HEALTH CARE REFORM REVIEW COMMITTEE

Preliminary list of questions that need to be answered when constructing an exchange

1) Will the exchange be state, multi state, regional, or federally administered?

2) Where will the governance of the exchange reside?

- Within existing state government agency
- Within newly established agency of state government
- Private commission, outside of existing state government
- Politically insulated while publicly accountable
- Board consisting of odd number of members (5, 7, or 9) with staggered five year terms, appointed by Governor, not civil servants, fitting within specified categories (e.g. one actuary, one provider, one consumer, etc), and recognized for expertise in: health care finance & economics; health actuarial science; management of benefits program, medical facility or integrated delivery system; health care provider reimbursement; etc.

3) How will the exchange be funded?

- Use of premium tax revenue? (Will no longer need to assess for CHAND)
- Provision for assessments, fees, or taxes paid by insurers and self-funded programs
- Required to be self-sustaining by January 1, 2015

4) Will the exchange be a clearinghouse or allowed to fully regulate/select/negotiate/limit entry of carriers?

- "Lite Exchange" = limited = clearinghouse = Utah?
- "Heavy Exchange" = selective & negotiating = Massachusetts?
- NAIC model?
- Exchange to limit entry of carriers and products? Negotiate prices?

5) What will be the functions of the exchange?

- Offer QHPs
- Offer limited scope pediatric dental plans
- Implement certification procedures and policies
- Provide toll-free assistance hot-line and web-based plan information
- Provide public ratings for exchange health plans
- Provide calculator for consumers to estimate individuals cost of coverage
- Grant exemptions from individual mandate based on affordability and notify employers and Dept of Treasury
- Provide information to employers and Dept of Treasury on employees determined eligible to enroll in exchange
- Establish Navigator program to assist consumers in selecting health plans
- Be self-sustaining by January 1, 2015
- Consult with stakeholders of exchange including consumers, small businesses, Medicaid offices, etc
- Provide standard format for consumers to compare health plans, including uniform outline of coverage
- Provide various plan and carrier financial and quality information to consumers
- Account for expenditures

6) Will there be one or two exchanges?

- Small group = 2 to 50 for 2014-2015, or 2 to 100
- Allow large groups access to Exchange in 2017?

7) Will there be benefit design Flexibility?

- One silver or many silvers?
- Require all four QHP levels (platinum, gold, silver, bronze)? Catastrophic Plans to age 29?
- Limit carriers to specified number of products

8) Will there be an off exchange market?

- Require individuals and small groups to purchase through Exchange, or allow off-Exchange market and products?
- PPACA allows for purchase of minimum essential coverage plans outside Exchange that will avoid individual mandate penalty

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9) How will CHAND fit into all this/Integration of Medicaid & State Children's Health Insurance Programs?

- Federal Pre-Existing Insurance Plans (PCIP) discontinued in 2014
- CHAND must also be modified or eliminated by 2014 so as to avoid conflicts with Federal Reinsurance Program
- Premium Tax currently provides for CHAND assessments
- Expanded eligibility for adults without children
- Transferability between Medicaid and Exchange products upon income changes (i.e. below 133% Federal Poverty Level, 133% to 400$ of FPL)
- Medicaid and SCHIP benefits must meet essential health benefits
- States required to revise enrollment process for Medicaid & SCHIP, to be integrated with Exchange

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10) Who will regulate/approve premiums, MLR rebates etc...the DOI or the exchange?

- Approval of premium rates to occur within Department of Insurance, or within Exchange?
- Potential for conflicts between Century Code requirements for rate adequacy and federal treatment of "Unreasonable Increases"
- Ensure level playing field for all carriers by state regulators (PPACA §1252)
- Administration of rebates generated by Medical Loss Ration requirements
- Treatment of agent and broker commissions within financial reporting
- Composite or list billing, premium tiers
- Tobacco, Lifestyle, age, and area factors
- Allow regional health plans, or require statewide plans?

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11) How will associations be treated?

- Allow associations that provide health benefits to be considered large groups or self-funded?

12) How will risk corridors, risk adjustments and federal reinsurance function?

- Temporary for years 2014 through 2016
- Covers high risk individuals in Non-grandfathered Individual Coverage
- $20 Billion in Federal Funds
- Requires non-profit state reinsurer for administration (re-charter CHAND?)
- Requires elimination of CHAND to avoid conflicts
- Temporary for years 2014 through 2016
- Apparently applies to QHPs within state exchanges
- Unclear what role state exchange will have, but will likely be involved in determining/approving target loss ratios, reporting plan financial experience and collecting/distributing assessments
- Permanent in 2014
- Plans self-score according to prescribed methodology?
- All plans submit to third party for scoring?
- Unclear what role state exchange will have, but will be involved in reporting and collecting/distributing assessments

13) Existing state benefit mandates