Pennsylvania Health Insurance Exchange

Draft Strategic Goals and Guiding Principles

For Discussion with the Exchange Subcommittee

In March 2010, the Patient Protection and Affordable Care Act of 2010 (PPACA) was adopted by Congress and signed by the President. The law makes a number of changes to the insurance market in the United States. Starting in 2014, individual and small group insurance will be offered on a guaranteed issue basis, meaning that individuals can not be refused insurance for past or current health care use or needs. The law also requires most U.S. citizens and legal residents to have health insurance coverage or face an annual financial penalty.

The law requires that Individual consumers and small employers have the opportunity to purchase health insurance through a health insurance exchange. 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. The exchange will also administer the new federal health insurance tax credits for those who qualify and make it easier to enroll in health insurance. Beginning in 2014, an exchange will be available in each state (or federally if states 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 Health and Human Services Secretary will provide guidance and regulations for states, if states choose to establish health insurance exchanges.

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 the state exchange be self-sustaining by January 2015;
- Requirement that the exchange consult with stakeholders.

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, 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 PPACA 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 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.

1 http://www.portal.state.pa.us/portal/server.pt/community/executive_orders/708
2 The Implementation Committee includes the Governor’s Chief of Staff; Secretary of Administration; Secretary of Aging; Secretary of the Budget; Director of the Governor’s Budget Office; Secretary of Health; Executive Director of the Office of Health Care Reform; Insurance Commissioner; Secretary of Legislative Affairs; Secretary of Planning and Policy; Secretary of Public Welfare; and the Deputy Secretary of Public Welfare for Medical Assistance.
3 The external HCR Advisory Committee includes consumers, large and small purchasers, unions, insurance industry executives, hospital representatives, medical professionals, large and small purchasers, unions, health and budget policy experts, and two appointees from each of PA’s four legislative caucuses.
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 these functions:

- Certify 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.
  - 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, prospective enrollees can get standardized comparative plan information.
  - Allow customers to compare qualified health benefits plans offered by different insurance carriers.
  - Use a standardized format to present four coverage options (bronze, silver, gold, and platinum), plus the catastrophic plan design for young adults/exemptions.
- Provide information to individuals and employers,
  - Provide information regarding eligibility requirements for Medicaid, CHIP and any applicable State/local public program.
  - Provide an electronic calculator that allows users to determine the actual cost of coverage after accounting for any premium tax credit and cost sharing reduction.
  - Publish: the average costs of licensing, regulatory fees, other payments required by exchange; exchange administrative costs; waste, fraud, abuse.
  - Provide employers with the names of any of their employees who stop coverage under a qualified health plan during a plan year.
- Administer exemptions to the individual responsibility penalty when:
  - No affordable qualified health plan is available through the exchange; or
  - The individual meets the requirements for another exemption from the requirement or penalty.
  - Certify individuals who are exempt from the individual mandate on the basis of hardship or other criteria to be established by HHS.
- Provide information to federal government regarding:
  - Pennsylvanians issued an exemption certificate;
  - Employees determined to be eligible for premium tax credits; and
  - People who tell the exchange they changed employers and stopped coverage during a plan year.
o Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded due to a failure on the part of a small employer to provide sufficient affordable coverage.

- Facilitate community based assistance by establishing a Navigator program.
- Have an annual open enrollment period, special enrollment periods, and monthly enrollment periods for Native Americans.
- Establish a network of navigators to raise awareness among customers of their coverage options and to help people select and enroll in health plans and subsequently access benefits.

Optional functions

The exchange may perform additional responsibilities outside of those required by federal health care reform – or none at all.

- 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, the exchange could limit the number of health plans available, perhaps by allowing only the highest quality plans to be available through the exchange after a competitive procurement.
- The exchange could also negotiate with insurers over items like benefits and premiums.
- 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., electronic health records) 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

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

The exchange should focus on improving service and access for consumers and must have a strong consumer-orientation and be for the benefit of Pennsylvanians.

The exchange should facilitate access, simplify options, enrollment and regulation, change how services are provided, 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

A strong governing board will ensure that the exchange is well-governed, sustainable, and responsive to consumers.

The governing board should:

- Be broadly representative and include members chosen for individual professional and community leadership and experience.
• Include the Sectaries of DPW and DOH 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 from MA and other programs to the exchange.
• Be responsive to the needs of the public.
• Be flexible enough to change with shifting market and political climates.
• Have expertise, authority, and sensitivity to work with:
  o Insurers
  o Third-party administrators
  o The Internal Revenue Service
  o Navigators
  o State Medicaid/CHIP offices
  o Consumers
  o Small businesses
  o A variety of other stakeholders

Governing Board Membership

• The federal law restricts those with relationships to insurance companies from serving on the board of the exchange, if the exchange has a board.
• Other membership restrictions due to conflicts of interest should be considered.

3. The exchange should be established as a independent public agency (or public corporation) such as a board or commission or an Authority

To facilitate the exchange’s ability to focus on consumers and to maintain good relations with the insurance carriers that will serve the consumers, the exchange must be able to act quickly on its consumers’ behalf. Due to state procurement, hiring and human resources rules, state agencies are generally not nimble or flexible. Exemptions may be made from specific rules, but authority to waive specific rules must be given in statute to ensure a state agency exchange has the flexibility it needs to be flexible and responsive. A public corporation can be independent from state fiscal processes and insulated from political wrangling, offering flexibility in the face of change. Like a public corporation, a private nonprofit model is inherently more flexible and agile than a state agency, although it does not have the accountability of a public corporation.

Oversight is easily achieved for a state agency. Its ability to be responsive to stakeholders outside of the state government would vary, potentially hampered somewhat by the limited flexibility of state rules. Some consumer advocates argue that a state agency would ensure accountability to consumers. A government agency would exist for the benefit of consumers. A public corporation or non-profit can build in accountability and responsiveness to the public by clearly identifying these as core missions of the organization, while simultaneously prioritizing flexibility and agility as well. To ensure this, clear governance in authorizing legislation will specify the terms of the exchange’s consumer-focused mission.

Another mechanism to ensure oversight and accountability is to require state officials to participate as ex officio members of the exchange’s governing board. To
strengthen the link between state agencies and the exchange, ex officio members could be included as full voting members of the exchange board.

For an exchange to be a successful business, it must enroll and retain customers. This is a business task as much as anything else. A state agency can provide good customer service if provided with strong leadership. An exchange is federally required to conduct a range of consumer oriented tasks. Concerns exist about the ability of a state-agency exchange to conduct its federally mandated business in tight fiscal times such as the one currently facing Pennsylvania.

The exchange can not be hobbled by the budget cuts or political wind changes that can affect state agencies. A public corporation funded by user fees would exist outside of the state budgeting and legislative cycles.

The public corporation and non-profit models also avoids the perception that a state agency running a government program must be a social service program aimed at the low income population. While many people understand that the subsidy portion of the exchange is available for both moderate and middle income Pennsylvanians, distaste for public programs could turn off potential enrollees.

In considering whether an exchange would best be created as a public agency, a private non-profit, or a public corporation we should consider the following issues:

- 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.
- State procurement, hiring, and human resource rules, and the flexibility and responsiveness of state agencies.
- 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.
- The oversight that will be needed in the implementation and structure of an exchange and what type of exchange will ensure accountability to consumers.

**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 PDW and the Insurance Department.

**Disadvantages**

- The exchange’s decision-making and operations being politicized;
Difficult for the exchange to be nimble in hiring and contracting practices, given most States’ personnel and procurement rules.

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

**Advantages**

- Enabling legislation would specify how board members would be appointed, the size of the board and the composition and terms of the members.
- The board would also select the exchange’s executive director.
- A public sector entity, outside of the executive branch is independent of the Governor and Legislature.
- Insulated from the political process more so than an executive branch agency.
- More nimble in hiring and contracting and it could be more independent.

**Disadvantages**

- The exchange would have more difficulty coordinating health care purchasing strategies and initiatives with key State agencies, such as DPW and the Insurance Department and their employees because the exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the Insurance Commissioner or the Governor).
- Accountable to the state and federal government but exempt from certain civil service and procurement laws that apply to executive branch agencies.
- Less access to the executive administration.

**Non-profit entity**

**Advantages**

- Would not be directly accountable to the government
- Would not be subject to government oversight.
- Would not be subject to civil service and 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 (given the absence of public sector requirements about procurements and personnel), the ability to be more nimble in decision-making and less chance of being politicized.

**Disadvantages**

- Isolation from state policymakers and key state agency staff and the potential for decreased public accountability.
- Greater distance from policymakers and the executive administration, more difficulty coordinating with other public sector health purchasers, and more difficulty being held publicly accountable.
4. **One exchange should service the entire state.**

**Individual and Small Group Exchanges**

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.

What is called the “exchange” actually could be two separate purchasing pools operated independently: one for individuals and another for small groups. Federal law gives states the option of combining these two exchanges into single exchange. One exchange for both markets would mean that all plans would have to follow the same rules and meet the same regulations, which may have added benefits, costs, and complications.

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.

**Individual and small group risk pools**

The law also 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. (Federal law defines “small employer” as an employer with 2-100 employees. Until 2016, states may limit this definition to 2-50 employees.)

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.

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.

The Pennsylvania Department of Insurance has received a $1 million planning grant that will allow it to study the positive or negative impact of merging the individual and small markets and the impact of allowing employers with employees between 51-100 to initially be part of the Exchange.

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.

Beginning in 2014, the existing individual market products will be converted to adjusted community rating, and carriers will be required to issue federally approved benefit designs. The combination of these factors likely will result in premium increases for healthy individuals in the current individual market. If so, there is a risk people will drop coverage, and the individuals who remain will be higher utilizers than the individuals who drop coverage. This could lead to instability in the market.

5. **The exchange should/should not allow individuals and small business consumers, eligible to purchase coverage through the exchange to buy insurance outside of the exchange due to adverse risk issues.*** **This is an important issue for discussion.**

Federal law does not eliminate the insurance market outside of the exchange. Pennsylvania must decide whether to require all carriers wishing to sell health insurance in Pennsylvania to participate in the exchange. The primary reason to require all individuals and small businesses eligible to purchase coverage in the exchange to do so, is that it reduces adverse risk and “the death spiral” that could occur if only bad risks bought coverage in the exchange, while good risks purchased outside the exchange. This has been somewhat of a problem in Massachusetts. California has just passed a law authorizing the creation of an exchange and they plan to prohibit purchase outside the exchange. In California, individuals not eligible for coverage through the Exchange (immigrants) will be able to purchase coverage.

If Pennsylvania decides to allow plans to sell in and outside the exchange, it should have the following protections:

- If a carrier must participate in the exchange to also sell in the outside market, a plan that fails to be certified for exchange participation would not be available out the market either.
- Require insurers to offer the same plans in the external market as they do inside the exchange.
- Require insurers in the exchange to offer plans at each of the four tiers of coverage.
- Design and bargain for high-quality, low-premium plans in the exchange.
- Some combination of the first two that makes the exchange the market for most insurance but allows insurance to be sold in the external market.
Federal health care reform specifies the following rules to protect against 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.

This is a major issue that needs more study and discussion.

6. **The exchange should require minimum standard for plans sold in the individual and small employer group markets including young adult/catastrophic plans. The minimum standards may include quality indicators.**

As required by the federal law:

- All health plans must meet federal essential benefits requirements.
- All companies selling insurance in Pennsylvania will offer which plan offerings (Gold, Silver, Bronze)?
- May carriers also offer plans in addition to these plan levels?
- Exemptions are made for so called “grandfathered plans” (those issued before March 23, 2010) and insurance purchased by large employer groups covered by ERISA law.

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 the federal law.
- Pennsylvania should take steps to ensure that insurance carriers do not attempt to market to low risk people by offering only the lowest cost and coverage plans.
- The federal law requires that carriers participating in the exchange offer at least both a silver and a gold level plan. While carriers not participating in the exchange may not want to offer all plan levels, the state can require carrier to offer both bronze and silver level plans.

Young adult/catastrophic plan

- The federal law allows for a catastrophic plan to be sold to individuals under age 30 and people with hardship exemptions from the insurance mandate.
- The catastrophic plan will provide coverage or 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 exchange provides and incentive to carriers to participate in the exchange. Young adults tend to be healthier than the average under-65 population making this group is 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.

7. The exchange should serve as a purchaser of insurance to promote low pricing and high quality.

Quality and Consistency

- The exchange has an opportunity to create great levels of competition by assuring consistency across plan to maximize comparability.
- The exchange should create metrics that consider customer satisfaction, quality within each plan’s provider network, and health outcomes.

8. The Insurance Department should have rate review authority and require the same premium rates for plans sold inside and outside the exchange.

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

9. Small employers may utilize insurance agents and brokers to assist them in obtaining health insurance coverage through the exchange, but will need to pay all associated costs.
The federal law allows states to decide whether to use agents in the exchange, directing states that do utilize them to follow certain rules. However, if the Exchange is user friendly and helps direct users to the plans that best meet their needs, including easy comparative information on cost and quality, the added expense of brokers and agents should not be needed.

Agent Education and Reimbursement
- Consistent with federal guidelines, the exchange board should 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.

Navigators
- Some agents may seek to become “navigators.”
- Other organizations will become navigators as well – consider whether some of their functions could be exempt from producer licensing requirements.

10. 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. 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.

11. The Exchange must become financially self-sustaining.

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

The federal law explicitly presents one financing option: the exchange is allowed to charge assessments or user fees to participating health insurance providers. However, federal health care reform neither suggests nor limits options to this one.

Other funding options include:
- State funds
- Assessing health plans, employers, and/or individuals
- Assessing health care providers
- Surcharging insurance premiums
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
- 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 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
- 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.