

To: Vermont Health Benefit Exchange Advisory Board
From: Bailit Health Purchasing (Beth Waldman, Amy Lischko, Brendan Hogan, Joshua Slen)
RE: Mandatory and Optional Functions of the Health Benefit Exchange
Date: April 11, 2011

This memo presents some background information on the functions of the Health Benefits Exchange (Exchange). It presents and delineates mandatory and optional functions and presents some key considerations for Vermont regarding how to implement these functions moving forward. The Secretary of HHS is required to promulgate regulations setting standards for meeting the Exchange requirements in the statute including: 1) the establishment and operation of Exchanges (including SHOP Exchanges); 2) the offering of qualified health plans; 3) reinsurance and risk adjustment programs; and other requirements as the Secretary determines appropriate.¹ The discussion presented here will be refined as more information becomes available and as the Exchange Planning and implementation phase continues.

This brief covers the following Exchange functions: 1) Marketing and Outreach; 2) Navigator Program; 3) Eligibility Determination; 4) Enrollment; 5) Website; 6) Exemptions from the Individual Mandate; 7) Procurement and Certification of Plans; 8) Interactions with Employers; 9) Risk Adjustment and Reinsurance; and 10) Reporting and Evaluation.

1. Marketing and Outreach

The ACA creates many new options for covering consumers. In all cases, streamlined eligibility and enrollment is envisioned. It is hoped that these options support consumers as they navigate within and through these new options for coverage. Undoubtedly, these new forms of coverage will create some initial confusion in the marketplace, challenging an exchange and other programs to live up to the expectations of administrative ease. Successful implementation of the ACA requires extensive marketing, public education, and outreach. For consumers, the focus is on the insurance mandate and the types of insurance assistance they are eligible for. For employers, the focus is on the employer requirements, employee affordability and vouchers, and tax credits.

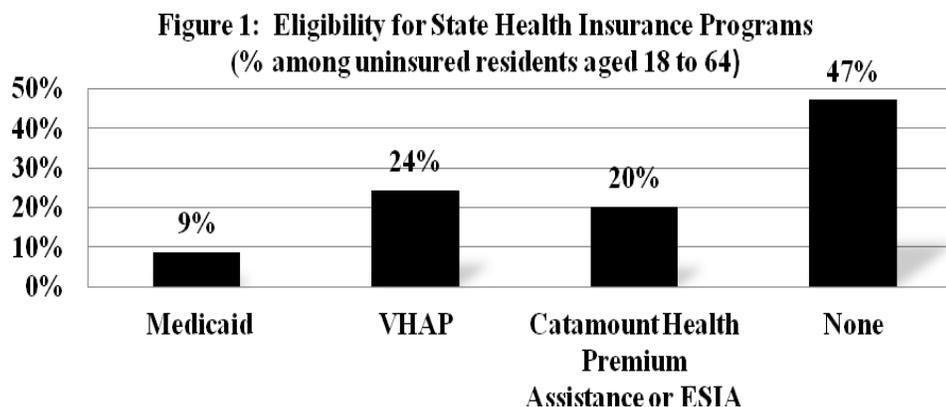
The ACA requires that the Exchange maintain a call center with a 1-800-number to assist individuals with their insurance transactions. This call center will also need to be a robust educational center and triage calls to the appropriate agency staff. In addition, the Exchange may need to launch numerous public education and outreach campaigns, collaborating with state agencies, community organizations, and corporate and civic organizations. The Connector in Massachusetts provides some examples of the types of outreach and marketing activities that were implemented. These activities were augmented by advertising campaigns of the insurance carriers, and outreach grants to community organizations and nonprofits.

¹ Section 1321 (a)(1) (A) – (D)

Some of the activities in Massachusetts included:

- 1) A series of statewide forums called Connect-to-Health events. In collaboration with state legislators, municipal officials, local hospitals, community health centers, and community groups, the Connector sponsored 30 events in 20 communities across the state;
- 2) A postcard mailing to nearly three million Massachusetts taxpayers. The card provided information on the requirements of the new law and the opportunities for purchasing insurance through the Connector;
- 3) Outreach activities in collaboration with the Massachusetts Bay Transportation Authority (MBTA). Public education included display posters addressing the law in MBTA cars and tear-away note cards for contacting the Connector in order get additional information on health insurance programs;
- 4) Partnerships with corporate and civic organizations in order to disseminate information on health reform to the public including CVS stores and the Red Sox.

Because Vermont is a more rural state than Massachusetts with fewer urban centers, it will need a marketing and outreach strategy tailored to its unique geography and population demographics. Vermont has a long history of providing successful education and outreach activities and recent experience with the Catamount Care expansion. However, of the state's current uninsured population, approximately one-third are currently eligible but unenrolled in various public assistance programs as shown in Figure 1 below. Like most state Medicaid programs, Vermont sees a high level of churning in its Medicaid population.²



Recent estimates have projected that 23,896 uninsured Vermont residents will be eligible for the premium tax credits through the Exchange beginning in 2014¹. Additional insured Vermonters may also be eligible for employer vouchers and/or tax credits because their available employer-sponsored coverage is either unaffordable or does not provide the essential benefits required under the ACA.

² As part of the Exchange Planning Process, Bailit is conducting a churn analysis to look at movement of residents receiving public health care coverage across available programs and in and out of coverage.

Vermont has studied the barriers its uninsured adults face regarding enrolling in a state health insurance program (see Table 1). In the 2009 household survey, 52% of Vermont’s uninsured reported they were concerned the cost would be too high. Thirty-three percent thought they were ineligible because their household made too much money, 8% were concerned they would not be able to see their choice of doctor, and 5% thought they were ineligible because their employer offered health insurance. Among uninsured adults aged 18 to 64, 9% indicated they did not want to be on public assistance and 7% did not see the need for health insurance.

Table 1: Major Reason for Not Applying for State Public Program

	Count		Rate	
	2008	2009	2008	2009
Worried costs would be too high	31,323	22,785	72%	52%
Not eligible because household makes too much money	16,526	14,370	38%	33%
Don't want to be on public assistance	4,146	3,970	10%	9%
Concerned you would not be able to go to the Dr you want.	8,796	3,621	20%	8%
Don't need insurance	2,975	3,018	7%	7%
Not eligible because employer offers insurance	4,244	2,165	10%	5%

Data Source: 2008, 2009 Vermont Household Health Insurance Surveys

In addition to providing outreach and education to individual consumers, employers will also require education and outreach around the ACA requirements to offer coverage and the availability of tax credits. Vermont is largely made up of small employers. According to Q1 2010 data from the Department of Labor, 96.8% of Vermont’s employers were under 50 employees and an additional 1.9% had between 50 and 99 employees. There is an opportunity to serve many of Vermont’s employers in the SHOP Exchange.

Lewin has estimated that 13,100 small businesses in Vermont are eligible for the small employer tax credits,³ and approximately 3,400 for the maximum tax credit amount. Although we do not know how many employers have taken advantage of this tax credit yet, it will be important to monitor this moving forward and understand reasons why employers do not take advantage of these credits when available.

Key Considerations

³ <http://govcha.state.nv.us/docs/SBHelpingHand.pdf>

As Vermont moves forward in its planning for a single-payer system, it will be important to consider strategies for maximizing enrollment in current programs to receive appropriate federal funding for its waiver post 2014. In addition, to realize significant reductions in the uninsured, special attention to outreach and education will be very important. Since Vermont has already expanded coverage, it is likely that those who remain unenrolled are the “difficult to reach.” Information from the 2009 Household survey can be used to target the uninsured and maximize the marketing and outreach dollars that will be available to Vermont.

Vermont will need to not only build upon past experiences to utilize proven outreach and education strategies, such as the strategy used to enroll newly graduating college students, but will also need to work with various stakeholders to better understand why people do not enroll in programs for which they are eligible.

A multi-pronged outreach and educational strategy may be necessary and should include Exchange employees, state employees working for social service agencies, schools-based promotional activities, community-based advocacy organizations, private employers, business groups, hospitals, community health centers, physicians, health insurers, paid media, and public service announcements.⁴

2. Navigator Program

An integral part of education and outreach for the Exchange is the Navigator Program. Section 1311(i) of the ACA requires an Exchange to establish a Navigator program that provides grants to entities that assist consumers as they seek services from an Exchange. To be eligible as a Navigator, an entity must demonstrate that it has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to enroll in a qualified health plan. Further, the law defines the duties of navigators to:

- Conduct public education activities that raise awareness of the availability of qualified health plans;
- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions;
- Facilitate enrollment in qualified health plans;
- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under the law, or any other appropriate state agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by an Exchange.

⁴ Carey, Robert; Health Insurance Exchanges: Key Issues for State Implementation, September 2010, AcademyHealth, State Coverage Initiatives, RWJ Foundation.

Navigators will be central to addressing special needs and gaps in the general education efforts of the State. The ACA envisions the consumer as the client for a Navigator. The ACA stipulates that payment will be in the form of grants. Payment should not create incentives to encourage or discourage certain consumer behavior or preferences. Information should be provided to consumers in a way that can be understood by the consumer, including presentation of information in a culturally sensitive manner or for those with low-proficiency English, and people with disabilities or who otherwise have special communication needs. Navigators can also help applicants and enrollees compare benefit designs and plan features. Navigators could also present information about the relative price and quality of the health plans offered through an exchange.

Key Considerations

It is important to keep in mind that the population needs for those purchasing insurance may be somewhat different than those seen in the private insurance market today. For example, because of the individual mandate, people who have not had health insurance before may be eligible for premium tax credits. In addition, most consumers have not purchased health insurance on their own and will need assistance with this complex process. Different Navigator entities will likely be needed to meet the diverse needs of the new consumers who will be accessing an Exchange for insurance coverage.

Identifying people and places where various populations currently seek information and assistance around health insurance issues will be critical in this process. For example, Vermont will need to meet with stakeholders, community organizations, and other state and federal partners to determine the needs of the various populations who will be served by an Exchange.

Vermont will need to consider who will be granted Navigator status in its Exchange. The ACA identifies the following entities as potential Navigators including: trade, industry, and professional associations, chambers of commerce, unions, and community-based non-profit groups. Further guidance is expected from HHS on standards relating to Navigators. However, federal law does preclude insurers from serving as Navigators and also prohibits Navigators from receiving direct reimbursement from insurers for enrolling someone in a Qualified Health Plan (QHP).

Because the federal government does not provide funding for Navigator services, Vermont will need to develop a financing plan for these services. It may be important to distinguish public Navigators from private-entity Navigators when determining potential financing schemes. There may also be a different Navigator role for outreach to individuals vs. businesses.

Vermont will also need to determine the appropriate role for brokers moving forward and to delineate it from the role of Navigator. The ACA requires the Secretary of HHS to “establish procedures under which a State may allow agents or brokers” to enroll in QHPs in the exchange and/or assist individuals in applying for premium tax credits and cost sharing reductions. The

Secretary may also establish rate schedules for brokers' commissions paid by plans offered through an Exchange.ⁱⁱ As the state moves to a single-payer system, the traditional services provided by brokers may change. Exchange implementation provides an opportunity to transition some of these skilled and knowledgeable people into new roles interacting with the Exchange.

3. Eligibility Determination

Section 1311(d)(4)(F) of the ACA requires Exchanges to evaluate and determine eligibility for applicants in Medicaid, the Children's Health Insurance Program (CHIP), and other health programs. The federal government will provide the tools, including a "single, streamlined form," and financial support to states for achieving this unified enrollment process. After eligibility is determined, an Exchange must also verify eligibility for premium tax credits for individuals with household incomes between 133% and 400% of the federal poverty level.

The state of Vermont is not new to coordinating eligibility for subsidized coverage among programs for low-income individuals. There are already numerous programs for which subsidized coverage must be coordinated including Dr. Dynasaur, Vermont Health Access Plan (VHAP), Medicaid, Catamount, ESI, etc. However, the ACA envisions a system that will require significant enhancements to Vermont's Information Technology systems in order to achieve the improvements in continuity of care across health programs envisioned by the ACA. Coordination among state-administered health care programs is a necessary first step in maintaining continuous, affordable coverage and continuity of care.

Table 2 summarizes the eligibility standards for individuals regarding Medicaid, the Basic Health Program, and the Exchange beginning in 2014.

Table 2: Eligibility Standards

Program	Eligibility
New individuals eligible for Medicaid	Premium and out-of-pocket expenses fully covered for individuals in households with incomes between 0 -133% FPL.
Federal basic health option	<p>The State receives 95% of the premium and out-of-pocket subsidies that would have been provided under the exchange for the same income group for:</p> <ul style="list-style-type: none"> ▪ Families with incomes between 134 -200%FPL; ▪ Individuals not eligible for minimum essential coverage including Medicaid and "affordable" employer-sponsored plans of "minimum value;" ▪ Lawful aliens with family incomes between 0 -- 133% FPL and not eligible for Medicaid.

Exchange	<p>Sliding-scale premium tax credits designed to cap premium contributions from 2% --9.5% of income.</p> <ul style="list-style-type: none"> ▪ Individuals with incomes between 134 and 400% FPL. ▪ Individuals not otherwise eligible for minimum essential coverage including Medicaid and “affordable” employer-sponsored plans. ▪ Lawful aliens from 0% -- 133% FPL and not eligible for Medicaid.
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In addition to premium tax credits, cost-sharing subsidies are available for people up to 250% FPL to reduce the cost-sharing amounts increasing the actuarial value of their silver plan as follows:

- 100-150% FPL: 94% of the benefit costs will be covered
- 150-200% FPL: 87% of the benefit costs will be covered
- 200-250% FPL: 73% of the benefit costs will be covered

The ACA also limits annual out-of-pocket cost-sharing for individuals and families up to 400% FPL as follows:

- 100-200% FPL: 1/3 HSA limit or \$1,983 individual/\$3,967 family
- 200-300% FPL: 1/2 HSA limit or \$2,975 individual/\$5,950 family
- 300-400% FPL: 2/3 HSA limit or \$3,967 individual/\$7,933 family

Key Considerations

One challenge for Vermont will be the timing of its new eligibility system. Vermont is planning to release a procurement in the next few months for a new eligibility system designed to determine eligibility for both current programs and coverage through the Exchange, and include the flexibility to meet the future needs of the single-payer system. To allow Vermont to administer a fully functional Exchange in 2014, the eligibility system must be completed by the summer of 2013. Large system builds are always complicated and often take more time than expected to complete. It will be important for Vermont to closely monitor the timeline and develop a back-up strategy as necessary.

In addition to requiring coordination of eligibility across public programs, the ACA also requires eligibility to be determined for Medicaid, CHIP and the Exchange through a Modified Adjusted Gross Income (MAGI) standard. However, federal regulations detailing the MAGI and how income and citizenship will be verified have not yet been issued. As Vermont works to build its new eligibility system, it is imperative that the state closely monitor federal regulations and understand where the state has flexibility to create its own system of eligibility.

Transitions between public programs are inevitable as families experience changes in their income and employment status. To avoid undue movement between Medicaid and the

Exchange due to frequent changes in income, Vermont may want to examine the trade-offs between the provision of accurate and equitable public subsidies and the burden of administering frequent changes in family accounts. Seamless transitions can also be enhanced by setting and consistently applying eligibility rules that clarify the populations to be covered by each program. How much flexibility Vermont will have, however, will not be known until the federal government releases regulations.

Continuity of care can be disrupted for families who experience relatively frequent changes in income. It might be worthwhile to explore methods for retaining or transferring enrollees between programs as their income changes in a manner seamless to enrollees and with minimal disruption to care.

Because the ACA builds upon our employer-based system, eligibility for premium subsidies through the Exchange is dependent on whether the applicant has access to employer-sponsored insurance and whether that insurance meets actuarial standards and provides “minimum essential benefits” and whether the employee’s share of the premium as a percentage of his/her income is above or below a certain percentage of his/her income. In addition, only legal residents will be allowed to purchase through the Exchange regardless of their eligibility for premium subsidies.

4. Enrollment

Although the Exchange is required to establish initial, annual and special enrollment periods following guidance from the HHS secretary, the Exchange is not required to enroll individuals in qualified health plans or serve as a premium aggregator as is done in the Massachusetts and Utah Exchanges. That is, the Exchange could be structured to serve primarily as a conduit, providing people with information about their health plan choice and eligibility, including the subsidy levels that may be available, and sending consumers to the health carriers to complete the transaction including enrollment and payment of premium

The process outlined by the ACA for eligibility determination and enrollment is quite complex and cannot be seamless to the consumer. The ACA dictates that the health insurers are responsible for coordinating with the federal government for the advance payment of tax credits for subsidy-eligible individuals. In addition, section 1411(c)(1) directs the Exchange to provide applicant information to the Department of Health and Human Services (HHS). HHS verifies the eligibility data with the Social Security Administration, Department of Homeland Security, and Department of Treasury. Section 1412(c) specifies that the Department of Treasury (IRS), after receiving notice from an Exchange, pays the advance premium tax credit subsidies to the insurer. This process requires both the insurer and the Exchange to be involved with the premium tax credits.

The ACA provides some flexibility to states regarding the payment of premiums by individuals, subsidized and non-subsidized, enrolled in qualified health plans through an Exchange. An Exchange could choose to perform the enrollment and billing function for the carriers in its Exchange or can maintain current billing and enrollment functions at the carrier level. These individual premium contributions will sometimes include free choice vouchers paid by employers to an Exchange.⁵

Key Considerations

Despite the ACA requirements that subsidy dollars flow directly to the carrier, Vermont should seriously consider including a mechanism for enrollment and collection of premium payments from individuals and small businesses purchasing through the Exchange. H.202 provides the authority for the Exchange to do this. Although the ACA is silent on the enrollment functions of the Exchange, Vermont will be motivated to expand this enrollment function as much as is feasible under the federal law in order to provide increased administrative simplification for individuals and employers in order to ensure easy enrollment and to reduce “churn.” Vermont may want to influence the federal government’s approach and subsequent rulemaking on the issue of whether the Exchange can collect tax credit revenues as that would allow for a seamless transaction for the consumer.

⁵ Section 10108(d)(2).

There are significant costs and benefits that must be considered when analyzing whether an Exchange should be a premium aggregator and provide for enrollment functionality. It would likely be easier for consumers to navigate a process that occurs completely within an Exchange as opposed to linking to the processes of each insurer. Vermont should analyze the current process for individuals enrolling in Catamount Health with Catamount Health Assistance to determine where there have been issues for consumers in order to learn from this experience. An Exchange may be able to better facilitate premium billing, collection, and remittance to insurers as well as changes in enrollment status, especially if these processes are performed for an entire population on a monthly basis. If an Exchange innovates, then simplified transactions can be experienced by consumers, employers, and insurers.

However, including this enrollment and billing capacity within the Exchange is resource intensive and will add significant administrative costs to an Exchange. Moreover, it does create some redundancy in the market as insurers already have individual and group enrollment processes, but not means-tested eligibility processes, in place. Administrative costs would be reduced only if it is more efficient for the exchange to aggregate premiums in a single location instead of each insurer performing that task.

Vermont will want to stay apprised of the work of the New England States Collaborative Insurance Exchange Systems (NESCIES) project which will create Health Insurance Exchange (HIX) Information Technology components that are consumer-focused, cost-effective, reusable, and sustainable that can be potentially leveraged by Vermont. As the project is just beginning, Vermont will want to closely monitor the develop direction Massachusetts takes and continue to pursue its own planning and implementation of this and other IT functionality.

5. Website

Section 1311(d)(4) of the ACA requires that an Exchange establish and maintain a website for providing information on plans to current and prospective enrollees. This website must include a display price and quality ratings of plans. The site will also present plan benefit options in a standardized format. In addition, the site must provide an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions. Presentation of plan enrollee satisfaction survey results is also required under Section 1311(c)(4).

Key Considerations

Vermont will want to consider what additional functionality is important to include on its Exchange website. An Exchange Website could promote additional transparency by presenting information regarding providers in carriers' networks; including hours and appointment wait times, patient satisfaction, outcomes data or other information that may be important to the consumer. Over time, tts website could be linked to Vermont's all provider claims database

(VHCURES) to provide information on provider outcomes. Best practices in areas other than health care may provide some guidance to Exchanges in this regard. For example, Consumer Reports has a longstanding reputation for providing useful price and quality information to consumers to help them make decisions among competing product choices. Many consumers are also fond of various online search engines for different types of purchases. Vermont will need to consider the amount of accountability and transparency desired for their Exchange and the amount of resources it has to dedicate to this effort. Working with consumer groups to learn about the types of information consumers would find useful for purchasing decisions and then developing appropriate and effective interfaces will be important to promote increased transparency.

6. Exemptions from Individual Mandate:

The Exchange is responsible for establishing a process to determine whether an individual is exempt from “the individual responsibility penalty” based on affordability, religion or hardship. HHS will develop the specific guidelines that will be used to grant exemptions. Information on each individual who is issued a certificate of exemption from the Exchange must be transferred to the secretary of the Treasury. The Exchange will need to set up a process by which individuals will be able to request an exemption from the mandate.

Key Considerations

Vermont will want to ensure a process that is simple to understand and allows people to access the necessary information from multiple sources.

7. Procurement and Certification of Plans

Exchanges are required to offer only qualified health plans (QHPs) that provide coverage for “essential health benefits.”⁶ Exchanges must allow limited scope dental plans (either separately or in conjunction with a QHP) to offer coverage in the Exchange.

QHPs must also be certified by the Exchange, be licensed and in good standing in the state, agree to offer one silver and one gold plan in an Exchange, agree to charge the same premium both in and outside the Exchange, and comply with other regulations that apply to Exchanges.⁷

QHPs will be made available in four levels of coverage based on “actuarial value” (the average percent of medical costs covered by a health plan), with an additional optional catastrophic policy. The bronze-level plan has to provide benefits equivalent to 60 percent of the actuarial value, with the silver level at 70 percent, the gold level at 80 percent, and the platinum level at 90 percent. Catastrophic policies are only available for persons under age 30 or those who cannot otherwise find affordable coverage or would suffer a hardship in buying other

⁶ Section 1302(b) (1)

⁷ HHS will establish criteria for certifying QHPs including marketing requirements, sufficient provider choice, include essential community providers, be accredited, implement uniform quality improvement strategy, use an uniform enrollment form, use a standard format for presenting options, and provide information on quality standards used to measure plan performance.

coverage.⁸ These benefit levels differ primarily on the amounts of point-of-service cost sharing, with the platinum level requiring, on average, ten percent of the cost of care through co-payments, co-insurance, or other types of cost sharing.

QHPs must implement a quality improvement strategy which includes improving health outcomes through care coordination and case management, preventing hospital readmissions, improving patient safety, implementation of wellness and health promotion activities, and reducing health care disparitiesⁱⁱⁱ QHPs must also meet standards for marketing that do not discourage the application of individuals with significant health needs, ensure sufficient choice of providers, including community providers in plan networks that serve predominantly low-income and medically underserved, standardized plan presentation and uniform enrollment forms.

QHPs must disclose claims payment policies and practices, financial information, data on enrollment and disenrollment, claims denials and rating practices, information on cost sharing for out of network coverage and on enrollees rights and must provide consumers with coverage summaries no longer than 4 pages.

Exchanges have additional oversight over premium increases, QHPs must submit justification for premium increases, and the Exchange must take premium increases into account in decisions about which QHPs are offered.

In addition to the QHPs Vermont wishes to offer in its Exchange, beginning in 2014, two multistate plans (one of which must be nonprofit) will be available in the Exchange and managed by the Office of Personnel Management (OPM). These plans will only be offered to individuals and small groups.

Key Considerations

There are numerous considerations for Vermont regarding procurement and certification of plans for sale in the Exchange. First, Vermont must decide whether it would like to establish an Exchange that is an “active or selective purchaser.” By being more selective, Vermont’s Exchange will likely set additional standards for qualified health plans to meet and will choose a plan(s) based on the comparative “value” they offer to consumers. To the extent possible Vermont’s Exchange will be an “active purchaser” and will “negotiate” health plan premiums with the insurer(s).^{9, 10}

It may be challenging for Vermont to initially function as an active purchaser with the number of rating and risk management issues that exist and the need for implementation to begin by

⁸ Section 1302(e)

⁹ Carey, Robert, Health Insurance Exchanges: Key issues for State Implementation, AcademyHealth, State coverage Initiatives, September 2010.

¹⁰ Jost, Timothy, Health Insurance Exchanges And the Affordable Care Act: Key Policy Issues, The Commonwealth Fund, July 2010.

January 1, 2014. This could also prove difficult to manage if products offered in an Exchange market are also offered outside the Exchange since prices are required to be the same for carriers offering products both in and outside an Exchange.¹¹ Vermont should consider the how to appropriately evolve from the current insurance market to an Exchange acting as an active purchaser.

A related question is how many health benefit choices will Vermont offer in its Exchange? In considering this question, the state should consider both the number of carriers who will be participating but also whether carriers should be restricted to offer a certain number of plans in the Exchange, including within a benefit level and also whether they should be required to offer plans in each benefit level. While choice is a value Exchanges are designed to encourage and provide to consumers, the experience of Medicare Part D in Vermont illustrates that too much choice can be confusing and complicated for consumers¹². Moreover, given that Vermont is moving towards a standardized benefit package under its single-payer system, it will be important to consider the number of participating carriers, and the number and variety of plans they offer in the Exchange.

The ACA only requires that plans be organized into the categories of coverage based upon minimal variation in actuarial value, although benefits could be further standardized in the federal regulations.¹³ Vermont may want to employ greater standardization in benefits. It will be important for the State to assess consumer preferences and allow some variety of plans at least initially so as not to provide an incentive for consumers to purchase insurance outside the Exchange.

Although states are permitted to enter into inter-state compacts, it is not advisable for Vermont to make these options available and neighboring states have expressed disinterest in this approach as well. Because Vermont will be seeking a waiver for a single-payer system, it will be important for the state to oversee all the insurance products in its Exchange. Exchanges are required to offer the two multi-state plans operated by OPM. Vermont may want to consider how this option can help with the issue of border employers whose employees may not be covered under the single payer system in Vermont.

There is some interest in exploring opportunities for offering Medicare Advantage and Part D plans through the Exchange before the single payer implementation, although additional federal guidance is needed on this issue. It may make good sense to develop the systems capacity to facilitate these add-ons during the Exchange design process and to highlight the Exchange as the one place to go to for health insurance.

Vermont may also want to consider how to standardize benefits across its Medicaid programs and the Exchange plans. Table 3 presents the ACA guidelines for the Medicaid benchmark

¹¹ Section 1301(a)(1)(C)(iii)

¹² Jost, Timothy; Health Insurance Exchanges and The Affordable Care Act: Key policy Issues. The Commonwealth Fund, July 2010.

¹³ Section 1302(d)(3)

benefits¹⁴, standard benefits and qualified health plans. These plans could all be aligned around the definition of essential health benefits with sensible, specific policy goals accompanying any differences in benefit designs.

Table 3: Health Plan Benefits by Program

Program	Health Plan Benefits
Medicaid	<p>Continued comprehensive state plan Medicaid benefits for children, pregnant women, aged, blind and disabled.</p> <p>Medicaid benchmark benefits allowable for non-disabled adults</p> <ul style="list-style-type: none"> • The benchmark benefits must include the essential health benefits. (Medicaid coverage must meet “minimum essential coverage” which is based upon the essential health benefits.)
Federal basic health option	<p>Standard Health Plans</p> <ul style="list-style-type: none"> • Cover at least the essential health benefits. • States encouraged by ACA to offer multiple standard health plans. • Offering insurers must meet Insurance Commissioner’s regulatory requirements. • Encouraged to include care coordination and other enhanced benefits • Must provide coverage equal to a minimum of 80% actuarial value
Exchange	<p>Qualified Health Plans</p> <ul style="list-style-type: none"> • Cover at least the essential health benefits. • Qualified Health Plans must meet Insurance Commissioner’s regulatory requirements. • Plans may vary in actuarial value between

¹⁴ Medicaid Benchmark Benefits are the required level of benefits that must be offered to certain categories of Medicaid members, including childless adults. To meet a benchmark benefit level, the state must either provide coverage that meets the HMO with the largest enrollment in the state, equals the federal employees health coverage, or receives Secretary approval.

	60-90%
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8. Interactions with Employers

The Exchange will have a number of interactions with employers of varying size. Beginning in 2014, small businesses (25 or fewer full-time equivalent employees) applying for a Small Business Tax Credit will be required to purchase health insurance through the Exchange. Exchanges will need to provide information to small businesses to help them apply for the tax credit.¹⁵

In addition, larger employers (>50) not offering affordable minimum essential coverage, who have at least one full-time employee receiving subsidized coverage in a qualified health plan through an Exchange, could be required to pay a “free-rider” penalty assessed and collected by the Department of Treasury.¹⁶ The ACA does not direct the Exchange to assist Treasury’s assessment of these large employers. However, if the federal government needs the Exchange to help apply the free-rider assessment (such as determining exemptions), then coordination will be necessary.

Employers of any size that offer minimum essential coverage are required to offer free choice vouchers to employees whose premium contributions are between 8%--9.8% of their household income. The voucher represents the amount of the employer’s premium contribution and can be used by the employee to purchase a qualified health plan in an Exchange. The employer is allowed a tax deduction for the amount of the voucher.¹⁷ The Exchange will likely need to verify the amount of the voucher with Treasury, apply the voucher to the employee’s qualified health plan, and coordinate the receipt of the voucher with the employer. The Exchange will also need to provide employers with lists of employees who are eligible for premium tax credit, voucher, and tax credits for small employers with low-income workers.

Exchanges are also required to establish a SHOP exchange, designed to support employer and employee choice. Many believe that the statute is ambiguous regarding the degree of plan choice for employees of employers participating in the exchange.¹⁸ Additional regulatory guidance should help to clarify these issues but states are advised to plan for establishing a SHOP Exchange that will be able to interact with employers and the enrolling firms’ individual enrollees.

¹⁵ Section 1421(b)(1)
¹⁶ Section 1513(a) and Section 1513(b).
¹⁷ Section 10108 following Section 1515 in PPACA and HCERA consolidated print.
¹⁸ Weil, Alan; Shafir, Adi; Zemel, Sarabeth. Health Insurance Exchange Basics, Briefing, National Academy for State Health Policy, February 2011.

Key Considerations

There are a number of important employer considerations for Vermont. First, as Vermont moves to a single payer system it will want to enroll as many employers as possible in its Exchange. Lewin has estimated that 13,100 small businesses in Vermont are eligible for a tax credit.¹⁹ Beginning in 2014, these employers will only be able to receive the tax credit if they purchase through the Exchange. The small group health insurance market in Vermont is currently very small – approximately 19,000. That is primarily because Association Health Plans have dominated the marketplace which has approximately 85,000. The state will need to work closely with the Associations to transition them to the Exchange in a manner which benefits the members. The risk adjustment and reinsurance programs noted below may help to mitigate any rate volatility among members as their risk is merged into the larger small group marketplace.

The Exchange will need to facilitate many complex interactions between employers, the federal government, and employees, particularly around employer vouchers and eligibility. The Exchange will need to collaborate with stakeholders in designing these processes, including general agents, brokers, chambers of commerce, and third party administrators. Deciding whether to build or buy the needed infrastructure to simplify the transaction for those purchasing through the Exchange is an important decision point. It will be equally important to consider where the Exchange can add value, rather than simply duplicate current tools that exist in the market. Simplifying the process for consumers may require additional work by the Exchange to understand what works for the many consumer types who will purchase through the Exchange.

9. Risk Adjustment and Reinsurance

While not an Exchange function per se, the risk adjustment and reinsurance components of the ACA will interact directly with the Exchange and should be considered an integral part of Exchange planning.

The ACA requires states to set up a permanent risk adjustment program for health plans operating both inside and outside the Exchange. The program will assess a charge on health plans in the state that have low cost enrollees, the revenue from which is then used to pay plans with high cost enrollees. The ACA requires HHS to work with states to establish the risk adjustment criteria and methodology, and encourages it to be modeled after the existing methodology for risk adjustment in the Medicare managed care and prescription drug plan programs. Grandfathered plans and self-insured group plans are exempt from the program.

The ACA also creates a temporary reinsurance program within each state in order to stabilize the individual market during the first three years of the insurance Exchange, when the risk of

¹⁹ <http://govcha.state.nv.us/docs/SBHelpingHand.pdf>

adverse selection as a result of the market reforms is the greatest. Since Vermont has already implemented guaranteed issue and adjusted community rating, the risk of adverse selection is minimal. The ACA requires each state, by 2014, to establish a non-profit entity within the state to administer the reinsurance program. This program is similar to the risk adjustment program, except in this case all plans in the state (except grandfathered plans) will make annual payments to this entity, which would then use that pool of funds to make payments to certain plans that had enrolled high-risk individuals.

The Department of Health and Human Services (HHS), in consultation with the National Association of Insurance Commissioners (NAIC), is charged with developing a model regulation that states can use to implement the program. The model regulation must define a “high-risk” individual and develop a formula for collecting the annual fee from health plans and then allocating the reinsurance payments among those plans with high-risk enrollees. The reinsurance program can help with the transition and keep premiums more affordable for exchange participants.

The ACA requires HHS to establish “risk corridors” for qualified health plans in the individual and small group markets for the first three years of the insurance exchanges. The program will be similar to the risk corridor program HHS runs for Medicare prescription drug plans. The risk corridor program is essentially another form of risk adjustment, except in this case administered by HHS as opposed to the states. The law requires HHS to give payments to plans that have higher than expected costs, and it requires plans that have lower than expected costs to make payments to HHS. Those payments will be based on a methodology HHS must establish by regulation. HHS is required to reduce any payments to plans by any amounts they receive under the state- based risk adjustment and reinsurance programs.

Key Considerations

Risk adjustment will require that Vermont and HHS have robust data collection systems that accurately reflect insurers’ costs based on the populations they enroll. In addition, the State and HHS will need work in partnership to conduct audits of plans to make sure they’re accurately reporting their costs and the risk profile of their enrollees. These programs will require continuous monitoring, adjustment, and enforcement. Vermont’s Department of Health Access (DVHA) has limited experience running risk adjustment programs as it does not contract with private managed care organizations to serve its Medicaid program. Instead of conducting this function on its own, DVHA may decide to subcontract this function to the Department of Banking, Insurance, Securities, and Health Care Administration (BISHCA) or some other entity.

Vermont will need to consider which reinsurance model it would like to use. While guidance from the federal government will be forthcoming, policymakers may want to work with experts and carriers in the state to determine what model will provide the best results for Vermont moving forward.

10. Reporting and Evaluation

There are a number of reporting and integration responsibilities that the Exchange will need to facilitate, in particular with the federal government. In addition to coordinating coverage among relevant State health programs the Exchange will also need to coordinate with the federal government in numerous issues related to eligibility. For example, the Exchange is required to inform the Department of Treasury of each employee, determined eligible for a premium tax credit subsidy, whose employer is not providing minimum essential, affordable coverage. (Generally, this is when an employee's premium contribution exceeds 9.5% of household income or the employer-sponsored plan covers less than 60% of benefit costs.)

The Exchange must also inform Treasury when an individual, whose employer is not providing minimum essential affordable coverage, has changed employers or the employee has ended coverage in a qualified health plan within the exchange. The Exchange is also responsible for coordinating with federal agencies in granting exemptions to the individual mandate. This task includes transferring a list of exempted people to the Department of Treasury. The Department of Treasury will, in turn, send an annual notice to each individual who filed a tax return and is not enrolled in minimum essential coverage. That notice will contain information on services and coverage available through that person's State Exchange. Each Exchange will need to coordinate with Treasury to produce this notice and prepare for the inquiries.

Each Exchange is also directed to assist with the reconciliation process of advanced premium and reduced cost-sharing tax credits by providing information to the taxpayer about any health plan provided through an Exchange. The Exchange will need the ability to provide the Treasury with information about a taxpayer's Exchange plan including the level of coverage, premium, all subsidy payments/tax credits, and any change of circumstances that impact eligibility for subsidies. The Exchange must inform the Treasury when an employee, whose employer is not providing minimum essential affordable coverage, has ended coverage in a qualified health plan within the exchange.²⁰ The Exchange must also provide that information to the employer.²¹

In addition to the federal reporting requirements noted above, accurate and timely public disclosure of coverage data and other key performance measures to facilitate research analysis and evaluation are required. In addition, Exchanges must post average cost of licensing, regulatory fees and other required payments, administrative costs and money lost to fraud waste or abuse.

Key Considerations

In addition to facilitating the above information to appropriate parties, the Exchange will also need to monitor and evaluate its own fiscal situation and progress towards meeting its goals. In

²⁰ Section 1311(d)(4)(I)

²¹ Section 1311(d)(4)(J)

Vermont's Exchange, an added responsibility of transitioning the Exchange to the single-payer system will be paramount.

Vermont should consider whether it would like to include additional reporting requirements beyond what the federal government requires. Vermont should also consider how it will evaluate the success of its Exchange, particularly in light of the state's efforts to move to a single payer system.

Summary

As described throughout this memo, the ACA places significant responsibility within the Exchange for the ultimate enrollment of individuals in insurance, through its marketing and outreach responsibilities, eligibility and enrollment requirements, certification of health plans, and reporting and evaluation functions. Over the next several months, Vermont will further define these functions and, to the extent there is flexibility, how Vermont will proceed towards implementation. As Vermont moves forward in its planning process, it will be important to closely monitor federal regulations issued related to these functions and to continue to work with stakeholders to establish an Exchange that can best meet the needs of Vermonters while helping to transition the current system to single-payer.

ⁱ Robertson, Brian et al. Study of the Uninsured and Underinsured. February 2011

ⁱⁱ S.1312(e) (1),(2)

ⁱⁱⁱ 1311 (g)