACA that would require states to mandate participation in both the individual and small group Exchange markets as a condition of participation. As a component of existing safety net plan membership shifts into the small group and individuals markets, some may elect to participate in both markets.

The key issues for safety net plans to consider are the stability of risk pools and limiting adverse selection. Factors that contribute to achieving both are the size of the insurance pool and the percentage of eligible individuals in a market that participate.

In the past, adverse selection has been a major factor in the failure of Exchanges. They essentially became high risk insurance pools as they disproportionately attracted higher risk individuals and were not able to achieve a balanced mix of health and high risk members. There are multiple provisions of the ACA that may help reduce adverse selection and potentially increase participation. As an example, like products in and out of the Exchange must be priced the same.

One example of mitigating risk is the merging of the small group and individual markets in the Massachusetts Commonwealth Choice program. Having enrollees from both markets may be a benefit to safety net plans that may attract a disproportionate share of subsidized members with higher risk profiles. This may be augmented by carving out the individual subsidized population into a separate risk pool such as the Commonwealth Care program.

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[26] §1311(d)(5)(A)

Another issue for safety net plans is whether or not plans will be required to offer their Exchange products both inside and outside the Exchange or if they can limit their products to the Exchange enrollees. Serving the commercial individual market outside the Exchange and competing with commercial insurers is very different from insuring low income and subsidized populations, which may not be attractive to safety net plans. Additionally, providing insurance products outside the Exchange may not be a good mission fit and exceed the strategic boundaries within the organization.

Options to Consider

There are multiple options depending on the taste a health plan has for pursing new markets. Safety net plan may consider advocating allowing a plan to limit Exchange participation to subsidized individuals on the Exchange because that is a discreet population with unique needs that safety net plans have long been addressing. The subsidized population is more consistent with current membership and more consistent with the historical mission of these plans. However, there may be a downside to relating to adverse risk selection and market perceptions of being second tier plans. In that case, safety net plans may want to keep all options open for enrollment, including both the greater individual market and the small group market because both markets could bring healthier risk cohorts. Safety net plans may also advocate for allowing qualified plans to elect to offer products only within the Exchanges because that is the target market for many. This could assist with keeping the target market closer to their mission.

2. Achieving Continuity of Care

ACA Provisions

The ACA provides for two general open enrollment periods:

- An initial open enrollment that will be determined no later than July 1, 2012
- Annual open enrollment periods

In addition to the open enrollment provisions, individuals may also enroll through qualifying events between open enrollment periods. There will also be the opportunity to enroll between open enrollment periods when there are qualifying events.

Safety Net Issues

On average, 40 percent of the nation's low income subsidized Exchange population[27] will have the following characteristics:

- Previously enrolled in Medicaid/CHIP
- Previously enrolled in a premium subsidy program for low-income populations
- Previously uninsured (with our without family members in Medicaid)

The proportion of individuals that fit these characteristics will vary from state to state and market to market based on income, employer and Medicaid factors. With their current membership in Medicaid and CHIP, premium subsidy programs and safety net plans may be the plan of choice for individuals who were enrolled prior to the date the Exchanges were implemented. Individuals will want to stay with their health plan in order to have continuity of care and to keep the care of their family under a single plan. This is also important from the health plan perspective. Safety net plans are familiar with the churn of low-income individuals in and out of their safety net programs and increases in service utilization that enrollment churn brings.

[27] Lewin Health Benefits Simulation Model

Options to Consider

There are several enrollment policy positions that will facilitate continuity of care for individuals previously in Medicaid:

- Initial open enrollment
  - Create a list of health plans for transitioning Medicaid eligibles that are prioritized with the first health plan being the Exchange offering of their current Medicaid MCO.
- Annual open enrollment
  - Lock in for one year to level and smooth risks
- Re-enrollment
  - If an individual is dis-enrolled for not paying his/her premiums for the three month grace period, but then back pays all premiums or loses eligibility due to changes in income, but is recertified for subsidization, then there should be automatic enrollment into the health plan in which they were previously enrolled or the health plan of other household members unless the individual specifically requests another plan
- Alignment of redetermination periods for Medicaid, CHIP and Exchanges
  - There are multiple benefits that would result, including reduced administrative expense for states, Exchanges and plans related to processing of enrollments and dis-enrollments, stability in risk pools and continuity of coverage

3. Benefit Design Standardization

ACA Provisions

Offer plans that include the minimum essential benefits package that include the following:[28]

- Ambulatory patient services
- Emergency services
- Hospitalizations
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services (including oral and vision care)

There are four benefit levels (not including the catastrophic plan)[29]

- Bronze Level — A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan

[28] §1302(b)(1)
[29] §1302(d)(1)

- Silver Level — A plan in the silver level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan
- Gold Level — A plan in the gold level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan
- Platinum Level — A plan in the platinum level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan

Safety Net Issues

A goal of the Exchanges is to provide individuals with easy access to insurance and a clear understanding of their choices. The less standardized the Exchange products, the more difficult it will be to compare offerings. Based on the ACA language, Exchange products may be able to be structured with varying levels of co-insurance, co-payments and deductibles. Federal regulations may provide more definition, including standardized benefit packages. However, states may take issue if federal requirements provide limited latitude. From a public policy perspective, standardized benefit packages will more provide clarity and more easily allow consumers to compare and contrast health plan options based on price, network, customer service and other qualifications.

Simplicity and clarity of product offerings on the Exchange is an issue central to the consumer focused expectations of reform. Standardized and limited plan design will facilitate comparability of products and insurers for consumers to make the best choices based upon price and quality. Standardized plan design at each level of the coverage that can be compared to a benchmark will allow for comparison and will help to establish a more level playing field. Administrative simplicity will also be favored by the provider community who will not want to take on the administrative burden of tracking a multitude of deductibles and copayments – especially during the first year of implementation.

Product design and underwriting are generally core competencies of commercial insurers. Therefore, they are likely to be better positioned, especially at the start, to utilize benefit design as a strategy for marketing and risk management. If they are successful in attracting lower risk members, this could in turn results in adverse selection for safety net plans. Lower income and higher risk individuals may be more likely to select less complicated products that reflect a product structure and network that they are more familiar with through their Medicaid experience. Note that many commercial plans have begun to limit their product designs largely due to the complexity of plan administration and the concentration of memberships within a small proportion of products.

In comparison, the risk of fewer products is that price becomes an even more important factor in consumer selection. This increases the importance of plans having the capabilities and actuarial depth necessary to accurately price products. This also is an area where safety net plans are likely to have less experience and capabilities. Flexible or standardized, both alternatives present risks to non-commercial plans.

Options to Consider

Safety net plans would benefit from a more limited number and standardized set of Exchange products. From the consumer perspective, fewer standardized plan designs can be more easily compared. From the plan perspective, standard benefits with a limited number of options at each actuarial level will limit administrative challenges and may mitigate some of the actuarial risks and underwriting requirements. It would put pressure on the safety net plans to effectively compete on prices, networks and other factors. It would also help to level the competitive playing field and limit adverse risk selection based on product design.

Another option is for the Exchanges to require that the Exchange plans offer all product levels, not just the silver and gold levels that the ACA requires. Otherwise, a plan could offer Bronze level benefits

outside the Exchange. Bronze level benefits are likely to be attractive to lower risk individuals because Bronze level plans will be lower in price with higher deductibles and co-pays, which would not be troublesome to a health person who rarely needs health care services. Requiring health plans to offer all benefits will mean that the healthier risk populations will stay in the Exchange and create more stable risk pools.

4. Accreditation/Deeming

ACA Provisions

The ACA requires that for a health plan to be qualified for the Exchange, it must:

"be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set (HEDIS®), patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans (so long as any such entity has transparent and rigorous methodological and scoring criteria); or receive such accreditation within a period established by an Exchange for such accreditation that is applicable to all qualified health plans."[30]

Safety Net Issues

The ACA accreditation requirements are both specific and general. The statute includes many of the same components that state Medicaid agencies incorporate as standards for their managed care contracts. They also resemble accreditation standards set by National Committee for Quality Assurance (NCQA), which DHHS recognizes as an accrediting body. NCQA is one of three independent entities that accredit health plans, the others being Utilization Review Accreditation Commission (URAC) and the Joint Commission of Accreditation of Healthcare Organizations (JCAHO). The majority of health plans, whether commercial, Medicare, or Medicaid, are not currently NCQA, URAC, or JCAHO accredited. Historically, commercial plans have been more likely to pursue NCQA accreditation. The NCQA accreditation process requires a significant investment by health plans. It is a multi-year process and requires a plan-wide commitment that often involves changes to core operational procedures and processes. Achieving and maintaining accreditation requires an ongoing plan investment. Based on the language contained in the ACA, states may consider establishing NCQA as a requirement for certification as a qualified Exchange plan because of the comprehensiveness of NCQA accreditation.

Only thirteen states require NCQA accreditation for Medicaid managed care plans by 2011[31]. Most states do not require NCQA accreditation because of certain federal regulations. For example, Medicaid managed care organizations are subject to the External Quality Review (EQR) process, which has a significant amount of overlapping compliance areas. There are currently NCQA accredited Medicaid plans in 19 states with scheduled reviews for plans in an additional seven states.

Options to Consider

Recommendation: States have the option for a grace period for accreditation. Therefore, safety net plans in states that do not require NCQA accreditation should advocate for deemed accreditation status based on achieving an established weighted score on their most recent EQR or based upon meeting state quality requirements that are more stringent than NCQA. This deeming could be effective during a transitional phase while the health plan becomes accredited by the Exchange accrediting organization. There are risks to safety net plans if participation standards are set differently or with what could be perceived as a lower level than commercial plans is that they may be perceived as a second tier or

[30] §1311(c)(D)
[31] http://www.ncqa.org/tabid/135/Default.aspx

lower level plan. Because equal quality evaluations will serve safety net health plans the best in the long term, transitional deeming during the grace period is favored over permanent deeming.

5. Licensure and Reserves

ACA Provisions

For a health plan to be qualified to participate in the Exchange, "a health plan must be licensed and in good standing to offer health insurance coverage in each state in which such issuer offers health insurance coverage…"[32]

Safety Net Issues

Not all states require Medicaid plans to be licensed as commercial plans or as health maintenance organizations by their DOI. Some states have additional categories of certification, such as New York States: pre-paid health services plans (PHSP). If commercial licensure is required, depending upon the state's application procedures and the lag time, non-licensed health plans will need to initiate the licensure process at some point in advance of the Exchange launch in order to be eligible to compete to become a qualified Exchange plan. Part of the licensing process includes establishing unencumbered reserves to protect the plan, providers, and consumers in the event of a health plan's insolvency. Raising the required amount of capital may be difficult for some safety net plans that run at smaller margins and which do not have external sources of capital.

Regardless of the licensure or reserve requirements, not-for-profit safety net plans need to begin evaluation of potential capital requirements as soon as possible. The plan will need adequate lead time to build capital reserves through current operations and may need to find external sources of funding.

Options to Consider

Safety net plans should advocate that state DOIs consider permitting multiple types of licensure or certification as a risk bearing entity. If commercial licensure is established as a requirement in states where Medicaid plans are not required to be licensed with the state DOI, then one option to advocate for granting plans in good standing with their state regulator (e.g., Medicaid agency), a transition period for achieving licensure during which they must remain in good standing as a Medicaid plan. During this period, the plan will build the required capital necessary to achieve commercial licensure. This will ease the requirements for an Exchange entry and help ensure that safety net plans will participate.

It should be noted that the time period for building reserves for non-licensed health plans will be the same time period when the temporary risk corridors and reinsurance methodologies will be implemented. The combination of risk adjustment and risk corridors will limit overall risk to plans while limiting profit and building reserves. However, at the same time, limited profit will limit a plan's ability to increase its reserves. Therefore, early planning and reserving during the next three years will be important.

Another option for Medicaid MCOs is for the state Medicaid agency to act as the certifying fiscal agent. Currently, CMS allows the Arizona Health Care Cost Containment System (AHCCCS) to act as the certifying fiscal agent for the Medicare Advantage Special Needs Plans (MA-SNP) plans because Arizona Medicaid MCOs are not required to be licensed by the state. This model could be applied to safety net plans where state Medicaid agencies currently complete this function.

[32] §1301(a)(C)(i)

6. Risk Adjustment

ACA Provisions

The ACA provides for three types of risk adjustment methodologies to protect Exchange health plans from the uncertain risks that will be inherent in the first years of a health coverage program. The first two transitional reinsurance and risk corridors are applicable within the first three years of operation. Risk adjustment payment methodology will be used in all years of the program. The reinsurance and risk corridors will limit the risk of health plans while sufficient data will be collected to develop stand alone risk adjusted rates. The following section describes the three types of risk adjustment programs.

Transitional Reinsurance for 2014–2016

- By January 1, 2014, states are required to establish (or enter into contract with) one or more applicable entities to operate a temporary reinsurance program which would provide reimbursement for partial costs of premiums. All insurers and Third-Party Administrators (TPAs) are required to make payments to the reinsurance entity. Non-grandfathered individual market plans covering high-risk individuals will receive payments from the reinsurance entity.
- Payments from the reinsurer will be made to health plans that have high risk individuals. High risk individuals are enrollees who have a health condition that is deemed high risk. The Exchange must choose at least 50 conditions, but no more than 100 conditions. High-risk individuals will be identified through diagnostic and procedure codes

Risk Corridors for individual and small group Exchanges for 2014–2016[33]

- Exchange plans will participate in a risk corridor program established by the Secretary to operate from 2014–2016
- The amount of the payment or recoupment calculated on the difference is the target ratio of the allowable costs to the aggregate premium and actual results
- Reinsurance and risk adjustment payments will be included in the calculation of the amount owed to or owed from the health plan
- The following are the calculations for the risk corridor payment(s) and recoupment(s)
  - Payment for a participating plan's allowable costs for any plan year are more than 103 percent, but no more than 108 percent of the target amount. The Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount.
  - Payment for a participating plan's allowable costs for any plan year is more than 108 percent of the target amount. The Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
  - Recoupment from a participating plan's allowable costs for any plan year is less than 97 percent, but no less than 92 percent of the target amount. The plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs.
  - Recoupment from a participating plan's allowable costs for any plan year is less than 92 percent of the target amount. The plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

Risk Adjustment for All Years [34]

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[33] §1342

- All insurers must participate in risk adjustment programs that states are required to establish, in which plans with enrollment of less-than-average risk will pay an assessment to the state and states will provide payments to plans with higher-than-average risk
- High risk and low risk plans will be assessed in the same manner as for determining eligibility for reinsurance payments
- DHHS may elect to utilize the same risk adjustment methodologies used for Medicare Part C and Part D health plans

Safety Net Issues

According to the Academy of Actuaries, a well-designed risk adjustment system is one that properly aligns incentives, limits gaming and protects risk-bearing entities. Two key byproducts of an effective risk adjustment methodology are fair and appropriate payment rates to insurers, ultimately balancing the effects of risk selection so that pricing and quality, rather than risk selection drive pricing.

Key considerations that are important in a state's selection of a risk adjustment methodology include:

- How powerful the model is in explaining variation in costs
- Types and sources of data used for risk adjustment
- Whether the model is prospective, retrospective or concurrent
- How effectively the model limits manipulation by plans or providers
- Administrative costs to plans for data collection

Considerations for health plans include:

- Data collection and reporting burden
- Predictive power of the model
- Inclusion of risk factors that are highly prevalent in lower income populations

Issues related to risk adjustment are the same for safety net plans as they are for other plans that will participate on the Exchange with an additional emphasis on the importance of the actual risk adjustment methodology accurately accounting for meaningful differences in risk. Almost by definition, safety net plans will have a higher risk membership. It is likely that safety net plans will advocate for incorporation provisions such as preferred enrollment of individuals previously eligible for Medicaid into their plan, which will likely result in a higher risk membership. The network composition of these plans also includes a higher proportion of providers that serve Medicaid and higher risk populations such as FQHCs, hospital-based clinics and other safety net providers. With a high risk membership, the importance of the predictive value of the state's risk adjustment methodology will be even more critical to safety net plans than it will be to other Exchange plans.

In concept, transitional reinsurance and risk corridors, both of which will be in effect during the first three years of Exchange operation, provide some protections and limitations on potential losses for participating plans. Among the benefits, they are intended to limit risk during the initial years, mitigate some of the risks associated with adverse selection and minimize the incentives for plans to attract only low risk individuals. All of these provisions are of particular importance to safety net plans and because of their historical membership base, they run the risk of attracting a higher risk membership.

[34] §1343

Options to Consider

Safety net plans may consider advocating for the same risk adjustment methodology that is used in the states for Medicaid. Assuming that the model is an accepted and valid method, a plan's experience in working with that methodology would put them at an advantage over commercial plans. Necessary financial systems, revenue and membership reconciliation processes as well as internal reporting and analytics are already in place. Efforts should be made – when possible – to incorporate past medical history into the risk adjustment fact to ensure that every effort is made to get the risk score a accurate as possible from the inception of the Exchange.

Overall, plans should advocate for a risk adjustment system that has reasonable data collection burdens, can be easily administered by the plan, limits potential for gaming and is highly predictive of future costs. This will help to mitigate differences between the networks of safety net plans and commercial carriers that result from adverse risk selection. Many safety net plans have a lot of members who receive health care services through community health centers. The cost for these services may be significantly higher than non-clinic providers because the ACA requires that FQHCs be reimbursed as the prospective payment system (PPS) rates for Exchange products.[35]

7. Plan Ratings — Quality and Price

ACA Provisions

The ACA requires the DHHS to develop a rating system based on quality and price. Each plan's ratings will be published on the Web portal for consumers to compare when choosing a health plan. The Exchanges will assign the ratings to the plans based upon the criteria defined by the DHHS[36]. In addition to plan ratings, DHHS will develop an enrollee satisfaction survey to evaluate the level of satisfaction[37]. This information will also be published on the Web portal.

Safety Net Issues

A standardized rating system may not create an equitable environment for safety net plans unless the performance rating system accounts for or adjusts for differences in populations. Consistent with risk adjustment, quality and performance evaluation systems also need to account for differences in member characteristics. Language, country of origin, education level, health literacy, as well as income may impact the ability to adhere to care standards and may increase plan care management requirements. Safety net plans may enroll a higher proportion of low-income subsidy members which include a disproportionate number of pre-Medicare and older individuals with multiple chronic conditions.

Experience with dual eligible MA-SNPs shows a disproportionate share of enrollees with cognitive disorders, mental health disorders and substance abuse diagnoses. On average, MA-SNPs serving largely dual eligibles have lower Stars ratings[38]. Therefore, common quality ratings metrics such as clinical outcomes and measurements and consumer satisfaction may not be the best indicators of quality for plans that treat lower income populations or they may need to be modified.

Price will be another area that will require a rating methodology that factors the differences in provider networks by type of health plan (commercial versus safety net). One example of network differences that will drive pricing is the relative ubiquity of FQHCs and their look-alikes in the health plans' networks. As mentioned earlier, the ACA requires that FQHCs be reimbursed by health plans at the same prospective payment system (PPS) rate as they are under Medicaid. The difference is that under Medicaid, the PPS wrap around payment is reimbursed by the federal and state governments, not the health plan. There will be challenges in how health plans will determine the PPS rates, and how that cost will become part of the product pricing. Safety net plans have long relied on close partnerships with FQHCs, which has

[35] §1302(g)
[36] §1311(c)(3)
[37] §1311(c)(4)
[38] Medicare Advantage plans are assigned ratings by CMS based upon the results of a variety of measures: HEDIS, CAHPS, HOS, and Administrative data. The maximum score is four Stars. This rating system will be extremely important in 2013 whe5% to 10% of a plans reimbursement will be tied to the Stars rating.

resulted in FQHCs becoming large network providers. Alternatively, commercial insurers do not have the same relationship with FQHCs and therefore will not steer a significant portion of their membership to them. This will result in an unlevel playing field for pricing, which needs to be corrected for in the rating system established by the state.

Options to Consider

Recommendation: ACAP should convene a workgroup of its membership and develop recommendations for DHHS to consider as it drafts the regulations in order to ensure a fair and equitable rating system that factors unique characteristics of different types of plans and plans with large shares of high-risk members. One such recommendation may be to have ratings be assigned by provider network or population cohort to ensure equitable comparisons.

Recommendation: ACAP should advocate with DHHS to reimburse the FQHCs the PPS wrap around for Exchange enrollees as they do for the Medicaid program.

Recommendation: Exchanges should have a robust education and outreach Navigator[39] programs to educate consumers on the different types of health plans in the Exchange and how to value plans factoring in considerations such as their provider networks.

8. Basic Health Program Option[40]

ACA Provisions

The ACA has a provision for states to elect to implement the Basic Health Program for non-Medicaid eligible individuals with incomes from 134–200 percent FPL. The following are core provisions of Basic Health Programs:

- States will administer the Basic Health Program with their Medicaid and CHIP programs and contract with at least one MCO through a competitive bidding process
- The Basic Health Program will offer the same essential benefits as within the Exchange, but will be encouraged to offer additional benefits:
  - Care management for individuals with chronic conditions
  - Incentives for accessing preventive care
  - Establishing relationships among providers and consumers to encourage proper health care decision-making and incentivize appropriately service utilization
- Individuals eligible for the Basic Benefit program may not purchase coverage through the Exchange
- The premium cannot exceed the amount of the second lowest Silver Plan in the rating area
- Cost sharing cannot exceed the amount of the cost sharing of the Platinum Plan for individuals with incomes of 134–150 percent FPL and of the Gold Plan for those with higher incomes
- The amount of estimated premium subsidies and cost sharing reductions that would have been applicable in the Exchange will reduce the amount of premiums and cost sharing in the Basic Health Program
- States will establish performance measures

[39] §1311(i)(3). In its intent to be consumer friendly the ACA requires Exchanges to crate a Navigator program. The Navigators are charged with providing transparent, linguistically competent, and impartial educational materials on Exchange health plans. They will also facilitate enrollment into the health plans.
[40] §1331

Safety Net Issues

One purpose of this legislation is to provide states that have created optional Medicaid adult expansion programs for individuals up to 200 percent FPL with a means to maintain that population in their current structure.[41] Some of these expansions are premium subsidy programs not unlike the future premium subsidized individual Exchange program. This lower income population is the mostly likely to churn in and out of Medicaid and those most likely to have children in CHIP programs that safety net plans serve. The crafters of the ACA also recognized that individuals up to 200% FLP often look like a Medicaid recipient and states may want to keep this population together, which could have a positive impact on the risk of the Exchange with members in excess of 200% FPL. As a result, safety net plans will have an interest in having their states exercise this option in order to maintain and grow their membership without having to develop products and increase operational infrastructure to meet Exchange participation requirements.

Options to Consider

In states where safety net plans serve these individuals, safety net plans may want to advocate for the implementation of the Basic Health Program in their state. This is particularly true if the safety net plan wants to keep its mission focused on the lowest income populations rather than serve the higher — even subsidized — populations. It is critical that this discussion occur with state Exchange planning committees early in the process so that the Exchanges can be structured accordingly. Additionally, if this option is exercised, then states will have extensive implementation planning such as new procurements and system redesign.

[41] Some state expansions include individuals with incomes greater than 200% FPL.

Conclusions

Health Benefit Exchanges may offer safety net plans a new market that both fulfills their mission to serve low income populations as well as providing a new market to offset potential future losses in their Medicaid markets as Medicaid is expanded and competition for Medicaid market shares increase. As safety net plans evaluate whether or not they should offer products in the Exchange, they should also be part of the Exchange planning and implementation processes to not only ensure that the Exchanges will coordinate with Medicaid and CHIP programs as required in the ACA, but also to ensure that there are no barriers to safety net plan entry into the Exchange market.

This paper identified several areas that health plans will need to consider as they work through their strategic planning processes and participate in the planning and design of the Exchanges at the state level. Each state will be different in how their Exchanges will be designed and what roles they will assume in their communities, but universally, the time to start the discussions on design and implementation is today.