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 and the Health Care and Education Reconciliation Act of 2010 (together, the “ACA”)\(^1\) 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 cannot 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. 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 have a role in providing information to allow individuals who qualify to claim the new federal health insurance premium tax credits and will facilitate the purchase of health insurance. Beginning in 2013 during the open enrollment period, 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 federal Department of Health and Human Services 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);

\(^{1}\) N.B. The ACA requires HHS to promulgate regulations and issue guidance on many of the topics addressed herein, such as, for example, ACA §1321(a), requiring regulations concerning “the establishment and operation of Exchanges” and “offering of qualified health plans through such Exchanges” and §1311(c)(1) (as amended), requiring regulations relating to the criteria for certification of qualified health plans. Therefore, any conclusions in this document may be subject to modification.

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• Requirement that a state’s exchange be self-sustaining by January 2015; and
• 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 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.

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2 http://www.portal.state.pa.us/portal/server.pt/community/executive_orders/708
3 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.
4 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.
Mandatory Functions

Under federal law, the exchange is required to perform the following 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 and prospective enrollees may 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 the following to individuals and employers.
  - Information regarding eligibility requirements for Medicaid, CHIP and any applicable state/local public program.
  - An electronic calculator that allows users to determine the actual cost of coverage after accounting for any premium tax credit and cost sharing reduction.
  - Publication of the average costs of licensing, regulatory fees, other payments required by exchange; exchange administrative costs; waste, fraud, abuse.
  - For employers, the names of any of their employees who stop coverage under a qualified health plan during a plan year.
- Administer the exemption process for the individual responsibility penalty when:
  - No affordable qualified health plan is available through the exchange or employer;
  - The individual meets the requirements for another exemption from the requirement or penalty; or
  - 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;
  - People who tell the exchange they changed employers and stopped coverage during a plan year; and
  - Transfer information to the federal Secretary of Treasury regarding individual mandate exemptions and subsidies awarded when/if a small employer does not provide sufficient affordable coverage.
• Have an annual open enrollment period, special enrollment periods, and monthly enrollment periods for Native Americans.
• 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 subsequently accessing 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 by allowing only the highest quality plans to be available through the exchange after a competitive procurement.
• Negotiate with insurers over elements of coverage if permitted by federal law and regulations.
• 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) 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 its attributes, and are requested to consider the Advisory Committee’s guiding principles in adopting the necessary legislation for an exchange.

1. The exchange must be accessible to consumers.
2. The exchange should be guided by a governing board and a strong executive team. (Majority not consensus recommendation.)
3. The exchange should be established as an independent public agency (or public corporation) such as a board or commission or an authority, or as a regulated non-profit entity. (Majority not consensus recommendation.)
4. One exchange may service the entire state, but decisions on if the small business and individual exchanges should be merged and the employee size of small businesses allowed to participate in the exchange should be postponed pending more information made available through the exchange planning grant.
5. Individuals and small business consumers, eligible to buy insurance through the exchange should also be allowed to buy insurance outside of the exchange.

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

7. The exchange should serve as a negotiator with insurance plans to promote low pricing and high quality for individuals and small employers. (This is a majority, but not consensus recommendation.)

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

9. The exchange should consider whether to utilize insurance agents and brokers to assist small employer groups in obtaining health insurance coverage through the exchange.

10. The General Assembly should retain authority to make changes to benefit requirements and mandates.


12. The exchange planning grant will help provide needed research and information to further inform the legislation, as will input from constituent groups impacted by the exchange.

The Governor and General Assembly must determine whether Pennsylvania will operate an exchange, and its attributes, and are requested to consider the Advisory Committee’s guiding principles in adopting the necessary legislation for an exchange.

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

**TIMELINE FOR LEGISLATION**

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.

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.

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5 Required by the federal legislation

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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 majority of the Advisory Committee members support that exchange should be guided by a governing board and a strong executive team6. However, representatives of the insurance industry feel it is too early to make this recommendation. The rationale for those who support this are:

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 secretaries 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 between MA and other programs and the exchange;
- Be responsive to the needs of the public;
- Be flexible enough to change with shifting market and political climates;
- Not be politicized
- Be stable
- Be independent
- Have professional management
- Be simple to understand and communicate
- Not be overly bureaucratic
- Have expertise, authority, and sensitivity to work with:
  - Consumers
  - Small businesses
  - Insurers
  - Third-party administrators
  - Producers (agents and brokers)
  - Navigators
  - Other stakeholders
  - State Medicaid/CHIP offices
  - The Internal Revenue Service

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6 This principle is contingent on which governance structure is determined by the General Assembly. The insurance representatives feel it is too early to make this recommendation.
Governing Board Membership

- Membership restrictions due to conflicts of interest should be considered.

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

A state-run exchange should:

- Be accountable, flexible, and responsive;
- Be free of conflict of interest and transparent in its operation;
- Focus on consumers;
- Maintain good relations with the insurance carriers that will serve the consumers;
- Be able to act quickly on consumers’ behalf;
- Strengthen its link with state agencies with state officials serving on the governing board with full voting rights;
- Be a successful business that enrolls and retains customers;
- Be able to conduct its federally mandated business in tight fiscal times;
- Exist outside of the state budgeting and legislative cycles; and
- Avoid the perception that a state agency is running a government social service program aimed at the low income population.

In considering this issue, the General Assembly should determine which structure would best govern the exchange, but it should be accountable, flexible, free of conflict of interest and transparent in its operation and 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;
- 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.

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7 This recommendation was supported by the majority of the Advisory Committee, but not by the insurance company representatives, who felt it was too early to make such a recommendation.
However, it is clear that legislation creating the exchange is needed, likely in 2011, to allow for all the interoperability that will be needed between agencies, IRS, Social Security and the health care plans to permit HHS to determine, by 1/1/13, that Pennsylvania will have an operational exchange by 1/1/14.

**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’s decision-making and operations may be politicized.
- 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.

**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 independent of the Governor and Legislature.
- Insulated from the political process more so than an executive branch agency.
- Likely more nimble in hiring and contracting.

**Disadvantages**

- The exchange would 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 (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.
- 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 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

• 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, more difficulty coordinating with other public sector health purchasers, and more difficulty being held publicly accountable.

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

**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. Federal law gives states the option of combining these two exchanges into a single exchange.

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.

**Issues to be decided:**

• Should the exchange limit participation in the exchange to employers with 2-50 employees in the first two years of operation?
• Should the individual and small group risk pools be merged?

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 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. Information gleaned through the planning grant study will inform any decision regarding the merger of the two pools. This will be a major focus of the planning grant, but without this analysis the Advisory Committee cannot make a recommendation about either combining the small group or individual markets or the size of employers allowed to purchase on the exchange.

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.

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.

5. **Individuals and small business consumers eligible to buy insurance through the exchange should also be allowed to buy insurance outside of the exchange.**

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 the states 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 not eligible to purchase health insurance in the exchange (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.

Allowing sales of health insurance both inside and outside an exchange would:

- Maximize the exchange’s ability to structure the market and influence the performance of the health care system.
- Maximize the number of insurers, and thus products available on the exchange, which in turn equates to maximizing the participating providers available to the insured. This will produce a higher likelihood that enrollees who “churn” into and out of the exchange (and into and out of Medicaid or CHIP) will be able to continue to use the primary care provider selected in the former program, thus having continuity of care for the insured. This would be true for others moving throughout the system due to employment status changes or other reasons that would cause movement from one insurer or plan to another.
- Maximize the possibility of having identical products offered outside the exchange by the insurers participating in the exchange (assuming the state would not make this a requirement for any insurer in the exchange). Having identical products outside the exchange reduces the risk of adverse selection between the exchange and the outside market.
- Create a large enough pool of enrollees to maintain a balance between the healthy and the sick.
- Offer more choice of plans and insurers to those purchasing insurance, which in turn would create more desire for the insurance companies to want to sell plans on the exchange.
- Attract a large and diverse population to avoid becoming the coverage source of last resort, serving only people who could not find coverage on more favorable terms elsewhere;
- Achieve economies of scale to keep administrative costs low; and
- Offer maximum choice to the “captive audience” of qualified individuals who must use the exchange in order to qualify for subsidies.

Ideally, insurers would 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.

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.

6. The exchange should require minimum standards for plans sold in the individual and small employer group markets including young adult/catastrophic plans. 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 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 may require carrier to offer both bronze and silver level plans.

Young adult/catastrophic plan should be available through the exchange.

- 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 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.

7. **If permitted by federal law and regulation, 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.**

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 produce 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.”

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8 The insurance representatives do not agree that the exchange should operate as an active purchaser.
Quality and Consistency

- The exchange has an opportunity to create great levels of competition by ensuring consistency across plans 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 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. 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.

9. **The exchange should consider whether to utilize insurance agents and brokers to assist small employer group in obtaining health insurance coverage through the exchange.**

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 for groups seeking to buy insurance through the exchange and seeking 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 should be considered in this light.

**Agent Education and Reimbursement**

- 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.

**Navigators**

- Some agents may seek to become “navigators.”
• Other organizations will become navigators as well -- consider whether some of their functions could or should 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 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 may not 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, 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.

In developing the state’s strategy for financing, it is important to consider how any funding option:

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9 PMS suggested language: Contracts with providers and claim filing processes should be standardized, and payment should be based on a fair market valuation and be sufficient to sustain required network participation.

10 PMS does not agree that health care providers should be assessed.
- 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.

12. The exchange planning grant and further clarification and information to be provided by the federal government will help provide needed research and information to further inform the legislation, as will input from constituent groups impacted by the exchange.

The Pennsylvania Insurance Department has received a $1 million planning grant that will allow it to study a number of issues related to establishing an exchange, including the impact of merging the individual and small markets and the impact of allowing employers having between 51-100 employees to initially be part of the exchange. The grant will also examine the impact of having regional or statewide risk pools. Further, the grant will allow study of potential governance structures and operating procedures, integration of the technical infrastructure behind the exchange, and financing mechanisms.

11 PMS comment: Funding the program by placing a tax on health care providers would be a disincentive limiting their participation.