ALABAMA'S EXCHANGE ROADMAP

ALABAMA DEPARTMENT OF INSURANCE

REPORT BMA10T1

Robert Carey, Public Consulting Group

JUNE 2011

NOTICE:

THE VIEWS, OPINIONS, AND FINDINGS CONTAINED IN THIS REPORT ARE THOSE OF LMI AND SHOULD NOT BE CONSTRUED AS AN OFFICIAL AGENCY POSITION, POLICY, OR DECISION, UNLESS SO DESIGNATED BY OTHER OFFICIAL DOCUMENTATION.

Contents

Tables

Figure

Alabama's Exchange Roadmap: Alabama Department of Insurance

INTRODUCTION

The American Health Benefit Exchange and the Small Business Health Options (SHOP) Exchange have the potential to serve as central points of access to affordable health insurance for hundreds of thousands of Alabama residents and businesses. By November 2013, individuals and small employers should be able to shop from a range of health carriers and a number of health plans offered through the Alabama Health Insurance Exchange (the Exchange) for insurance coverage that will take effect January 1, 2014.

Lower- and middle-income individuals and families earning up to four times the federal poverty level (FPL)—$89,400 for a family of four in calendar year 2011—may be eligible for premium subsidies for private health insurance; small employers with lower-wage workers that provide employer-sponsored insurance (ESI) may be eligible for tax credits to partially offset the cost of their employees' health benefits.

People who today cannot afford health insurance or are denied coverage due to poor health will soon be able to purchase insurance through the Exchange. In addition to premium subsidies, the health plans available through the Exchange will limit point-of-service cost sharing (copayments, coinsurance, and deductibles) and cap members' out-of-pocket expenses.

The US Census Bureau estimates that approximately 789,000 Alabamians were uninsured in 2009, about 16.9 percent of the state's 4.7 million residents. This uninsured rate is roughly on par with the US average.[1] The expansion of Medicaid for non-elderly residents with income up to 138 percent of the FPL and the availability of premium subsidies through the Exchange for people with income up to 400 percent of the FPL will provide access to affordable health insurance to hundreds of thousands of currently uninsured residents of the state. Well over a million Alabamians are likely to access health coverage through the Exchange, which will serve as the gateway to Medicaid, the Children's Health Insurance Program (CHIP), known as ALL Kids, and Exchange-based subsidized health insurance.

The Patient Protection and Affordable Care Act (ACA) sets broad parameters for the Exchange, and soon-to-be released federal regulations will contain further guidance, but the law allows some flexibility in how Alabama sets up its

[1] US Census Bureau, Current Population Survey, 2009 Annual Social and Economic Supplement. In 2009, the US average rate of uninsured was 16.7 percent.

Exchange. As a result, the state will need to make key decisions over the next several months to establish an Exchange that best meets the needs of Alabama residents and businesses.

This *Alabama's Exchange Roadmap* serves as the overarching framework to help the state plan, design, and implement an Exchange. It discusses the goals for the Exchange, describes its functions and responsibilities, reviews important milestones, and identifies key features and requirements needed to establish and operate a fully functioning, self-sustaining Exchange.

Although this report will serve as the planning document for Alabama's Exchange implementation, further guidance from the Center for Consumer Information and Insurance Oversight (CCIIO), an entity within the Centers for Medicare and Medicaid Services (CMS), is scheduled for release in late spring, according to officials at CCIIO. The state will need to carefully review new federal guidance and other Exchange-related regulations to assess the extent to which its approach to establishing an Exchange complies with them.

Furthermore, given the litigation concerning the constitutionality of various provisions of the ACA, to which Alabama is a party, as well as the ongoing debate over federal healthcare reform and efforts to defund certain provisions of the law, we recognize the need to develop a roadmap that gives the state the nimbleness and flexibility to react to an evolving set of circumstances and changing policies, both internally and externally.

GOALS FOR THE ALABAMA EXCHANGE

A successful roadmap for the Exchange requires up-front agreement on its goals, its role in the marketplace, and how it fits into the state's health insurance and healthcare system. We propose seven goals for Alabama's Exchange:

1. Pursue a market-based approach that promotes choice and competition in the health insurance market.

2. Develop consumer-friendly, administratively efficient processes by which individuals, families, and employers can purchase health insurance.

3. Promote consumerism through plan design and state-of-the-art decision support tools.

4. Encourage consumers to take better control of their health through wellness and promote healthy behaviors.

5. Minimize any unintended disruption of the existing private health insurance market.

6. Build on public- and private-sector resources and capabilities.

7. Achieve cost-efficiencies by leveraging Exchange-related functionality and resources developed by other states.

KEY MILESTONES

Table 1 shows key milestones established by the ACA for the development and implementation of a health insurance Exchange

Table 1. Exchange Milestones

Milestone	Deadline
Level one "cooperative agreement" applications are due (see below)	June 30, September 30, and December 30, 2011
Level two "cooperative agreement" applications are due (see below)	June 30, September 30, and December 30, 2011; March 30 and June 29, 2012
Alabama's legislature enacts legislation to establish the Exchange	January 2012
The Exchange readiness assessment is completed	December 2012
The HHS secretary decides whether the Exchange is on track for operation	Early 2013
"Qualified health plans" are certified to be offered through the Exchange	May 2013
Exchange functionality is beta tested	July 2013
The Medicaid program begins to preenroll existing and newly eligible populations	July 2013
Open enrollment for Exchange-based health plans begins	October/November 2013
Coverage for health plans sold through the Exchange is effective	January 1, 2014
Federal "cooperative agreement" funding ends	December 31, 2014
The Exchange achieves financial self-sustainability	January 1, 2015

Note: HHS = US Department of Health and Human Services.

COOPERATIVE AGREEMENTS

Findings

In January 2011, the federal government announced a new round of funding for states, the District of Columbia, and consortia of states to provide financial assistance for the establishment of state-operated Exchanges. Under this arrangement, states may choose to apply for "level one" or "level two" funding on the basis of their progress in establishing an Exchange.

The cooperative agreement funding opportunity, which is 100 percent federally funded with no state match required, is designed to give states multiple opportunities to apply for funding as they progress through establishment of an Exchange. Level one award recipients may reapply for another year of funding in the level one category, or they may apply for level two awards after making sufficient

progress in the initial level one project period and satisfying the level two eligibility criteria (described below).

Level one funds are available to states that have made some progress under their Exchange planning grant but are not yet able to meet the level two eligibility requirements.

Level two awards will provide funding through December 31, 2014, at which point the Exchange will need to be financially self-sufficient. This category is designed to fund applicants further along in the establishment of an Exchange that demonstrate achievement of specific criteria:

- The necessary legal authority to establish and operate an Exchange that complies with federal requirements at the time of the application
- A governance structure for the Exchange
  - Complete budget through 2014
  - Initial plan discussing financial sustainability by 2015
  - Plan outlining steps to prevent fraud, waste, and abuse
- A plan describing how capacity for providing assistance to individuals and small businesses in the state will be created, continued, or expanded, including a provision for a call center.

Recommendations

Given Alabama's progress in the plan, design, and establishment of an Exchange, it should submit an application for level one funding in time for either the September or December 2011 application due dates. Level two funding could then be applied for in March or June 2012.

For level one funding, the governor will need to designate a state agency or quasi-government agency to oversee the preparation and submission of the funding request. According to the cooperative agreement announcement, nonprofit entities are not allowed to request funding directly from the federal government.

KEY FUNCTIONS OF THE EXCHANGE

The Exchange's principal functions include the following:

- Serving as a market organizer and distribution channel for private insurance

- Providing access to premium subsidies and health plans with reduced cost sharing for lower-income individuals and families
- Facilitating the purchase of health insurance by small employers through the SHOP Exchange and giving eligible small employers access to premium tax credits
- Enforcing compliance with the individual mandate
- Submitting information to the federal government, including reporting on health insurance and applicable premium tax credits for individuals and families that purchase coverage through the Exchange, individuals granted an exemption from the individual mandate, and employers liable for assessments under the ACA's "play or pay" employer-sponsored insurance provision.

At its core, Alabama will need to decide which of the following three models it wants to use for selecting health carriers and health plans: (1) a market organizer/distribution channel; (2) a selective contracting agent; or (3) an active purchaser.

Under the "market organizer/distribution channel" model, the Exchange would establish threshold criteria and offer all health carriers and all health plans that meet the criteria. The Exchange acts as an impartial source of information on health plans that are available in the market, provides structure to the market to enable consumers to compare health plans based on relative actuarial value, administers premium subsidies, and serves as a broker of health insurance.

In the "selective contracting agent" model, the Exchange plays a more active role. The Exchange may attempt to exert its influence in the market and enhance competition by contracting with a limited number of carriers offering a select group of health plans, or by requiring that health carriers and health plans meet certain cost and/or quality metrics. The Exchange might solicit plans based on plan design parameters or preferred plan types or, depending on the number of carriers operating in the state, the Exchange might offer only the four or five lowest-priced carriers, for example. Under the "active purchaser" model, the Exchange establishes plan designs and purchases health insurance on behalf of its members, much like a large employer establishes and purchases health benefits on behalf of its employees. This model is predicated on the Exchange covering a large and broad risk pool that enables carriers to offer competitively priced plans.[2]

The Exchange must attract and retain customers by offering "qualified health plans." It must also establish a streamlined eligibility and enrollment process, adjudicate transactions effectively and efficiently, give members the information

[2] Carey, Robert. *Health Insurance Exchanges: Key Issues for State Implementation.* AcademyHealth, State Coverage Initiatives, September 2010.

needed to make decisions, and administer a process that enables individuals to apply for waivers exempting them from the health insurance mandate.

The Exchange has specific responsibilities in four main functional areas:

1. Eligibility

    - Certify that prospective enrollees for coverage in the Exchange are US citizens or nationals or lawfully present aliens.

    - Determine whether individuals qualify for Medicaid, ALL Kids, or premium subsidies and reduced cost sharing through the Exchange.

2. Outreach, enrollment, and customer service

    - Establish a website that gives individuals information on health plans available through the Exchange.

    - Utilize a standard format for presenting health plans' benefit information.

    - Operate a toll-free number and customer service unit to respond to inquiries from consumers.

    - Make available an electronic calculator that allows individuals to determine the net cost of coverage after premium tax credits and reduced cost sharing have been applied.

    - Establish an outreach and enrollment program, including a grants program for "navigators" responsible for apprising people of their health coverage options and helping individuals enroll in a health plan through the Exchange or in other publicly subsidized health coverage programs available in Alabama.

    - Establish a standardized enrollment form for health plans offered through the Exchange.

    - Give enrollees and prospective enrollees information on the availability of in-network and out-of-network providers.

    - Facilitate enrollment of individuals, families, and employer groups in private health plans; enroll individuals in Medicaid and ALL Kids if they are found eligible during the screening of an application; and develop policies pertaining to the payment of premiums and the application of premium subsidies from the federal government.

3. Health plan selection, evaluation, and management

   - Establish health plan selection criteria, consistent with requirements to be issued by the federal government, and certify "qualified health plans" from health carriers to be offered through the Exchange.

   - Implement procedures for certification, recertification, and decertification of qualified health plans.

   - Evaluate premium levels and increases in determining whether to allow a health plan to be offered through the Exchange.

   - Require plans to meet marketing standards and ban the use of marketing practices or benefit designs that discourage enrollment of high-risk individuals and groups.

   - Ensure that health plans offer enough provider choices.

   - Require health plans to include essential community providers, where available, that serve predominantly low-income, medically underserved populations.

   - Rate each health plan offered through the Exchange on the basis of price and quality criteria to be established by the federal government.

   - Require plans to implement a quality improvement strategy designed to improve health outcomes.

   - For all eligible applicants, make available four levels of "qualified health plans"—Platinum, Gold, Silver, and Bronze—on the basis of their actuarial values, which range from 90 percent (Platinum) to 60 percent (Bronze).

   - For individuals under 30 years of age and for those determined exempt from the individual mandate, make available a "catastrophic," or high-deductible, health plan (HDHP).

   - Allow an issuer of a standalone dental plan, which may be sold separately or in conjunction with a qualified health plan, to offer the product through the Exchange.

4. Enforcement of the individual mandate and reporting

   - Determine whether an individual is exempt from the individual mandate to maintain health coverage on the basis of affordability, religious beliefs, or hardship.

- Give the federal government information on individuals who have been granted a certification of exemption from the individual mandate.
- Give the federal government information on employers who are subject to a penalty for not offering minimum essential coverage, offering coverage that was determined unaffordable to employees, or offering coverage that did not meet the required minimum actuarial value and whose employees received a premium subsidy for coverage through the Exchange.
- Report to employers the name of each of their employees who ceases coverage under a qualified health plan purchased through the Exchange.
- Publish costs of licensing, regulatory fees, and any other payments required by the Exchange and the administrative costs of the Exchange.
- Collect information from insurers that offer qualified health plans through the Exchange on their claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, denied claims, cost sharing and payments for out-of-network coverage, enrollee and participant rights, customer satisfaction, and other information as determined by the secretary of Health and Human Services (HHS).

GOVERNANCE AND ADMINISTRATION

Findings

One of the most immediate and important decisions for Alabama is the governance model and administrative structure for the Exchange. The ACA allows states to organize their Exchanges in one of three ways: state agency, quasi-public authority, or nonprofit entity. Each is discussed briefly below.

Alabama could choose to establish and operate the Exchange in much the same way other public programs are administered, by designating an existing state agency or establishing a new agency to run it. Under this approach, the agency would implement, oversee, and manage the day-to-day operations of the Exchange. An advisory board could be established to guide and counsel on Exchange policies and procedures, but the ultimate decision-making authority would rest with the state agency. The Utah Exchange, established in 2008, is administered by the Governor's Office of Economic Development.

An alternative approach is to establish a quasi-public authority, possibly under the direction of a governing body separate from state agencies. A governing board responsible for setting policy and overseeing the operations of the Exchange could help establish the independence of the Exchange and might include individuals with relevant business and insurance expertise, as well as representatives

from across the political spectrum. The Massachusetts Connector Authority, the Commonwealth's Exchange, was established as a quasi-government authority, overseen by an 11-member board of directors. California's Exchange is also a quasi-government authority under the direction of a five-member board.

The third option is for the state to designate a nonprofit entity to run the Exchange. This option likely provides the greatest amount of separation from state government. The nonprofit entity, much like the quasi-public authority, might be governed by a board of directors, and the staff would be employees of the nonprofit corporation. If Alabama opts to designate a nonprofit to operate the Exchange, the state will need to apply for federal funds on behalf of the nonprofit entity, as the cooperative agreement prohibits nonprofits from applying for these funds. To date, no state has opted to establish its Exchange as a nonprofit, although legislation under consideration in North Carolina would establish that state's Exchange as a nonprofit entity overseen by a public/private 14-member board.

Because the Exchange will need to coordinate with the activities of other state agencies, in particular the Department of Insurance, state Medicaid agency, and Alabama Department of Public Health, which administers ALL Kids, its governing board might include state officials with expertise in those areas. Such ex officio members could either be voting or nonvoting members. The board might also include expertise from individuals with private health insurance experience, those with experience in the distribution of health insurance products, and a consumer representative.

Board representation from organizations with experience in the individual or small group markets could also be useful, offering insight into these markets and firsthand knowledge of the types of plans consumers have selected in the past. These individual and small group markets operate under rules that differ greatly from those of the large group market, and including an individual with that experience on the Exchange board would likely benefit Alabama.

A related decision involves whether to establish one Exchange to serve the individual and small group markets or a separate SHOP Exchange for the employer market. It is important to point out that the decision to administer a single Exchange that serves both markets does not necessarily mean that the individual and small group markets need be, or should be, combined for risk-pooling purposes. That is, Alabama may choose to designate a single administrative entity to operate the Exchange for both individuals and employers, while still maintaining separate risk pools for the individual and small group markets.

Many of the requirements of the SHOP Exchange will be identical or similar to those of the individual market Exchange, including the health plans offered, summary of benefits information provided to consumers, rating of health plans based on quality and price, and health plan reporting requirements.

Recommendations

The broad range of tasks under the Exchange's purview does not lend itself to a familiar organizational structure, either public or private. On one hand, the Exchange has governmental responsibilities, such as determining eligibility for publicly subsidized coverage, verifying citizenship of enrollees, certifying exemptions under the individual mandate, and exchanging information with the federal government. On the other hand, the Exchange will need to operate like a private enterprise, serving as a distribution channel for private health insurance, working with small employers—and potentially with large employers—to provide their employees with private coverage, generate revenues to support operations, and sell health insurance.

To obtain federal funds through the level two cooperative agreement, Alabama must adopt "the necessary legal authority to establish and operate an Exchange that complies with Federal requirements available at the time of the application" and have "established a governance structure for the Exchange."[3] This provision of the cooperative agreement will require the state to enact a statute establishing a governance structure for the Exchange before applying for level two funding. ***The statute will need to be enacted in the 2012 legislative session.***

Pending enactment of a statute, the state could direct a state agency to oversee the planning, design, and implementation of the Exchange. To date, the Department of Insurance has been working closely with the Alabama Medicaid Agency and ALL Kids on the Exchange planning grant through CCIIO. However, in the coming months, the work required to establish an Exchange and coordination among multiple agencies will significantly increase. Due to the increasing complexity of planning that will be required for Exchange implementation, we recommend the state establish an office to serve as a central hub in Exchange planning and implementation. This office, possibly located in the Office of the Governor, would house the key personnel who could assist in the coordination of efforts among the different agencies. This office would closely coordinate and link to Medicaid's health information exchange efforts, as well. In addition, the state will need to increase staffing levels at affected state agencies to address the increased health insurance and health information Exchange efforts. Funding received through both level one and level two cooperative grants could offset these costs during the implementation phase.

Alabama can apply for additional federal funding to support implementation of its Exchange through the cooperative agreements (see "Cooperative Agreements"). A request for these funds may be submitted by a state agency or quasi-government agency designated by the governor. However, nonprofit entities are

[3] HHS Office of Consumer Information and Insurance Oversight, *Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges*, Funding Opportunity Number IE-HBE-11-004, CFDA: 93.525, p. 12.

not allowed to directly request federal funding to support the establishment of a state-based Exchange.

In regard to the decision to establish one or two Exchanges to serve the individual and small group markets, we recommend that the state proceed with a single Exchange, while recognizing the need to develop functionality and customer support that may differ for these two market segments.

ELIGIBILITY DETERMINATION

Findings

The ACA directs states to use a

> single, streamlined form that: may be used [by individuals] to apply for all applicable state health subsidy programs within the state; may be filed online, in person, by mail, or by telephone; may be filed with an Exchange or with state officials operating one of the other applicable state health subsidy programs; and is structured to maximize an applicant's ability to complete the form satisfactorily, taking into account the characteristics of individuals who qualify for applicable state health subsidy programs.[4]

In short, Alabama is expected to establish a single application or entry point—possibly feeding into a single eligibility engine—to determine eligibility for Medicaid, ALL Kids, and the Exchange. The intent of the ACA is to enable an individual to supply a limited amount of information to determine whether the person is eligible for coverage under the various medical assistance programs available in the state.

The federal government will be issuing regulations regarding the single-portal eligibility system and is charged with developing a standard eligibility form for use by the states. In the meantime, the state of Alabama will need to start planning for the development of a system that can process applications and determine eligibility for all subsidized health insurance programs. In addition, a mechanism to capture and store eligibility and enrollment information for all publicly subsidized health coverage programs will be needed to minimize the potential for individuals to be covered under more than one program simultaneously and to coordinate coverage across programs.

The eligibility process, whether via a single system or modular systems connected through an enterprise service bus, will determine whether an individual or family is eligible for coverage through Medicaid, ALL Kids, or the Exchange and whether the individual or family qualifies for premium subsidies and reduced cost sharing through the Exchange. Eligibility will be determined using four key pieces of information: (1) residency status (whether the applicant is a legal US and

[4] Section 1413 of the ACA.

Alabama resident), (2) availability of "affordable" and "qualified" ESI,[5] (3) family status and number of dependents, and (4) modified adjusted gross income (MAGI) and percentage of the FPL (Figure 1).

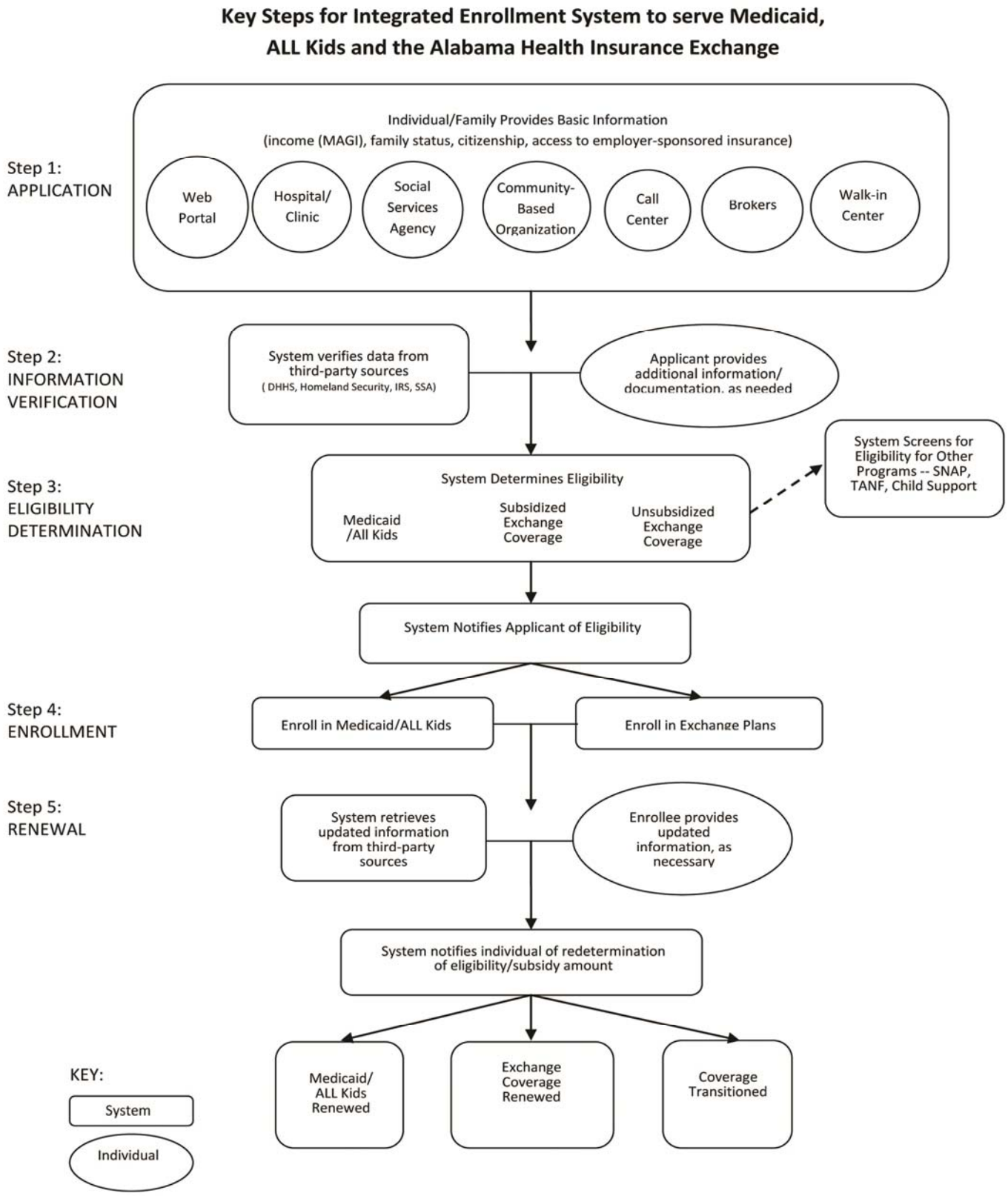
Potential enrollees will need to provide the following information:

- Name, address, and date of birth for each member of the family
- Social security number and information on the enrollees' immigration status, to be determined by the HHS secretary
- MAGI and family size
- Availability of employer-sponsored insurance, including
  - name, address, and employer identification number (if available) of the employer;
  - whether the applicant is a full-time employee and is offered coverage that meets the federal government's minimum standards; and
  - whether the employer offers coverage that meets the federal standards, the lowest cost health plan offered by the employer, and the employee's share of the premium for single coverage.

This information, and potentially other data, will need to be captured to determine an applicant's eligibility for the various health coverage programs. Eligible members would then be transferred to the appropriate health coverage program (such as Medicaid, ALL Kids, or the Exchange), at which point the applicant will continue with the enrollment process.

[5] For the purpose of determining eligibility for subsidized coverage through the Exchange, ESI will be considered affordable if the employee's share of the premium is no more than 9.5 percent of the applicant's MAGI and the insurance has an actuarial value of at least 60 percent (the health plan's premiums cover 60 percent of the cost of care for the average enrollee).

Figure 1. Key Steps in Integrated Enrollment System



Recommendations

To establish a streamlined, single application to determine eligibility for an expanded Medicaid program, ALL Kids, and the Exchange, Alabama should utilize a single eligibility process that will adjudicate applications for all health coverage programs, including the Exchange. To assess the feasibility of modifying the state's current eligibility process to meet the needs of an expanded Medicaid program, ALL Kids, and the Exchange in time to enroll people in coverage with an effective date of January 1, 2014, the state should

- review the requirements for a single portal under the ACA;
- provide an overview of the infrastructure, applications, interfaces, and business processes used to determine eligibility for publicly subsidized health coverage programs;
- develop budget estimates for the design, development, and implementation of a modified eligibility engine, if necessary and appropriate; and
- develop a timeline for completing the eligibility engine project to meet the January 1, 2014, effective date, as required by the ACA.

The state, in developing a plan for a single, streamlined eligibility process for all medical assistance programs, should also consider incorporating, over time, the eligibility processes and requirements for nonmedical assistance programs available to lower-income residents, including Temporary Assistance for Needy Families, Supplemental Nutrition Assistance Program, and child support. These efforts should also include myalabama.gov as the state seeks to incorporate eligibility determination for all public programs.

In addition, the Exchange should leverage the customer service centers for Medicaid and other social service programs that are being established across the state. Utilizing this infrastructure should help Alabama efficiently and effectively enroll people in the appropriate health coverage program.

STAKEHOLDER ENGAGEMENT

Engaging the participation of a broad cross-section of stakeholders in the planning and development of the Exchange will help it meet the needs of its residents. Alabama has already begun to engage stakeholders in discussions about how best to design and implement an Exchange that will complement the state's health insurance market and its existing public health coverage programs. Meaningful engagement will require reaching out to a wide range of individuals and groups, including business associations, small employers, consumer advocates, insurers, hospital executives, physicians, brokers, legislators, and other interested parties.

The ongoing involvement of a broad cross-section of individuals and groups who may directly benefit from Exchange operations will help Alabama design an Exchange that reflects its needs and desires. Engaging Alabamians in the planning efforts can also serve as an effective way to disseminate information about healthcare reform, in general, and the Exchange, in particular.

Early in 2011, the state established a Stakeholder Task Force with around 110 members. This group has been organized into four standing committees: Enrollment and Consumer Assistance, Exchange Administration, Qualified Health Plan Administration, and IT and Technology Requirements. We envision convening the entire Stakeholder Task Force for at least two meetings:

1. The first forum will review the overall planning process and the key decisions Alabama will need to make.

2. The second forum, held toward the end of our process, will preview recommendations to be made to state decision makers, solicit additional guidance on options still under review, and offer guidance for building support for the recommended plan. Specifically, we will discuss the stakeholders' roles in building support for the recommendations being made through this process.

In addition to the meetings with the Stakeholder Task Force, we will conduct six focus groups with the following key stakeholder groups during the month of June: two with small business owners and one each with insurers, brokers, advocacy groups, and primary care physicians and other providers. Table 2 shows the proposed schedule.

Table 2. Proposed Focus Group Schedule

Trip	Focus group	Participants	Location	Date
1	1	Insurers	Birmingham	June 8, 2011
	2	Brokers	Birmingham	June 9, 2011
2	3	Small Businesses	Birmingham	June 22, 2011
	4	Small Businesses	Mobile	June 23, 2011
3	5	Providers	Birmingham	June 28, 2011
	6	Advocacy Groups	Montgomery	June 29, 2011

OUTREACH, EDUCATION, AND ENROLLMENT

Findings

The Exchange will need to help people apply for health coverage, determine their eligibility for subsidized healthcare (Medicaid, ALL Kids, and Exchange subsidies), aid people in their assessment of health coverage options, and facilitate

enrollment in a health plan. Instituting a proactive outreach, education, and enrollment program will be critical to the Exchange's success.

If the Exchange is to attract the necessary volume of individuals, families, and small businesses to support its operations, it will need to develop a multipronged outreach, education, and enrollment program using the paid media, public-service announcements, and other means. Such an effort might include a wide array of organizations and individuals, including the Exchange, Medicaid, ALL Kids, other social service agencies, brokers, schools, community-based organizations, faith-based organizations, private employers, business groups, associations, hospitals, community health centers, physicians, and health insurers.

In addition to establishing a website, a customer service unit, and a call center, as well as walk-in centers, to help people with the eligibility and enrollment process, the Exchange will need to contract with outside entities that can assist individuals with eligibility and enrollment. The federal health reform law requires Exchanges to contract with navigators, which will inform people of their health coverage options and help them enroll in an Exchange-based health plan or in other publicly subsidized health coverage programs, as appropriate.

Navigators are entities such as trade, industry, and professional associations; chambers of commerce; unions; community-based nonprofit groups; and other groups that have established, or can readily establish, relationships with employers, employees, consumers, or self-employed individuals. The Exchange will need to establish a selection process for awarding grants to navigators.

Navigators will be responsible for

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

The HHS secretary will establish standards for the navigators. However, federal law prohibits health insurers from serving as navigators and prohibits navigators from receiving "direct or indirect payments" in connection with the enrollment of an individual or an employee in a qualified health plan. This latter exclusion may preclude brokers from serving as navigators.

In addition to navigators, the Exchange will need to determine how best to use brokers to help consumers. The state must thoroughly understand the role that brokers play in Alabama's individual and small group markets and consider that information when setting up the Exchange. Failure to adequately consider whether or how the Exchange could or should work with the broker community could adversely affect Exchange viability and success.

Alabama officials have already identified as many as 250,000 parents of Medicaid-eligible children who will likely be eligible for coverage through either the expansion of Medicaid or subsidized coverage through the Exchange. Proactive outreach to these and other groups of potentially eligible state residents will greatly increase the chances that the Exchange can quickly ramp up enrollment and become a viable and sustainable operation in short order.

Recommendations

The Exchange should develop a robust outreach, education, and enrollment program, establishing a work group to develop a plan and schedule for this purpose. In addition, Alabama's Exchange will need to determine the appropriate role that brokers and navigators will play in the operation of the Exchange.

Alabama should consider certain key issues in the plan development, including the following:

- How various organizations currently help consumers and beneficiaries obtain information on health insurance options and how the Exchange could involve these groups in its outreach, education, and enrollment efforts
- The role of navigators and whether they should be "credentialed," and if so, how the credentialing could be structured and administered
- The role brokers currently play in Alabama's individual and small group markets and how the Exchange could best leverage their expertise
- How brokers are compensated today and the type of broker compensation model the Exchange could establish
- The role of insurers in regard to outreach, education, and enrollment
- How providers, hospitals, community health centers, and other frontline entities can support outreach and enrollment efforts
- The types of information individuals will need to make informed decisions
- Whether the outreach, education, and enrollment needs of individuals differ from those of small employers and their employees.

Determining how best to leverage the expertise of health insurance brokers, community-based organizations, health centers, and other key groups and proactively including them in the outreach and enrollment program will be critical to the success of the state's Exchange.

As noted previously (see "Eligibility Determination"), the Exchange should also take advantage of the customer service centers for Medicaid and other social service programs that are being established across the state. Utilizing this infrastructure will help the Exchange efficiently and effectively enroll people in coverage.

We recommend establishing a separate work group to determine how best to structure the scope of services for navigators vis-à-vis brokers. Forthcoming guidance from the federal government on the role of navigators and brokers will also be helpful in structuring an arrangement that best serves the needs of the Exchange and the hundreds of thousands of people who will be eligible for coverage through the expansion of Medicaid and establishment of the Exchange.

HEALTH PLAN SELECTION

Findings

Regardless of which model the state adopts for the Exchange (market organizer/distribution channel, selective contracting agent, or active purchaser), health plans offered through the Exchange will be available in five benefit levels: Platinum, Gold, Silver, Bronze, and Catastrophic. The benefit levels will vary on the basis of "actuarial value," which is a summary measure of the amount of medical claims that would be paid by the health plan as a percentage of the total medical claims incurred for a standard population. The different benefit levels will have different amounts of point-of-service cost sharing (deductibles, copayments, and coinsurance).

Platinum plans will cover 90 percent of the cost of care. This means that a member enrolled in a Platinum level plan would, on average, pay 10 percent of the cost of care through copayments, coinsurance, or other types of cost sharing. The actual amount of cost sharing will vary for each member on the basis of their use of services and supplies.

Gold plans will cover 80 percent, Silver plans 70 percent, and Bronze plans 60 percent. Catastrophic plans, which are limited to individuals younger than 30 or people who are exempt from the insurance mandate due to affordability or other hardship, are HDHPs.[6] These plans will not be offered to employers purchasing insurance through the SHOP Exchange.

[6] An HDHP offered through the Exchange must cover all of the essential health benefits, as determined by the HHS secretary, but may have annual deductibles up to the limits established each year by the Internal Revenue Service. In 2011, the HDHP deductible limits are $5,950 for individual coverage and $11,900 for family coverage.

Alabama must decide the extent to which health plans offered through the Exchange will have standardized benefits (such as point-of-service cost sharing and the types of plans offered—health maintenance organization, preferred provider organization, or indemnity) within each of the benefit levels. Federal law provides flexibility in regard to the plans offered and the cost sharing, within the parameters of actuarial value set by the ACA and "essential health benefits," which will be set by the HHS secretary (as discussed below).

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

Furthermore, the law limits the maximum up-front deductible for health plans purchased by small employers. In 2014, small group health plans may not have an up-front deductible that exceeds $2,000 for single coverage and $4,000 for family coverage. These limits do not apply to the individual market though the actuarial value standards noted above will effectively cap the amount of up-front deductible that may apply to individual coverage sold through the Exchange.

Federal law requires that Exchanges offer only "qualified" health insurance plans that provide coverage for "essential health benefits." The HHS secretary and Exchange will determine, in part, what "qualified" and "essential" mean.

Although Alabama may require plans to cover benefits beyond the minimums established by the federal government, ***the cost of any additional benefits must be borne by the state***. That is, the state must pay any added cost for state-mandated benefits not considered essential health benefits. This will be less of an issue for Alabama than it will be for other states, given the limited number of state-mandated benefits.

In addition to the potential cost to the state for any mandates that go beyond the federal government's list of essential health benefits, the administrative challenge of adjusting premiums and paying health carriers separately for the cost of those additional benefits could be a significant administrative and operational burden. Alabama will need to carefully review the federal regulations that establish the essential health benefits and compare those benefits to the state's mandates and benefit requirements.

The federal law also requires that health plans in both the individual and group markets comply with a common set of rules:

- Guaranteed issue and guaranteed renewal (an applicant cannot be denied coverage and cannot be dropped at the time of renewal)

- No use of health status as a rating factor (a person cannot be charged a higher premium on the basis of his or her health status or a preexisting condition)
- A limited set of factors used to set premiums (such as age, geographic location, and family composition)
- No variation in rates of more than 3:1 on the basis of age (for example, the rate charged an older applicant is limited to no more than three times the rate charged the youngest applicant).

Although health plans sold in the individual and small group Exchange will have common rating requirements, unless the risk pools are combined, the premiums for coverage will likely differ between these two markets. That is, a health plan offered in the individual market may have a different premium than an identical plan offered in the small group market.

The ACA also requires the Exchange to rate qualified health plans offered in each benefit level (Platinum, Gold, Silver, Bronze, and Catastrophic) on the basis of quality and price. This information will need to be provided to potential enrollees and displayed on Alabama's Exchange website. Enrollee satisfaction survey results, for plans with more than 500 enrollees in the previous year, must also be posted on the Exchange website.

Recommendations

Alabama should initiate meetings with health carriers operating in the state to discuss the types of health plans that may be offered through the Exchange, the manner in which the Exchange wants to standardize the benefits within each tier of coverage, and the overall structure and operations of the Exchange.

The state will also need to review its mandated benefits, compare them with the essential health benefits required under the ACA, and determine whether any Alabama mandates exceed the federal minimums. For any mandates that exceed the federally defined essential health benefits, the state will need to determine the cost of paying for those mandates for coverage purchased through the Exchange.

To align its rating and underwriting rules with the federal requirements that will take effect in 2014, the Department of Insurance will need to review current statutory and regulatory provisions pertaining to the individual and group markets. In addition, the Exchange will need to consult with the Department of Insurance and with insurance carriers to ensure rating and underwriting rules inside the Exchange are comparable to those that apply outside the Exchange.

WEB PORTAL

Findings

The web portal will serve as a central point of access for individuals and employers to obtain information on private health insurance available through the Exchange, compare health plans, enroll in coverage (and possibly make premium payments), and update their account throughout the year. In addition, the web portal will need to allow individuals to apply for an exemption from the individual mandate.

The web portal will need to include at a minimum, the following functionality:

- *A seamless link to the state's eligibility engine to allow individuals and families to enter information and determine their eligibility for all health coverage programs*. Individuals determined eligible for Medicaid or ALL Kids will be pointed to those programs to complete the enrollment process; individuals eligible for coverage through the Exchange—whether or not they are eligible for premium subsidies and reduced cost sharing—will continue on the Exchange website to evaluate their health plan options and continue with the enrollment process.

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

- *A cost calculator that provides an estimate of the total cost of coverage, including premiums and potential out-of-pocket exposure associated with point-of-service cost sharing*. The cost calculator could be set up to allow an individual to enter member-specific information on expected healthcare utilization (such as office visits, prescription drugs, outpatient care, and inpatient admissions), which could then be used to generate potential member costs for the various health plans offered through the Exchange. This will require linking benefit designs (deductibles, copays, and coinsurance) for the various health plans offered through the Exchange to a tool that is capable of generating member-specific cost estimates.

In addition to the capability to generate premiums and cost sharing reductions, the Exchange website will need to display benefit summaries to allow a customer to compare health plans. This will likely include both a summary plan description

that captures the major benefits and applicable cost sharing, as well as a link to more detailed benefits information.

Additional website functionality might include a provider search to enable an individual to enter his or her doctor's name or a hospital's name to determine which of the Exchange's health plans include the doctor or hospital in the respective provider network.

The Exchange might also consider making available on its website a health risk assessment (HRA) tool to allow an individual to enter a limited amount of personal health information that might then be shared with the health carrier selected by the applicant to enable the latter to determine whether the new enrollee might benefit from care management or disease management programs.[7] Given that many of the people enrolling through the Exchange will be "new" to the insurance marketplace, putting in place an HRA may be an added value the Exchange can provide for the carriers offering coverage through the Exchange.

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

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

Recommendations

Alabama's Exchange planning and implementation team should establish a web portal and business processes workgroup charged with detailing the specifications for all of the functionality and business requirements for the Exchange. Since the state has established a web-based application for its Medicaid and ALL Kids programs—an application that is maintained by the Department of Public Health—Alabama should be able to leverage some of its existing web-based applications

[7] Because carriers will be prohibited from using health status or preexisting conditions in setting the rates for coverage offered through the Exchange—and in the individual and small group market overall—in 2014 and beyond, health insurers may not have access to important medical information about enrollees at the point of enrollment. The Exchange's ability to provide the health plans with member-specific information on new enrollees could help the carriers identify at-risk members before they use services and incur claims.

and functionality to serve the Exchange. This should also include efforts to incorporate myalabama.gov into future plans.

As part of this effort, the state should consider issuing a request for information for the various component pieces associated with a fully functioning Exchange, including a premium generator/rating engine, premium aggregator, health benefits display and comparison, consumer decision-support tools, enrollment brokerage system, cost calculator, and HRA tool. A review of existing private-sector systems that currently operate in the marketplace would allow the state to better understand the types of systems available, their strengths and weaknesses, and the potential to leverage existing technologies.

The Exchange will also want to monitor the activities of other states and the "early innovator" grantees, which are states or consortia of states that have been funded by CCIIO to lead efforts on various information technology components and infrastructure associated with the development of Exchanges across the country.

CUSTOMER SERVICE AND CONSUMER ASSISTANCE

Findings

The need for consumer assistance reflects the fact that most Alabamians—and most US residents, in general—have never purchased health insurance on their own. People either obtain insurance through their employer (perhaps choosing from among a limited number of plans) or they receive publicly subsidized coverage from Medicaid or Medicare. The Alabama Department of Insurance estimates that approximately 165,000 people, or roughly 3.5 percent of Alabama residents, were covered by individual (not employer-sponsored) health plans. Through the Exchange, hundreds of thousands of new "customers" will be responsible for purchasing health insurance, many of whom will be doing so for the first time. These new customers will need help wading through their options.

Recommendations

Alabama's Exchange team will need to develop a robust consumer assistance and customer support team that can help individuals determine eligibility for public or private health coverage, help new consumers shop for insurance, help people file grievances and appeals, provide information on consumer protection provisions, and collect information on inquiries and problems and how they were solved.

In setting up the customer service center, the Exchange will need to consider the services now being provided by the state's health insurance consumer assistance program and seek to leverage any available resources. In addition, the Exchange will need to work with Medicaid, ALL Kids, and other social service programs that are collaborating to establish customer service centers across the state,

designed to assist people in completing applications for public assistance programs and provide information to existing and potential beneficiaries.

In regard to the establishment of a call center to assist people with the shopping experience, Alabama will need to consider the role of navigators, brokers, and health insurers, among others, to determine the types of questions the call center will handle, services provided, and workload distribution.

The state will also need to determine the types of services that might be required to assist individual purchasers vis-à-vis employer groups. These groups are likely to differ in key ways, and the Exchange may wish to establish a dedicated unit to assist employers (and potentially brokers working on their behalf).

APPENDIX. ABBREVIATIONS

ACA	Affordable Care Act
CCIIO	Center for Consumer Information and Insurance Oversight
CHIP	Children's Health Insurance Program
ESI	employer-sponsored insurance
FPL	federal poverty level
HDHP	high-deductible health plan
HHS	Department of Health and Human Services
HRA	health risk assessment
MAGI	modified adjusted gross income
SHOP	Small Business Health Options