Pennsylvania Health Insurance Exchange

Draft Strategic Goals and Guiding Principles for Discussion with the Exchange Subcommittee

The Patient Protection and Affordable Care Act, known as the ACA or the national health care reform law, requires that individual consumers and small employers have the opportunity to purchase health insurance through a health insurance exchange starting in 2014. A **health insurance exchange is a central marketplace for health insurance that provides one-stop shopping for individuals and small businesses to compare rates, benefits and quality among plans.**

By pooling people and reducing transaction costs, the exchange should create more efficient and competitive markets for small employers and individuals. The exchange will also serve as the marketplace for purchasing health insurance for individuals who qualify for assistance paying for health care through new federal health insurance premium tax credits.

Lewin estimates that in 2014, 1.3 million Pennsylvanians will purchase health insurance through a Pennsylvania exchange. RAND Corporation estimates that the number will grow to 2.1 million by 2016.

Beginning in 2013, during the open enrollment period, an exchange will be available in each state (operated federally in states that choose not to operate an exchange) to help consumers make comparisons between plans that meet quality and affordability standards. Use of the exchange by the purchaser is voluntary, although premium tax credits will be available only for plans purchased through the exchange. Starting in 2014, small employer tax credits will be tied to purchasing group insurance through the exchange.

The federal law establishes parameters and identifies areas in which the federal Department of Health and Human Services (HHS) Secretary will provide guidance and regulations for states, if states choose to establish health insurance exchanges. An “Initial Guidance to State on Exchanges” has already been issued.

The federal law guides the state’s development of an exchange in a number of areas:

- Basic exchange functions (e.g., plan certification, customer service, information provision, exemption administration);
- Open enrollment periods;
- Minimum benefits standards for exchange products (to be defined in regulation);
- Requirement that a state’s exchange be financially self-sustaining by January 2015; and
- Requirement that the exchange consult with stakeholders.
Because HHS will issue a number of regulations that will impact the creation of state exchanges, recommendations in this document may change as a result of those federal regulations.

The federal government will approve state exchange plans before January 1, 2013. This will allow states to implement their exchanges in time to conduct a public education campaign and an open enrollment period in the summer or fall of 2013. Coverage under plans sold through the exchange will begin January 1, 2014. If a state does not have an approved exchange plan in January 2013, the federal government will operate an exchange for the state.

**Strategic Goals**

In July 2010, Governor Rendell established the Commonwealth Health Care Reform Implementation Committee and the Commonwealth Health Care Reform Implementation Advisory Committee to assist the Commonwealth in planning for the implementation of ACA and developing goals for the Pennsylvania exchange. The Advisory Committee defines the strategic goals for Pennsylvania’s exchange as follows:

1. To facilitate and encourage the purchase and provision of affordable health care coverage.
2. To improve the health care coverage marketplace by structuring the exchange to promote competition on the basis of value and to avoid adverse risk selection.
3. To provide a one-stop, easy to use, accessible portal for consumers and businesses to learn about and compare options for coverage.
4. To provide a unified and integrated approach for consumer application and enrollment in all health care coverage that is publicly-subsidized, with linkages to existing access points for other health and human services for which people may be eligible.
5. To assure administrative efficiency and to maximize the leveraging of all administrative funding.
6. To ensure increased access to quality health care through a diverse, robust network of health care providers including safety net health care providers.
7. To support the goals of health care reform: transformation of the health care system to support improved quality of health care and reduced cost of care.

**Functions Performed by Health Care Exchange**

Federal health care reform specifies the basic functions a state-operated exchange must carry out. *States may choose to include additional functions.*

**Mandatory Functions**

Under federal law, the exchange is required to perform the following functions:
• Certify health insurance plans for participation in the exchange, including implementing procedures for plan certification, recertification and de-certification based on federal guidelines.

• Grade health plans in accordance with criteria to be developed by the federal Department of Health and Human Services. This includes using a standardized format for presenting health benefit plan options in the exchange, including the use of the uniform outline of coverage, and maintaining a website through which enrollees and prospective enrollees of qualified health plans may get standardized comparative plan information.

• Make qualified health plans available to eligible individuals and employers.
  o Provide customer assistance via telephone and website. Have a toll-free telephone hotline to respond to requests for assistance and maintain a website through which enrollees and prospective enrollees may get standardized comparative plan information.
  o Allow customers to compare qualified health benefits plans offered by different insurance carriers.
  o Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions.

• Provide the following to individuals and employers.
  o Information regarding eligibility requirements for Medicaid, CHIP and any applicable state/local public program.
  o An electronic calculator that allows users to determine the actual cost of coverage after accounting for any premium tax credit and cost sharing reduction.
  o Publication of the average costs of licensing, regulatory fees, other payments required by exchange; exchange administrative costs; waste, fraud, abuse.
  o For employers, the names of any of their employees who stop coverage under a qualified health plan during a plan year.

• Certify individuals who are exempt from the individual responsibility penalty (for not having health insurance) when:
  o No affordable qualified health plan is available through the exchange or employer;
  o Purchasing insurance is not possible on the basis of hardship or other criteria to be established by HHS.

• Provide information to the federal government regarding:
  o Pennsylvanians issued an exemption certificate;
  o Employees determined to be eligible for premium tax credits;
  o People who tell the exchange they changed employers and stopped coverage during a plan year; and
  o Individual mandate exemptions and subsidies awarded when a small employer does not provide sufficient affordable coverage.

• Have an annual open enrollment period and special enrollment periods.

• Establish a network of community-based “navigators” to raise awareness among customers of their coverage options and to facilitate people selecting and enrolling in health plans and accessing benefits.
Optional Functions

At each state’s discretion, the exchange may perform additional responsibilities outside of those required by federal health care reform:

- Additional regulatory and market functions. These additional functions would be incorporated into the exchange’s role in an attempt to meet certain public policy objectives.
- Increase competition and quality and decrease cost by allowing only the highest quality plans to be available through the exchange after a competitive procurement.
- Negotiate with insurers over elements of coverage.
- Coordinate purchasing and procurement decisions with Medicaid and CHIP so that consumers have continuity with the same plan and provider network in transitions across exchange-based carriers and MA plans.
- Reward adoption of new tools (e.g., use of a medical home model – which is discussed in the “Other Critical Reforms” section of this report) in purchasing decisions.
- Require additional reporting from insurers aimed at providing consumers and the public with additional information.
- Actively elicit information from consumers covered through exchange products in order to remove barriers and modify future purchasing decisions based on consumer needs and consumer feedback.

Guiding Principles for Exchange

The Governor and the General Assembly must determine whether Pennsylvania will operate an exchange and, if so, the exchange’s attributes.

The Advisory Committee strongly recommends that Pennsylvania establish its own exchange and it recommends the following guiding principles in adopting the necessary legislation for an exchange. Unless otherwise noted, each recommendation reflects a consensus of all of the committee’s members:

1. The exchange must have a strong consumer-oriented mission and goals.
2. The exchange should be guided by a governing board and a strong executive team. (Majority recommendation.)
3. The exchange should be established as an independent public agency (or public corporation) such as a board, commission or an authority, or as a regulated non-profit entity. (Majority recommendation.)
4. One exchange should service the entire state, but plans would compete on a regional basis.
5. Two decisions on the exchange’s initial insurance pools require additional data and analysis, and should be made based on providing the greatest benefit to consumers..
6. Individuals and small business consumers who are eligible to buy insurance through the exchange should also be allowed to buy insurance outside of the exchange (without a subsidy).
7. The exchange should set minimum standards for plans sold in the individual and small employer group markets. The minimum standards should include quality indicators.
8. Young adult/catastrophic plans should be available through the exchange.
9. The exchange should serve as a negotiator with insurance plans to promote low pricing and high quality for individuals and small employers. (Majority recommendation.)
10. The Insurance Department should have rate review authority, in addition to requiring the same premium rates and rules for plans sold inside and outside the exchange (as required by federal law).
11. Agents and brokers should be neither required nor prohibited, and there should be total transparency as to their fees or commissions.
12. Pennsylvania should determine the role, oversight and compensation model for Navigators.
13. The General Assembly should retain authority to make changes to benefit requirements and mandates.
14. The exchange planning grant should be used to develop estimates of the cost of operating the exchange and options for funding, to provide the General Assembly with options to meet the federal requirement that the exchange must become financially self-sustaining by 2015.

TIMELINE FOR LEGISLATION

Understanding the need for legislation to establish an exchange in Pennsylvania under the present federal law, the Legislature should consider necessary legislation during 2011.

October 2010 – HHS awards planning grants to states for implementation planning for exchanges.

January 2013 – HHS will approve that states are able to implement exchanges by 1/1/2014.

July 2013 – Exchanges must begin accepting applications.

January 2014 – Exchange must be fully operational.
Recommendations

1. **The exchange must have a strong consumer-oriented mission and goals.**

The exchange should focus on improving service and access for consumers and be for the benefit of all Pennsylvanians.

The exchange should facilitate access, simplify options, enrollment and regulation, and contain costs to improve the experience of getting and keeping insurance coverage.

To do this, the exchange must have a strong mission and goals that will guide the work of the exchange. These goals must be clearly articulated and signal to consumers and businesses that the exchange is working in their best interest and exists to improve access and service.

2. **The exchange should be guided by a governing board and a strong executive team. (Majority recommendation.)**

The governing board should:

- Be broadly representative and include members chosen for individual, professional and community leadership and experience;
- Be free of conflicts of interest among its members;
- Include the secretaries of the Departments of Public Welfare and Health, and the Insurance Commissioner;
- Provide policy guidance to the exchange;
- Guide the design, implementation, and administration of the exchange;
- Develop a plan for integration and transition of existing public programs to ensure the seamless transition between Medicaid and other programs and the exchange;
- Be responsive to the needs of the public;
- Be flexible enough to change with shifting market and economic environment;
- Not be politicized;
- Be stable;
- Be Independent;
- Have professional management;
- Ensure that the exchange is not to be overly bureaucratic;
- Employ a strong executive team that has the expertise, authority, and sensitivity to work with:
  - Consumers
  - Small businesses
  - Insurers
  - Third-party administrators
  - Producers (agents and brokers)
  - Navigators
  - Other stakeholders
This recommendation reflects the Committee’s majority. Dissenting members felt that recommendations regarding governance should be made solely through the legislative process.

3. **The exchange should be established as an independent public agency (or public corporation) such as a board, commission or an authority, or as a regulated non-profit entity. (Majority recommendation.)**

Federal law gives states the ability to decide how the exchange is structured. It could be administered by a state agency (e.g., the way that parents apply for subsidized children’s health insurance through the Insurance Department even though the coverage is provided by private insurance companies) or it could be administered by an independent commission (e.g., the Pennsylvania Health Care Cost Containment Council operates independently with appointees from the Governor and Legislature).

In considering this issue, the General Assembly should determine a structure to govern the exchange so that the exchange is accountable, flexible, free of conflicts of interest and transparent in its operation. In addition, the following issues should be weighed in determining the optimal structure:

- The exchange’s ability to focus on consumers and to maintain good relations with insurance carriers and health care organizations who will serve the consumers;
- How state procurement, hiring, and human resource rules, and the flexibility and responsiveness of state agencies may affect exchange governance;
- If an exchange independent from state fiscal processes and insulated from political influence would best serve the needs of the Commonwealth;
- The federal requirements for a consumer oriented exchange and the ability for the exchange to conduct its federally mandated business in tight fiscal times;
- The necessity of user fees and other financial requirements, including potential for support through Medical Assistance, for the continued operation of the exchange; and
- The oversight that will be needed in the implementation and structure of an exchange and what type of exchange will ensure accountability to consumers.

Regardless of the exchange’s structure, it is clear that legislation creating the exchange is needed, likely in 2011, to allow for all of the set-up and interoperability to permit HHS to determine, by 1/1/13, that Pennsylvania will have an operational exchange by 1/1/14.

The majority recommendation of the Committee is that the exchange should be established as an independent public agency (or public corporation) such as a
board, commission or an authority, or as a regulated non-profit entity. The Committee identified advantages and disadvantages of the major options:

**State agency**

**Advantages**
- The exchange would have a direct link to the state administration and a more direct ability to coordinate with other key state agencies, such as DPW and the Insurance Department.

**Disadvantages**
- The exchange would not be governed by an independent board as recommended above.
- The exchange’s decision-making and operations may be politicized.
- It would be potentially difficult for the exchange to be nimble in hiring and contracting practices, unless exceptions are made to the state’s personnel and procurement rules while ensuring accountability and transparency.

**Independent public agency or public corporation such as a board or commission**

**Advantages**
- Enabling legislation could specify how board members would be appointed, the size of the board and the composition and terms of the members.
- The board may select the exchange’s executive director.
- A public sector entity outside of the executive branch is more independent and is therefore insulated from the political process more so than an executive branch agency.
- Likely more nimble in hiring and contracting.

**Disadvantages**
- The exchange could have more difficulty coordinating strategies and initiatives with key state agencies, such as DPW and the Insurance Department, because the exchange would not be located at a state agency.
- Potentially less access to the executive administration.

**Non-profit Entity**

**Advantages**
- Would not be directly accountable to the government unless established as an entity subject to regulatory oversight as a licensed entity.
- Would not be subject to government oversight unless established as an entity subject to regulatory oversight as a licensed entity.
Would not be subject to civil service and undue delays with procurement laws.
The board of the non-profit entity would be more insulated from the political process than the other two options, which may maximize freedom and flexibility in decision making.
Greater flexibility in governance the ability to be more nimble in decision making and less chance of being politicized.

Disadvantages

Would be more difficult being held publicly accountable.
Unless specified in the enabling legislation, potential isolation from state policymakers and key state agency staff and the potential for decreased public accountability.
Depending on the structure, potentially greater distance from policymakers and the executive administration and more difficulty coordinating with other public sector health purchasers.

This recommendation reflects the Committee’s majority. Dissenting members felt that recommendations regarding governance should be made solely through the legislative process.

4. One exchange should service the entire state, but plans would compete on a regional basis.

Federal health care reform requires that all states establish an American Health Benefit Exchange for the individual market and a Small Business Health Options Program (referred to as a “SHOP” exchange) for the small group market. Federal law gives states the option of combining these two exchanges into a single exchange. Even if Pennsylvania elects to have separate exchanges for the individual small employers, it would appear to be a single exchange serving the entire state. One prospective purchasers entered the portal, they would be directed to the appropriate exchange and the appropriate regional insurance products. The Pennsylvania exchange should operate as a single organization offering products and services to individuals and small employer group customers and utilizing a common entry point, access to correct information and assistance based on information provided about the consumers’ needs and interests.

5. Two decisions on the exchange’s initial insurance pools require additional data and analysis, and should be made based on providing the greatest benefit to consumers.

States have the opportunity to make two decisions about how they structure the insurance pools in the exchange’s initial years:

1. Small businesses with 51-100 employees. Federal law defines “small employer” eligible to purchase insurance on the exchange as an employer with 2-100 employees. Until 2016, states may limit this definition to 2-50 employees. This issue
requires additional analysis. The vast majority of Pennsylvania employers have less than 50 employees. There are 258,856 employers with fewer than 50 employees, employing 1,456,313 employees. If Pennsylvania were to allow firms with up to 100 employees to purchase health care coverage on the exchange, it would add the opportunity for 6,314 businesses with 432,913 employees to purchase on the exchange.

2. Merging the individual and small group insurance pools. The law allows states to either pool all of their individuals into one risk pool and all of their small employer group members into another risk pool or pool all covered individuals into one pool. Maintaining separate risk pools for individuals and small employer group members would result in insurers rating premiums separately for each of the two groups; that is, the adjusted community rating rules in federal health care reform would still apply, but the two groups would be rated separately.

These issues will be a major focus of the planning grant, but without additional data and analysis the Advisory Committee could not make a recommendation about whether to combine the small group or individual exchanges or whether to initially limit participation on the exchange to small businesses with 50 or fewer employees.

In general, a strong and stable market relies on a large, variable risk pool to reduce destabilization by large claims or a small number of high users (people with very poor health status). Therefore, in order for the exchange to be successful with separate risk pools, each pool must be large enough to be stable.

In order to prevent the exchange from becoming a high-risk pool, it will be critical to consider rating, pools, and take-up rate if the individual and small group risk pools are separated. Pooling individuals and small employer group members into one pool will also present a need to promote take-up, but the pool would be larger. In this case, the profiles of individuals and small employer group members must be determined to ensure that the two groups are not so drastically different that they cause a single pool to be more unstable than two separate pools.

Another consideration for the exchange is the current individual health insurance market. Currently, the association and non-association plans in the individual market are underwritten. In addition, the association plans are not subject to state-mandated benefit laws. As a result, these markets offer relatively affordable premiums to the individuals who are offered coverage and who are healthy.

The Pennsylvania Department of Insurance is in the process of seeking data from insurance companies in order to analyze the impact of these options. The study should be conducted as expeditiously as practicable and its results should be made publicly available so that decision-making is transparent. The state should ultimately adopt the policies that provide the greatest benefit to individual and small business consumers.
6. **Individuals and small business consumers who are eligible to buy insurance through the exchange should also be allowed to buy insurance outside of the exchange (without a subsidy).**

Federal law requires the creation of health insurance exchange(s), but does not eliminate the insurance market outside the exchange. Some argue that the federal law allows a state’s discretion to eliminate sales of health insurance outside the exchange. Eliminating sales outside the exchange could ensure a larger pool of enrollees inside the exchange, and eliminate risk selection between the exchange and the insurance market outside the exchange. However, eliminating sales outside the exchange would mean that individuals who choose not to use the exchange or who are not eligible to purchase health insurance in the exchange (such as non-citizens or undocumented immigrants) could not purchase health insurance. Likewise an individual eligible for Medicaid or CHIP would have no alternative for insurance coverage if the individual chose not to enroll in those programs.

Federal health care reform specifies the following rules to protect against adverse selection issues in a dual market.

- Plans sold inside and outside the exchange must be in the same risk pool.
- Plans sold inside and outside the exchange must have the same premium rate.
- Plans sold inside and outside the exchange must meet the same minimum benefits standards.
- Insurers inside and outside the exchange may not deny coverage on the basis of pre-existing conditions, medical status, or claims history.
- Premiums may vary based on age, geographic location, and smoking status but must apply to plans inside and outside the exchange.
- Insurers inside and outside the exchange must participate in reinsurance and risk adjustment to ensure that plans covering a sicker population are not penalized.

The best outcome would be for insurers to sell identical plans inside and outside the exchange because doing so puts all into one risk pool. There is a risk to the exchange if insurers inside the exchange sell slightly different products outside the exchange – especially if those products are priced less expensively because (1) they would not be in the risk pool and (2) they would attract consumers to purchase a product outside the exchange, meaning healthy people might buy a less expensive product (even with a lesser benefit), and that would cause the exchange to become the insurer of last resort, and could end up driving up rates inside the pool.

If insurers offer identical products inside and outside the exchange, they will benefit from the exchange providing some of the administrative tasks and thus save on administrative costs when they are in the exchange, and benefit from what will hopefully be a new market of insured individuals with subsidies to help purchase insurance. It would protect against adverse selection in the exchange if Pennsylvania mandated that insurers must have an identical product outside the exchange; otherwise they could not participate inside (and hopefully benefit from) the exchange. But forcing companies to only sell products in Pennsylvania if they are in the exchange is risky because insurers may leave Pennsylvania altogether.
7. The exchange should require minimum standards for plans sold in the individual and small employer group markets. The minimum standards will include quality indicators.

As required by the federal law:

- All health plans must meet federal essential benefits requirements;
- All companies selling insurance in Pennsylvania must offer at least one silver and one gold plan; and
- Some exemptions are made for “grandfathered plans” (those issued before March 23, 2010) and insurance purchased by large employer groups covered by ERISA.

Maximize participation of carriers:

- The exchange should consider strategies to maximize the participation of private insurance plans offered through the exchange;
- Pennsylvania will need to ensure that its insurance laws and regulations are consistent with federal law;
- Pennsylvania should take steps to ensure that insurance carriers do not attempt to route low risk people outside the exchange by offering less comprehensive coverage (and less expensive) plans only outside the exchange; and
- The federal law requires that carriers participating in the exchange offer at least silver and a gold level plan. While carriers not participating in the exchange may not want to offer all plan levels, the state may require carriers to offer both bronze and silver level plans.
- The exchange should create metrics that consider customer satisfaction, quality within each plan’s provider network, and health outcomes.

8. Young adult/catastrophic plans should be available through the exchange.

The federal law allows for a catastrophic plan to be sold to individuals under age 30 and to people with hardship exemptions from the insurance mandate. The catastrophic plan will provide coverage of the essential health benefits, with deductibles based on those allowed for HSA-qualified high deductible health plans. Deductibles will not apply to at least three primary care visits.

As these plans are only open to specific categories of purchasers, it will be necessary to certify that the buyer is eligible to enroll in a catastrophic plan. This can most easily be done through the exchange.

This is particularly important for individuals deemed exempt from the insurance mandate, as the exchange is responsible for granting exemptions and informing the federal government about which Pennsylvanians are receiving exemptions. If the plans are sold in the outside market, additional coordination will be required to ensure the exchange receives the information it needs.

Young adults have a financial stake in the offering of a catastrophic option. Qualified consumers may opt out of comprehensive coverage and choose to pay a
penalty if this option is not available. By offering this option, qualified consumers would be more likely to purchase such a plan at a more reasonable cost.

Offering catastrophic coverage through the exchange provides an incentive to carriers to participate in the exchange. Young adults tend to be healthier than the average under-65 population, making this group a lucrative market. It is also a group that has historically had high uninsurance, thus many Pennsylvanians in this age group will be new entries into the health insurance market.

If catastrophic plans are exclusively offered through the exchange, this hard-to-reach group will already have a relationship with the exchange and insurers with qualified offerings when they are required to purchase more comprehensive coverage.

9. **The exchange should serve as a negotiator with insurance plans to promote low pricing and high quality for individuals and small employers purchasing through the exchange. (Majority recommendation.)**

The interim guidance issued by CMS states: “State have a range of options for how the Exchange operates from an ‘active purchaser’ model, in which the Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an ‘open marketplace’ model, in which the Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings. In both cases, consumers will end up with options, and States should provide comparison shopping tools that promote choice based on their price and quality and enable consumers to narrow plan options based on their preferences."

There was consensus that initially the exchange should permit all qualified plans to sell via the exchange to ensure adequate plan participation.

The majority recommends that the exchange should be able to gradually cull poor performers based on cost and quality, and should use market leverage to obtain optimum price for individual and small business purchasers.

Minority representatives from the insurance industry pointed out that their rates had to be approved by the Insurance Department and they were opposed to a second set of rate negotiations. Representatives of hospitals were also concerned about the impact this leveraging might have on the adequacy of health care provider reimbursement.

The exchange has an opportunity to create greater levels of competition by assuring consistency across plans to maximize comparability.
10. The Insurance Department should have rate review authority, in addition to requiring the same premium rates and rules for plans sold inside and outside the exchange (as required by federal law).

As required by federal law, a given plan sold both inside and outside of the exchange must be offered at the same premium rate in both venues. The federal law requires that premiums rates be the same for a given health plan offered both inside and outside of the exchange.

State law must follow the federal requirement; rates for plans offered both inside and outside the exchange will be subject to regulation by the Insurance Department, with pricing consistent inside and out. However, current Pennsylvania law does not require most for-profit insurers to file rates for small group plans with the Insurance Department for review. The department’s rate review authority should be strengthened to ensure compliance with federal law and to ensure that insurers are pricing plans appropriately.

11. Agents and brokers should be neither required nor prohibited, and there should be total transparency as to their fees or commissions.

The federal law allows states to decide whether to use agents in the exchange, directing states that do utilize them to follow certain rules. Agents can be knowledgeable about a range of insurance products and helpful to individuals and employers seeking to buy insurance through the exchange, and provide information about how to access premium tax credits and how to offer a range of coverage choices to their employees. If the exchange is sufficiently user friendly, providing easily understood comparative information on cost and quality, the added expense of brokers and agents may not be necessary. However, the new medical loss requirements may limit the ability of plans to provide some services now provided by brokers. Therefore, the Committee recommends that agents and brokers should be neither required nor prohibited, but there should be total transparency as to their fees or commissions so consumers can make an informed choice as to their use.

Consistent with yet to be issued federal guidelines, the exchange board may have the authority to determine the manner and amount of agent reimbursement.

The board should allow for a certification process with standards set by the exchange board for agents selling exchange products.

12. Pennsylvania should determine the role, oversight and compensation model for Navigators.

ACA requires that exchanges award grants to eligible entities that meet standards established by HHS to carry out exchange education and enrollment. There will be more lower-income, ethnic and racial minorities and special needs populations than are in the insurance market today. The law says that Navigators are to be available
to provide personal assistance to those who need it to be able to purchase health insurance and qualify for subsidies. ACA sets forth the duties of navigators to:

- Conduct public education activities to 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 under 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 the exchange or exchanges.

The Advisory Committee recommends implementation of the following NAIC recommendations regarding Navigators:

- Navigators should be credentialed and reviewed for performance, but not licensed;
- They should be compensated on the quality of the information provided and not the volume so as not to create incentives to encourage or discourage certain consumer behavior or preferences;
- Navigators must have the consumer as their client; and
- They must provide understandable consumer information provided in a culturally sensitive manner for those with low-proficiency English and people with special needs.
13. The General Assembly should retain authority to make changes to benefit requirements and mandates.

Once the federal government establishes requirements for essential health benefits, the General Assembly may want to consider additional requirements. Pennsylvania should retain its authority to make changes to benefit requirements once more information is known on the federal requirements.

To ensure that the exchange is responsive to needs identified over time, the exchange board should be given statutory responsibility for establishing contract standards with an emphasis on quality, access and evidence-based care. Additionally, the exchange should require standardization for as many processes as possible to reduce administrative costs for providers and consumers. For benefits requirements that would affect all plans offered both inside and outside the exchange, the General Assembly should retain the authority to change the rules as needed. This is not an exchange role as it would affect all plans whether they were offered inside the exchange or not.

14. The exchange planning grant should be used to develop estimates of the cost of operating the exchange and options for funding to provide the General Assembly with options to meet the federal requirement that the exchange must become financially self-sustaining by 2015.

Federal law allows states to apply for federal grants to assist with costs associated with establishing an exchange. In addition, federal funds will be available to support the costs of operating the exchange during 2014. Beginning January 1, 2015, federal law requires that state exchanges must be financially self-sustaining and the exchanges may not rely on federal funds for support. In order to accomplish this, Pennsylvania needs to determine the method by which the exchange’s operations will be financed. This will depend on the function of the exchange and the cost of operation.

The federal law explicitly presents one financing option: the exchange is allowed to charge assessments or user fees to participating health insurance providers. However, the federal health care reform law neither suggests nor limits options to achieve financial sustainability. Regulations to be issued by HHS may address this point.

Other funding options include:

- State funds;
- Assessing health plans, employers, and/or individuals;
- Assessing health care providers; and
- Surcharging insurance premiums.

If the exchange is used to enroll Medicaid beneficiaries in plans, 90% of that cost will be paid through federal funding.
In developing the state’s strategy for financing, it is important to consider how any funding option:

- Encourages or discourages participation in the exchange by individuals, small businesses, and insurers;
- Affects the reputation of the exchange;
- Affects accountability, transparency, and cost-effectiveness; and
- Is sustainable over time.

Possible effects include the following:

- Charging user fees to insurers may discourage participation in the exchange by insurers;
- Attaching administrative fees to health care providers may discourage providers from serving members insured through the exchange;
- Attaching administrative fees to health plans may discourage individuals and small businesses from participating in the exchange;
- Assessments on premiums may discourage participation in the exchange by insurers who are required to charge the same premiums inside and outside the exchange and, thus, may retain less of the cost inside the exchange;
- Using state-appropriated funds may cause some to view the exchange as a public program instead of a marketplace; and
- Using state-appropriated funds may make the exchange vulnerable to the under-funding of essential functions during periods of state fiscal distress.

Establishing a reliable, sustainable way to finance the exchange is vital to its ability to reach its goals. Throughout the process, it is important to keep in mind the potential effects on enrollment as well as the economic, social, and political implications of each financing option. The exchange planning grant should be used to determine costs of operation and the positive and negative effects various funding methods would have.