PUBLIC CONSULTING GROUP

State of Delaware

Delaware Health and Social Services

Overview of a Health Benefits Exchange

May 3, 2011

Version History

Version	Date	Comments
R. Chacon, v1.0 Draft	4/28/11	
R. Chacon, v2.0 Final	5/3/11	

Table of Contents

I. INTRODUCTION....1
II. PURPOSE AND FUNCTIONS....1
III. KEY CONSIDERATIONS....4
IV. RESPONSIBILITIES....5

I. Introduction

The Health Benefit Exchange (“Exchange”) is one of the key provisions of the Patient Protection and Affordable Care Act (ACA), designed to assist uninsured individuals and small businesses purchase coverage, improve competition and transparency in the marketplace, and provide for continuity of coverage.

The ACA requires states, by the end of calendar year 2013, to establish an individual market Exchange (i.e., American Health Benefit Exchange) and a Small Business Health Options Program (SHOP) Exchange; or cede that authority to the federal Department of Health and Human Services (HHS) to establish and operate an Exchange on behalf of the state. This statutory requirement creates a platform for a centralized competitive marketplace that facilitates coverage for consumers in these two markets.

II. Purpose and Functions

Through the Exchange, individuals and small employers will be able to purchase health coverage from a range of health plans and health insurers. Lower- and middle-income individuals earning up to four times the Federal Poverty Level (FPL) – which is more than $89,000 for a family of four in calendar year 2011 – may be eligible for premium subsidies for commercial coverage; while small employers with lower-income workers may be eligible for premium subsidies for up to two years. The Lewin Group estimates that as many as 76,800 Delawareans will be eligible for premium subsidies in 2014, generating approximately $288 million in federal tax credits. People in working families, those at or above 200% of FPL, will constitute two-thirds of those eligible to receive the tax credits.

The table below shows the monthly premiums for four income groups and three family sizes, based on the 2011 Federal Poverty Levels. For individuals with income between 300% and 400% FPL, premiums will be equal to 9.5% of a family’s annual income.[1]

[1] “Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit in Delaware,” prepared by The Lewin Group for Families USA, September 2010.

FPL Level	Family Size	Annual Income	Premium as % of Income	Monthly Premium
133%	Individual	$14,484	3.0%	$36
	Family of 4	$29,726		$74
	Family of 6	$39,887		$100
FPL Level	**Family Size**	**Annual Income**	**Premium as % of Income**	**Monthly Premium**
150%	Individual	$16,335	4.0%	$54
	Family of 4	$33,525		$112
	Family of 6	$44,985		$150
200%	Individual	$21,780	6.3%	$114
	Family of 4	$44,700		$235
	Family of 6	$59,980		$315
250%	Individual	$27,225	8.05%	$183
	Family of 4	$55,875		$375
	Family of 6	$74,975		$503

At its core, the Exchange must achieve the following objectives:

- Attract and retain customers by offering “qualified” health plans;
- Establish a streamlined eligibility and enrollment system for all medical assistance programs (e.g., Medicaid, Delaware Healthy Children Program, subsidized coverage available through the Exchange);
- Process transactions effectively and efficiently;
- Provide members with information to make informed choices; and
- Enable individuals to apply for waivers that exempt them from the law’s health insurance mandate.

To achieve these objectives, there are several key business functions required for the successful operation of an exchange including:

- Website development, hosting and maintenance – Technical support to develop and maintain the Exchange web portal.

- Interface with state and federal agencies – Technical interfaces to direct applicants who qualify for public programs to the appropriate agencies.
- Establishment of "Navigators" – Navigators will assist consumers in the application process.
- Enrollment process – vehicles for consumers to apply for coverage – a web portal, toll-free telephone, and paper application processes.
- Eligibility determination process – a process to determine if the applicant qualifies for public programs, premium subsidies, and qualified plans.
- Call center – Customer service telephone support to assist consumers with general questions regarding the exchange.
- Rating engine – Used to establish premium rates for consumers.
- Premium billing, collection and remittance – Operational processes and resources to bill, collect and remit premiums.
- Certification of exemptions to the mandate – Business process to certify exemption claims related to the individual mandate.
- Appeals process – a process for consumers to appeal eligibility determination / coverage decisions.
- Financial management – Overall financial management of the Exchange Operations.
- Public reporting – Analytical reporting resources to ensure transparency.
- Health carrier and plan selection evaluation and management – Processes for evaluating and managing the health carriers and plans operating in the Exchange.
- Program integrity –processes to identify potential fraud and abuse, monitor enrollment in the Exchange, and guard against potential for adverse selection.
- Health plan quality rating – Processes for assigning health plan quality ratings.
- Health plan reporting – Analytical resources to provide information across health plans offered through the exchange.

Additional information on these functions is provided under Section IV Responsibilities.

III. Key Considerations

Achieving the proper balance between public accountability and transparency with the need to be nimble and responsive to consumer demands will require an entity that is subject to government oversight but also has sufficient flexibility to achieve its commercial objectives.

As the state considers the establishment of a Health Benefit Exchange for Delaware, and the crucial decisions around governance and administration of the Exchange, developing a full understanding of the functions and responsibilities of the Exchange will be critical to establishing an organizational and operational structure that can effectively execute these responsibilities and best meet the needs of Delawareans.

Determining how best to position Delaware's Exchange so that it meets the state's objectives and is compliant with the ACA will require collaboration across state agencies, with the federal government, among stakeholders, and throughout the state's health insurance industry.

A number of key decisions will need to be made in order to set up an Exchange that works for Delawareans, including, but not limited to, the following:

- What are the overall goals of the Delaware Exchange?
- How will the Exchange be governed and administered? Should the Exchange be run by an existing state agency, new state agency, quasi-public authority, or a non-profit?
- Should the state establish an individual market Exchange and a small group market Exchange, or should a single entity be responsible for both markets?
- How can Delaware's Exchange effectively conduct outreach and enrollment activities, and help individuals and small businesses review, compare and purchase health insurance?
- How will the Exchange operate alongside existing commercial health insurance markets to avoid disrupting or destabilizing those markets?
- What policies and procedures can be established to minimize the potential risk selection for health plans purchased inside and outside the Exchanges?
- How will the Exchange interact with the state's Medicaid and CHIP programs?
- What level of customer service will the Exchange need to provide?

These are but a few of the key issues that will need to be addressed as Delaware goes about the challenge of establishing a Health Benefit Exchange. While the federal government will establish parameters within which Delaware's Exchange may operate, the state is provided some flexibility to design and develop a Health Benefit Exchange that best meets the needs of Delaware residents and businesses.

IV. Responsibilities

The Exchange has a broad array of responsibilities that cross both the public and private insurance sectors. Governmental responsibilities include such tasks as determining eligibility for publicly subsidized coverage, verifying citizenship of enrollees, certifying exemptions under the individual mandate, and exchanging information with the federal government.

The Exchange will also need to act as a private enterprise, serving as a distribution channel for commercial health insurance, working with small employers (and potentially with large employers) to provide their employees with commercial coverage, generating revenues to support operations, and competing against or partnering with existing distribution channels for customers.

These responsibilities are divided into four key areas:

- ✓ Eligibility
- ✓ Outreach, Enrollment, and Customer Service
- ✓ Health Plan Selection, Evaluation, and Management
- ✓ Enforcement of Individual Mandate and Federal Reporting

Eligibility

The Exchange must support eligibility determination functions including the ability to certify that prospective enrollees in the Exchange's individual market are citizens or nationals of the United States or are lawfully present aliens, are not eligible for "affordable" and "qualified" employer-sponsored insurance, and are not eligible for other medical assistance programs (e.g., Medicaid, CHIP, Medicare, etc.)

An eligibility rules engine will evaluate applications to determine if individuals qualify for Medicaid, Children's Health Insurance Program (CHIP), other public health coverage programs, or premium subsidies and health plans with reduced cost sharing through the Exchange.

Outreach, Enrollment, and Customer Service

A key responsibility of the Exchange is to establish a website that provides individuals and employers with information on health plans available through the Exchange, using a standard format for presenting health plans' benefit information. It will be critical that the design of the website considers the consumer's perspective and health insurance literacy through simplicity and readability. Purchasing insurance coverage is a daunting and complex task, to the extent that this can be eased through web design features and navigation, the better the experience will be

for the consumer. The Exchange will also need to provide a toll-free number and customer service unit to respond to inquiries from consumers.

Another requirement of the Exchange is an electronic calculator that allows individuals to determine the net cost of coverage after premium tax credits and reduced cost sharing have been applied. This will help consumers determine their potential out-of-pocket costs for coverage.

The Exchange will need to establish an outreach and enrollment program, including a grants program for "Navigators" that will be responsible for apprising people of their health coverage options and helping individuals enroll in a health plan through the Exchange or in other publicly subsidized health coverage programs available in the state. Advocacy groups, public health workers, and community groups that provide trusted services for Delawareans will be important ambassadors of this outreach support. Determining the proper role for brokers and agents, and how they may interact with Navigators, will be another critical decision for the Delaware Exchange.

To support enrollment, the Exchange will need to establish a standardized enrollment form for health plans offered through the Exchange; provide enrollees and prospective enrollees with information on the availability of in-network and out-of-network providers; and facilitate the enrollment of individuals, families, and employer groups in commercial health plans. In addition, the Exchange will need to facilitate the enrollment of eligible individuals in Medicaid, Delaware Healthy Children Program (CHIP program), or other public programs if found eligible during the screening of an application.

Policies will need to be developed pertaining to the payment of premiums and the application of premium subsidies from the federal government.

Health Plan Selection, Evaluation, and Management

To support health plan selection, the Exchange will need to establish criteria, consistent with any requirements to be issued by the federal government, to offer "qualified health plans" from health carriers; implement procedures for certification, recertification, and decertification of qualified health plans; and evaluate premium levels and premium increases in determining whether to allow a health plan to be offered through the Exchange.

The Exchange will also be required to obtain, and make publicly available, information from health carriers, including, but not limited to, enrollment and disenrollment, claims payment practices, claims denial rates, rating practices, out-of-network coverage, and customer satisfaction; require plans to meet marketing standards and not use marketing practices or benefit designs that discourage enrollment of high-risk individuals and groups; ensure that health plans offer a sufficient choice of providers; and require that health plans include essential community providers, where available, that serve predominantly low-income, medically underserved populations.

The Exchange will rate health plans offered through the Exchange on the basis of price and quality criteria to be established by the federal government; and require plans to implement a quality improvement strategy designed to improve health outcomes.

For all eligible applicants, the Exchange will need to make available four levels of "qualified health plans"— Platinum, Gold, Silver, and Bronze — based on their actuarial values, which range from 90 percent (Platinum) to 60 percent (Bronze); and for individuals under 30 years of age and for those exempt from the individual mandate, make available a "catastrophic" (high-deductible) health plan; and allow issuers of stand-alone dental plans, which may be sold separately or in conjunction with qualified health plans, to offer the products through the Exchange.

Enforcement of Individual Mandate and Federal Reporting

To enforce the individual mandate of the ACA, the Exchange must determine whether an individual is exempt from the individual mandate to maintain health coverage based on affordability, religious beliefs, or hardship; and provide the federal government with information on individuals who have been granted a certificate of exemption from the individual mandate.

The Exchange is required to provide the federal government with information on employers who are subject to a penalty for not offering minimum essential coverage, offering coverage that was determined to be unaffordable to employees, or offering coverage that did not meet the required minimum actuarial value; and whose employees received a premium subsidy for coverage through the Exchange. The Exchange must also report to employers the name of each employee who ceases coverage under a qualified health plan purchased through the Exchange.

Finally, the Exchange must make publicly available its costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of the Exchange.

Finally, the Exchange is obliged to collect information from insurers that offer qualified health plans through the Exchange on their claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, number of denied claims, cost-sharing and payments for out-of-network coverage, enrollee and participant rights, and other information as determined by the U.S. Secretary of Health and Human Services.

Overview of Health Benefit Exchange

The Health Benefit Exchange ("Exchange") is the centerpiece of federal health insurance reforms in the Patient Protection and Affordable Care Act (ACA). By the end of calendar year 2013, all states are required to establish an individual market Exchange (i.e., American Health Benefit Exchange) and a Small Business Health Options Program (SHOP) Exchange; or cede that authority to the federal Department of Health and Human Services (HHS) to establish and operate an Exchange.

Through the Exchange, individuals and small employers will be able to purchase health coverage from a range of health plans. Lower- and middle-income individuals earning up to four times the Federal Poverty Level (FPL) – which is more than $88,000 for a family of four in calendar year 2011 – may be eligible for premium subsidies for commercial coverage; while small employers with lower-income workers may be eligible for premium subsidies for up to two years.

The table below shows the monthly premiums for four income groups and three family sizes, based on the 2011 Federal Poverty Levels. For individuals with income between 300% and 400% FPL, premiums will be equal to 9.5% of a family's annual income.

FPL Level	Family Size	Annual Income	Premium as % of Income	Monthly Premium
133%	Individual	$14,484	3.0%	$36
	Family of 4	$29,726		$74
	Family of 6	$39,887		$100
150%	Individual	$16,335	4.0%	$54
	Family of 4	$33,525		$112
	Family of 6	$44,985		$150
200%	Individual	$21,780	6.3%	$114
	Family of 4	$44,700		$235
	Family of 6	$59,980		$315
250%	Individual	$27,225	8.05%	$183
	Family of 4	$55,875		$375
	Family of 6	$74,975		$503

At its core, the Exchange must attract and retain customers by offering "qualified" health plans; establish a streamlined eligibility and enrollment system for all medical assistance programs (e.g., Medicaid, DE Healthy Children, subsidized coverage available through the Exchange); process transactions effectively and efficiently; provide members with information to make informed

choices; and enable individuals to apply for waivers that exempt them from the law's health insurance mandate.

The table at the end of this overview lays out the specific responsibilities within the Exchange's four main functional areas: (1) eligibility; (2) outreach, enrollment, and customer service; (3) selection, evaluation, and management of the health plans offered through the Exchange; and (4) enforcement of the individual mandate and federal reporting.

The Exchange will straddle public and private health insurance markets, and is charged with a broad range of duties. The tasks under the Exchange's responsibility do not lend themselves to a familiar organizational structure, either public or private. On the one hand, the Exchange has governmental responsibilities, such as determining eligibility for publicly subsidized coverage, verifying citizenship of enrollees, certifying exemptions under the individual mandate, and exchanging information with the federal government.

On the other hand, the Exchange will need to operate like a private enterprise, serving as a distribution channel for commercial health insurance, working with small employers (and potentially with large employers) to provide their employees with commercial coverage, generating revenues to support operations, and competing against or partnering with existing distribution channels for customers.

Achieving the proper balance between public accountability and transparency with the need to be nimble and responsive to consumer demands will require an entity that is subject to government oversight but also has sufficient flexibility to achieve its commercial objectives.

As the state considers the establishment of a Health Benefit Exchange for Delaware, and the crucial decisions around governance and administration of the Exchange, developing a full understanding of the functions and responsibilities of the Exchange will be critical to establishing an organizational and operational structure that can effectively execute these responsibilities and best meet the needs of Delawareans.

Determining how best to position Delaware's Exchange so that it meets the state's objectives and is compliant with the ACA will require collaboration across state agencies, among stakeholders, and throughout the state's health insurance industry.

A number of key decisions will need to be made in order to set up an Exchange that works for Delawareans, including, but not limited to, the following:

- What are the overall goals of the Delaware Exchange?
- How will the Exchange be governed and administered?

- Should the state establish an individual market Exchange and a small group market Exchange, or should a single entity be responsible for both markets?
- How can Delaware's Exchange effectively conduct outreach and enrollment activities, and help individuals and small businesses review, compare and purchase health insurance?
- How will the Exchange operate alongside existing commercial health insurance markets to avoid disrupting or destabilizing those markets?
- What policies and procedures can be established to minimize the potential risk selection for health plans purchased inside and outside the Exchanges?
- How will the Exchange interact with the state's Medicaid and CHIP programs?
- What level of customer service will the Exchange need to provide?

These are but a few of the key issues that will need to be addressed as Delaware goes about the challenge of establishing a Health Benefit Exchange. While the federal government will establish parameters within which Delaware's Exchange may operate, the state is provided some flexibility to design and develop a Health Benefit Exchange that best meets the needs of Delaware residents and businesses.

HEALTH BENEFIT EXCHANGE KEY RESPONSIBILITIES

Eligibility

1. Certify that prospective enrollees for coverage in the Exchange's individual market are citizens or nationals of the United States or are lawfully present aliens; and
2. Determine if individuals qualify for Medicaid, Children's Health Insurance Program (CHIP), other public health coverage programs, or premium subsidies and health plans with reduced cost sharing through the Exchange.

Outreach, Enrollment, and Customer Service

1. Establish a website that provides individuals with information on health plans available through the Exchange;
2. Utilize a standard format for presenting health plans' benefit information;
3. Operate a toll-free number and customer service unit to respond to inquiries from consumers;
4. Make available an electronic calculator that allows individuals to determine the net cost of coverage after premium tax credits and reduced cost sharing have been applied;
5. Establish an outreach and enrollment program, including a grant program for "Navigators" that will be responsible for apprising people of their health coverage options and helping individuals enroll in a health plan through the Exchange or in other publicly subsidized health coverage programs available in the state;
6. Establish a standardized enrollment form for health plans offered through the Exchange;
7. Provide enrollees and prospective enrollees with information on the availability of in-network and out-of-network providers;
8. Facilitate enrollment of individuals, families, and employer groups in commercial health plans, and enroll individuals in Medicaid, Delaware Health Children (CHIP program), or other public programs if found eligible during the screening of an application; and
9. Develop policies pertaining to the payment of premiums and the application of premium subsidies from the federal government.

HEALTH BENEFIT EXCHANGE KEY RESPONSIBILITIES (cont.)

Health Plan Selection, Evaluation, and Management

1. Establish criteria, consistent with any requirements to be issued by the federal government, to offer “qualified health plans” from health carriers;
2. Implement procedures for certification, recertification, and decertification of qualified health plans;
3. Evaluate premium levels and premium increases in determining whether to allow a health plan to be offered through the Exchange;
4. Require health carriers to publicly disclose information, including, but not limited to, enrollment and disenrollment, claims payment practices, claims denial rates, rating practices, out-of-network coverage, and customer satisfaction;
5. Require plans to meet marketing standards and not use marketing practices or benefit designs that discourage enrollment of high-risk individuals and groups;
6. Ensure that health plans offer a sufficient choice of providers;
7. Require that health plans include essential community providers, where available, that serve predominantly low-income, medically underserved populations;
8. Rate each health plan offered through the Exchange on the basis of price and quality criteria to be established by the federal government;
9. Require plans to implement a quality improvement strategy designed to improve health outcomes;
10. For all eligible applicants, make available four levels of “qualified health plans”— Platinum, Gold, Silver, and Bronze — based on their actuarial values, which range from 90 percent (Platinum) to 60 percent (Bronze); and for individuals under 30 years of age and for those exempt from the individual mandate, make available a “catastrophic” (high-deductible) health plan; and
11. Allow issuers of stand-alone dental plans, which may be sold separately or in conjunction with qualified health plans, to offer the products through the Exchange.

HEALTH BENEFIT EXCHANGE KEY RESPONSIBILITIES (cont.)

Enforcement of Individual Mandate and Federal Reporting

1. Determine whether an individual is exempt from the individual mandate to maintain health coverage based on affordability, religious beliefs, or hardship;
2. Provide the federal government with information on individuals who have been granted a certificate of exemption from the individual mandate;
3. Provide the federal government with information on employers who are subject to a penalty for not offering minimum essential coverage, offering coverage that was determined to be unaffordable to employees, or offering coverage that did not meet the required minimum actuarial value; and whose employees received a premium subsidy for coverage through the Exchange;
4. Report to employers the name of each employee who ceases coverage under a qualified health plan purchased through the Exchange;
5. Publish costs of licensing, regulatory fees, and any other payments required by the Exchange, and the administrative costs of the Exchange; and
6. Collect information from insurers that offer qualified health plans through the Exchange on their claims payment policies and practices, periodic financial disclosures, enrollment, disenrollment, number of denied claims, cost-sharing and payments for out-of-network coverage, enrollee and participant rights, and other information as determined by the U.S. Secretary of Health and Human Services.

Issue Brief: The Health Benefit Exchange and the Small Employer Market

Overview

The federal health care reform law directs states to set up health insurance marketplaces, called "Health Benefit Exchanges," that will enable individuals, families and employers to purchase health insurance from a range of commercial insurers offering a variety of health plans. Starting in 2014, the Exchange will serve as a central point of access for health insurance, providing eligible individuals, families and small employers with the ability to select from a number of "qualified health plans" offered by a range of insurers. The plans available through the Exchange will have varying amounts of cost sharing and monthly premiums.

Lower- and middle-income individuals and families with income up to four times the Federal Poverty Level (FPL) – which for a family of four is $89,400 in calendar year 2011 – may be eligible for subsidized health insurance (i.e., premium tax credits and reduced out-of-pocket costs) through the American Health Benefit Exchange. Small employers will be able to purchase health coverage through the Small Business Health Options Program or "SHOP" Exchange.

During its first two years of operation, firms with 50 or fewer full-time workers will be eligible to purchase coverage through the SHOP Exchange. In January 2016, employers with up to 100 workers will be allowed to buy health insurance through the SHOP Exchange, although the State does have the option to expand the definition of small group to include employers with up to 100 employees prior to the January 2016 federal requirement. In 2017, the State may choose to allow large employers (i.e., businesses with over 100 full-time employees) to purchase coverage through the Exchange.

Small employers with 25 or fewer lower-wage workers may be eligible for premium subsidies for up to two years if they purchase coverage through the Exchange. However, in general, employees that purchase coverage through the SHOP Exchange will not be eligible for premium tax credits and reduced cost-sharing, unless the employees' share of the premium for employer-sponsored coverage exceeds 9.5 percent of the employees' income.

While the law sets out certain requirements, Delaware will need to make a number of key decisions in setting up its SHOP Exchange. This issue brief discusses the key issues and policy decisions associated with the Exchange and the small group market.

One Exchange or Two?

The law allows states to establish two separate Exchanges – a SHOP Exchange for employers and an American Health Benefit Exchange for individuals and families – or a single Exchange to serve the individual and small group markets. It is important to point out that the decision to

administer a single Exchange that serves both markets does not necessarily mean that the individual and small group markets need be, or should be, combined for risk pooling purposes. That is, Delaware may choose to designate a single administrative entity to operate the Exchange for both individuals and employers, while still maintaining separate risk pools for the individual and small group markets.

Many of the requirements of the SHOP Exchange will be identical or similar to those of the individual market Exchange; including, but not limited to, the health plans offered, the summary of benefits information provided to consumers, the rating of health plans based on quality and price, and the health plan reporting requirements.

Both the SHOP and individual Exchange may only offer "qualified health plans" within specific benefit levels: Platinum, Gold, Silver, and Bronze. The benefit levels will vary based on "actuarial value," which is a summary measure of the amount of medical claims paid by the health plan (excluding a member's point-of-service cost sharing), expressed as a percentage of the total medical claims incurred for a standard population.

$$\frac{\text{Premiums}}{\text{Expected Claims}} = \text{Actuarial Value}$$

Platinum plans will cover 90 percent of the cost of care, which means an individual purchasing a Platinum plan can expect to have 90 percent of his/her medical costs covered by the premium, with the remaining ten percent paid through point-of-service cost sharing (i.e., co-payments, co-insurance, deductibles). Gold plans will cover 80 percent; Silver plans will cover 70 percent; and Bronze plans will cover 60 percent.

The individual market Exchange may also offer a high deductible health plan to certain individuals (i.e., under age 30 or people who are exempt from the individual mandate based on affordability of coverage). These plans will not be offered to employers purchasing insurance through the SHOP Exchange.

In addition, the law limits the maximum upfront deductible for health plans purchased by small employers. In 2014, small group health plans may not have an upfront deductible that exceeds $2,000 for single coverage and $4,000 for family coverage.[1] These limits do not apply to the individual market, although the actuarial value standards noted above will effectively cap the amount of upfront deductible that may apply to individual coverage sold through the Exchange.

All plans sold through the Exchange must cover "essential health benefits." The health reform law outlines a basic definition of essential health benefits and requires the U.S. Secretary of

[1] See Appendix for overview of small group market regulations that will take effect in January 2014.

Health and Human Services (HHS) to further define what constitutes essential health benefits. In making this determination, the HHS Secretary must ensure the coverage is equal to the typical coverage provided by an employer, as well as other principles described in the federal law.

The law also requires that health plans in both the individual and group markets comply with a common set of rules, including:

- Guaranteed issue and guaranteed renewal (i.e., an applicant cannot be denied coverage and cannot be dropped at the time of renewal);
- No use of health status as a rating factor (i.e., a person or group cannot be charged a higher premium based on his/her health status or a pre-existing condition);
- A limited set of factors may be used to set premiums (e.g., age, geographic location, family composition); and,
- Rates may not vary by more than 3:1 based on age (e.g., the rate charged an older applicant can be no more than three times the rate charged the youngest applicant).

While health plans sold in the individual and small group Exchange will have common rating requirements; unless the risk pools are combined, the premiums for coverage will likely differ between these two markets. That is, a health plan offered in the individual market may have a different premium than an identical plan offered in the small group market.

Health Plan Selection by Employers and Employees

The manner by which employers – and ultimately employees – may purchase coverage through the Exchange will be one of the most important policy decisions, and will likely determine the ultimate success of the Exchange in serving the employer market. Key policy decisions include participation requirements, contribution requirements, and the number and type of health plans from which employees may choose. Each is discussed briefly below.

Participation Requirements

Currently, health carriers that offer coverage in the small group market require a minimum percentage of employees to enroll in coverage as a pre-condition for selling group coverage. An employer with five or fewer employees is typically required to enroll all of his/her employees in the group's health plan, unless an employee is covered as a spouse or as a dependent under another employer's plan. For groups of six or more employees, the participation requirement is generally 75 percent. If an employer cannot meet these enrollment thresholds, the health carrier will not sell the policy to the group.

Contribution Requirements

Carriers also require employers to contribute a minimum amount of the monthly premium – generally 50 percent of the premium for single coverage – as a pre-condition for insuring a

group. Employers unable or unwilling to contribute at least 50 percent of the premium are not allowed to purchase group insurance.

The participation and contribution requirements protect against adverse selection and the risk of bad debt. Adverse selection involves a situation in which an individual's demand for insurance, and level of coverage, is directly related to the individual's perceived need for insurance. Older and sicker individuals may be more prone to participate in the insurance plan or enroll in the most comprehensive coverage because they have a known health care need or perceive that they need insurance; while younger and healthier individuals may choose to go without coverage or opt for a more limited health policy based on their perceived need for coverage.

Because the carriers may not know the health status of the group's members, they are unable to adjust prices to account for this selection bias. By requiring all employees or a majority of employees to be covered by the group policy, the carriers can minimize the potential for adverse selection. The contribution requirement helps reduce the risk of bad debt.

Key policy decisions for the Exchange will be whether the participation and contribution requirements that currently apply to employers purchasing coverage outside of the Exchange will apply to employers that purchase coverage through the Exchange. The Exchange's group purchasing model, discussed below, may also influence policy decisions regarding the contribution and participation requirements.

Employer Purchasing Models – Options for the Exchange

The manners by which employers – and by extension their employees – purchase coverage through the SHOP Exchange will impact the extent to which the Exchange can effectively serve the group market. While there may be any number of purchasing models that one could develop, listed below are four options that Delaware may consider for its SHOP Exchange. These models are not necessarily mutually exclusive, in that the Exchange may choose to allow employers to select from two or more purchasing options.

One Carrier, One Plan

This model reflects the traditional way that employers, particularly small employers, purchase health insurance. The employer selects a carrier and a health plan, and his/her employees are offered one health plan. The Exchange could be used by the employer – aided, perhaps, by an agent or broker – to compare health plans, assess premium contribution options, and select a carrier and health plan for his/her employees.

Monthly Premiums for Single Coverage				
Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	$420	**$413**	$403	$431
Bronze	$360	$354	$345	$369

A composite rate could be developed for the group (i.e., a monthly premium for single coverage, employee plus spouse/child, and family coverage), and the employer's and employees' share of the premiums would be set for the entire group.

One Carrier, Multiple Plans

Under this purchasing model, the employer selects a health carrier and allows employees to enroll in any of the health plans offered by that carrier through the Exchange. The table below illustrates how this might be structured. A modification to this model could restrict employees' choice to a sub-set of the health plans offered by a carrier (e.g., Silver and Gold level only, or Silver and Bronze level only).

Monthly Premiums for Single Coverage				
Health Plan/Carrier	Carrier A	**Carrier B**	Carrier C	Carrier D
Platinum	$540	**$531**	$518	$554
Gold	$480	**$472**	$460	$492
Silver	$420	**$413**	$403	$431
Bronze	$360	**$354**	$345	$369

Under this example, the employer "selects" Carrier B and his/her employees may choose from any of the health plans offered by that insurer. The employer could set its share of the premium contribution as a percentage of the cost of a specific plan (e.g., 70% of the cost of Carrier B's Silver plan), as a percentage of all plans' premiums, or as a flat dollar amount.

In the example below, if the employee selects the Silver plan, the employee would pay 30% of the cost. The employee would have the option of taking the employer's contribution – in this case $289 – and purchase a Gold or Platinum Plan, which would cost the employee more, or a Bronze Plan, which would cost the employee less, and pocket the difference in premium. The employer's share of the cost is fixed, while the employee's amount will vary depending on which plan the employee selects. The table below shows how this might work for an employee looking to enroll in single coverage.

Carrier B	Total Monthly Premium	Employer's Share of the Premium	Employee's Share of the Premium
Platinum	$531	$289	$242
Gold	$472	$289	$183
Silver	$413	$289	$124
Bronze	$354	$289	$65

Because employees may select from a number of health plans offered by a single carrier, it is likely that the group's premiums would need to switch from composite rating to list bill rating. Under composite rating, premiums are set on a group basis. The carrier establishes one premium for single coverage and one premium for family coverage, based on the composition of the entire group.

Under list bill rating, premiums are set for each employee that enrolls in coverage, based on the demographics of the individual employee. For example, a 25-year old employee would be charged less than a 55-year old employee. However, even under list bill rating, the Exchange's purchasing model could be structured to eliminate, or greatly reduce, any age-based differences in the employees' share of the premium by modifying the employer's contribution to reflect differences in premiums due to age.

All Carriers, One Plan Level

Under this purchasing model, the employer selects a plan level (i.e., Platinum, Gold, Silver, or Bronze) and allows his/her employees to select from any of the health carriers within a particular Level. The table below illustrates how this might be structured.

Monthly Premiums for Single Coverage				
Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	**$420**	**$413**	**$403**	**$431**
Bronze	$360	$354	$345	$369

Under this example, the employer selects the Silver Level plan and his/her employees may choose from any of the health carriers that offer a Silver Level plan offered through the Exchange. The employer could set its premium contribution as a percentage of the cost of a specific plan (e.g., 70% of the cost of Carrier B's Silver plan), as a percentage of all plans' premiums within the plan level, or provide a flat dollar amount that employees could then use to subsidize any of the plans offered on the Silver Level.

For example, if the employee selects Carrier B's Silver plan, the employee would pay 30% of the cost. The employee would then have the option of taking the employer's contribution – in this example, $289 – and purchase a Silver plan from any of the other carriers. The employer's share of the cost is fixed, while the employee's share of the premium will vary depending on which carrier the employee selects. The table below shows how this might work for an employee looking for single coverage.

Carriers' Silver Level Plan	Total Monthly Premium	Employer's Share of the Premium	Employee's Share of the Premium
Carrier A	$420	$289	$131
Carrier B	$413	$289	$124
Carrier C	$403	$289	$113
Carrier D	$413	$289	$141

Because employees may select from a number of health carriers within a plan level, premiums would likely need to switch from composite rating to list bill rating, as discussed above.

<u>All Carriers, All Plans</u>

Under this purchasing model, employees would be allowed to select from any of the health plans offered by the health carriers participating in the Exchange. The employer's share of the premium could vary based on the percentage of the premium (e.g., 70% of any plan's premium), could be set based on the premium of a particular plan offered by a specific carrier (e.g., 70% of the Silver Level Plan offered by Carrier B), or the employer could provide employees with a flat dollar amount and allow them to apply the employer's defined contribution to any health plan offered through the Exchange.

Monthly Premiums for Single Coverage				
Health Plan/Carrier	Carrier A	Carrier B	Carrier C	Carrier D
Platinum	$540	$531	$518	$554
Gold	$480	$472	$460	$492
Silver	$420	$413	$403	$431
Bronze	$360	$354	$345	$369

As with the previous two purchasing models, because employees may select from any of the health carriers, premiums would likely need to be established on a list bill basis.

Each of these models brings with it implications for the Exchange's attractiveness and sustainability, operational and administrative challenges, the potential for adverse selection, and ramifications for the broader commercial insurance market. Delaware will need to evaluate the

advantages and disadvantages of each purchasing option, and determine which model may work best for Delaware's employers, employees, residents and insurers.

Premium Billing, Collection and Remittance

The need for the Exchange to administer premium billing, collection, and remittance on behalf of small employers purchasing coverage through the Exchange will be particularly crucial. Depending on how the SHOP Exchange structures its purchasing model, employees may be able to choose coverage from a number of health carriers. If the health plans are responsible for premium billing and collection from the business, an employer purchasing coverage through the Exchange would likely need to pay multiple health carriers for, and will need to establish contractual relationships with, the various health carriers selected by his/her employees.

From an employer's perspective, the prospect of paying multiple insurers will greatly diminish the attractiveness and value of purchasing coverage through the Exchange. In addition to receiving multiple invoices and issuing multiple checks for his/her employees' health coverage, by not centralizing the premium billing and other administrative functions, the employer would need to deal with various health carriers to handle mid-year changes in employment, changes in status for existing employees, and all of the other administrative tasks that are now handled through one health carrier or through a broker.

In light of those administrative challenges, the Exchange may be the appropriate entity to assume responsibility for premium billing, collection, and remittance to the carriers, as well as other mid-year administrative tasks, such as changes in enrollment, COBRA notification, etc. In addition, the Exchange will be responsible for administering the premium tax credits program for eligible small employers that employ low-wage workers.

Key Issues for Delaware

As discussed above, the State will need to address a number of issues as it goes about the task of setting up the SHOP Exchange, develops the administrative processes and procedures to offer insurance to employers, and works with health carriers to structure a market that works for Delawareans. Listed below are a few of the key questions that will need to be resolved over the course of the next two years.

- Should the State establish one or two Exchanges to serve the individual and small group market?

- Should the individual and small group market risk pools be combined or remain separate?

- What type of purchasing model will best meet the needs of employers, employees and insurers?

- Is there a market segment, particularly among small employers, that may be interested in offering employer-sponsored insurance but are unable to meet the minimum participation and/or contribution standards?

- Can the Exchange fill this gap and promote an alternative means by which employers can subsidize insurance on a defined contribution basis?

- If the participation and contribution requirements are modified, what might be the effect on the small group risk pool, and should these "groups" be included in the individual market instead of the small group market?

- What might be the effect on the broader small group market from the introduction of an Exchange and the availability of premium subsidies for individuals who are not offered employer-sponsored insurance?

APPENDIX

Overview of ACA's Small Group Regulatory Requirements

The federal health care reform law will require Delaware to make a number of changes to its small group rating rules, and will restrict the number and types of rating factors used to set plan premiums in the small group market, as well as place limits on annual deductibles and require that certain benefits be covered by the health plans sold in the small group market.

For coverage effective January 2014, the federal law requires health plans to cover essential health benefits. While the specifics regarding what constitutes essential health benefits will be further defined by the federal Secretary of Health and Human Services (HHS), the law[2] enumerates a number of services that must be covered by health plans, including:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

In addition to these federal requirements, Delaware has 32 mandated benefits and services that must be covered by commercial health plans. However, for coverage purchased through the Health Insurance Exchange, the federal law requires that the cost of mandated benefits that exceed essential health benefits must be paid for by the State.

Delaware will need to review carefully the essential health benefits, which are due to be released in the fall of 2011, and compare those requirements to the State's mandated benefits. A policy decision will then need to be made regarding whether the State will continue to require health plans to cover benefits and services above and beyond the essential health benefits; and, if so, how the State will pay for those benefits for the policies that are purchased through the Exchange.

[2] Section 1302 of the Patient Protection and Affordable Care Act.

Furthermore, in the small group market, annual deductibles – that is, out-of-pocket expenses that must be paid by the member for services before the health plan's coverage begins – will be limited to $2,000 for single coverage and $4,000 for family coverage.

In addition to the rating rules and benefits changes that will take effect in January 2014, by January 2016, the small group market will include businesses with up to 100 employees. Currently, the Delaware small group market is defined as businesses with up to 50 employees.

Listed below are the major requirements that will take effect in 2014. These changes may affect the number of people covered in the small group market, the number of employers that offer employer-sponsored insurance, as well as the number of carriers offering small group coverage in Delaware.

Definition of Small Group	Up to 50 employees until 2016 (state option); after 2016, up to 100 employees
Guaranteed issue	Yes
Guaranteed renewal	Yes
Rating factors allowed	• Age -- 1:3 max ratio • Geography • Tobacco -- 1:1.5 (max) ratio • Family composition • Wellness program -- up to 30% premium discount
Annual deductible limits	$2,000 (single) $4,000 (family)
Benefits included in the plan	State mandates and "essential health benefits," to be defined by the US Secretary of Health and Human Services