PUBLIC CONSULTING GROUP

State of Delaware
Department of Health and Social Services

Health Benefits Exchange Planning Resources and Capabilities Report

Version 2.2

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Version History

Version	Date	Comments
Version 1.0 – A. Holmes/R. Chacon	August 5,2011	Initial draft
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1 Executive Summary

This report provides Delaware with a detailed assessment of the functions and responsibilities of a Health Insurance Exchange, and outlines options for the State to consider as they seek to establish an Exchange that best works for Delaware residents and small business employers. This report reviews the major components of an Exchange – pursuant to the Patient Protection and Affordable Care Act (ACA) and federal guidance – and offers recommendations on setting up an Exchange in time to meet the October 2013 deadline. By this date, based on the Notice of Proposed Rulemaking (NPRM) issued in July 2011 by the Centers for Medicare and Medicaid Services (CMS), the State's Exchange must be operational, able to process eligibility, and capable of enrolling people in coverage that will take effect starting January 1, 2014.

For each function identified, the State needs to decide whether to leverage existing public resources with the understanding that use of those resources may impact other current business processes. It is likely that, for most functions, the State needs to choose among three options:

1. Enter into an agreement with another state Exchange to share functionality.
2. Staff the function internally by hiring additional staff.
3. Procure functionality from the private sector.

As part of the business operations planning phase, Public Consulting Group (PCG) will work with the State to assist this decision making process for each function and plan for next steps accordingly.

In order to establish a fully-functioning ACA-compliant Exchange in time to meet the October 2013 deadline, the State of Delaware needs to make a number of critical decisions in the coming months. This report outlines the issues that need to be addressed and the functionality that needs to be developed to handle all of the tasks required of the Exchange.

The report includes the following sections: Governance and Administration (2); Eligibility (3); Enrollment and Disenrollment (4); Customer Service and Call Center (5); Exchange Website (6); Financial Management and Risk Management (7); Health Plan Certification, Recertification and Decertification (8); Network Adequacy Standards (9); Rate Review and Approval (10); Monitoring and Evaluation of the Exchange (11); Consumer Assistance and the Role of Navigators and Brokers (12); Correspondence and Notifications (13); Oversight and Program Integrity (14); and Security (15).

2 Governance and Administration

2.1 Governance Structure

Given that the broad range of tasks under the Exchange's purview does not lend itself to a common or typical organizational structure, either public or private, the ACA provides four governance and administrative options for the Exchange: an existing State agency, a new State agency, a quasi-public authority, or a non-profit organization.

At the present time Delaware favors creation of a new quasi-public authority. This option offers more flexibility than an agency-based Exchange and may be a better fit for its public/private roles and responsibilities. However, opposed to a State agency that has built-in accountability standards, management structure, and operating guidelines, the creation of a quasi-public authority will require policymakers to determine how it is governed and the extent to which State hiring procedures, procurement rules, and finance requirements are followed.

2.2 Governance Board

As part of the decision to establish a quasi-state agency to oversee the Exchange, including a board or commission to oversee the operations of the Exchange, Delaware officials needed to make several decisions that includes the size of the board and how board members are appointed.

2.2.1 Composition

Because board composition and qualifications are of critical importance to the success of the Delaware Exchange, policymakers face a number of key decision points. A board that is too large may prove unwieldy and incapable of acting nimbly. With this in mind, the following structured was recommended:

- 11 members;
- 5 members appointed by the Governor;
- 1 member appointed by President Pro Tempore of Senate;
- 1 member appointed by Speaker of the House of Representatives; and
- 4 ex-officio members (voting – members by virtue of position in state government):
    - Secretary, DHSS;
    - Director, Office of Management and Budget;
    - Insurance Commissioner; and
    - Controller General.

To ensure diverse expertise is represented on the Governing Board, it is important for appointing authorities to consider a range of skills, knowledge, experience, geographic, and stakeholder perspectives. Common subject matter experts included on Exchange governing boards include health economists, health actuaries, and people with experience purchasing or managing health benefits. A board without individuals with specific expertise may lack the know-how to develop and execute an effective business

plan. Additional considerations for appointing board members include ensuring an appointee does not hold elective office or be state or municipal employee (except ex-officios) and that they do not have an affiliation with a health insurer (employee, consultant, member of the board, ownership interest).

This new quasi-state entity needs close coordination with the Department of Insurance (DOI), since it needs to delegate or even contract with the DOI to perform various functions. The Exchange will also need to be closely coordinated with the Division of Medicaid and Medical Assistance (DMMA) which is responsible for the oversight of Delaware's Medicaid program and the State's Children's Health Insurance Program – known as the Delaware Healthy Children Program (DHCP).

2.2.2 Operations and Authority

The Executive Order drafted by Delaware outlines the operational guidelines of the Governing Board and specifies that the board will elect a chair and vice-chair who will serve one year terms with option for reelection up to three terms. Vacancies will be filled by the same appointing authority.

The Governing Board will meet at least once per quarter – and more often if necessary. Voting by proxy will not be allowed with the exception of ex-officio board members.

The Governing Board will possess the authority to:

- Appoint subcommittees and advisory committees to focus on relevant issues managed within the scope of the Governing Board;
- Adopt regulations to carry out powers of Exchange;
- Prepare special reports concerning the Exchange to the Governor and the General Assembly; and
- Contract for professional, technical and operational services.

As the State considers the establishment of the 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. While the federal government will establish parameters within which Delaware's Exchange may operate, the State is provided some flexibility to design and develop an Exchange that best meets the needs of Delaware residents and businesses.

3 Eligibility

One of the key responsibilities of the Exchange will be determining eligibility for medical coverage programs, including Medicaid, DHCP, and the advanced premium assistance tax credits for qualified health plans (QHPs) available through the Exchange. Furthermore, the Exchange must:

- Certify exemptions from the individual mandate to obtain and maintain health coverage;
- Determine an employer's eligibility to purchase coverage through the Exchange;
- Verify eligibility of the employer's employees, and
- Assist small businesses in applying for premium assistance tax credits.

Each of these responsibilities is discussed below, along with options for Delaware to meet these requirements.

3.1 Determination of Eligibility for All Publicly-Subsidized Health Coverage Programs

The ACA calls for a streamlined, simplified user-friendly approach to health coverage eligibility and enrollment and for a comparable consumer experience regardless of the program for which a person is eligible (e.g., Medicaid, DHCP, or the Exchange). It is the intent of the health care reform law to allow consumers to complete one standardized application to determine eligibility for Medicaid, DHCP, and the Exchange, instead of requiring individuals to submit separate applications for each program.

Consumers are to be offered multiple access points – web-based, phone, paper – to apply for coverage, with eligibility for all publicly-subsidized medical assistance programs based primarily on the applicant's modified adjusted gross income (MAGI) (see box below for an overview of the MAGI standard).

3.1.1 MAGI

The ACA establishes a new income standard for "newly-eligible" Medicaid recipients and for subsidy-eligible individuals and families seeking coverage through the Exchange. For coverage effective January 1, 2014, Delaware will be required to use MAGI to determine eligibility for publicly-subsidized health coverage programs for most non-elderly, non-disabled individuals. This income standard consists of adjusted gross income, as defined in the federal tax code, plus foreign income and tax-exempt interest. The new MAGI formula also eliminates asset tests and income disregard adjustments and, therefore, eliminates the need for applicants to report and provide paper verification of expenses as part of the eligibility determination process.

Elderly, disabled, medically needy, and individuals eligible for Medicaid through other programs or waivers, such as long-term care, will continue to have their eligibility determined using "traditional" Medicaid rules and will continue to be subject to an asset test.

HHS has indicated that it will provide further guidance and regulations on the methods and definitions used to calculate family size and household income as these apply to eligibility based on MAGI.

In addition to MAGI, the eligibility determination process needs to verify:

- Citizenship or legal residency status;[1]
- Age of the applicant;
- Access to employer-sponsored insurance;
- Whether the applicant is a Native American; and
- The incarceration status of the applicant.

Based on information provided by the applicant, eligibility will be verified by accessing multiple federal agencies' databases, as well as through electronic matches with Delaware-specific data sources. Because verification will require coordination with multiple federal agencies, including HHS, the Social Security Administration, the Internal Revenue Service (IRS), the Immigration and Naturalization Service, and the Department of Homeland Security (DHS), the federal government is in the process of establishing a Data Services Hub that will coordinate verification of data across all federal agencies.

Delaware will be expected to utilize State data sources to verify information submitted by the applicant. This might include interacting with the Delaware Department of Labor (DOL), Department of Revenue, Department of Corrections, and Department of Health and Social Services (DHSS), as well as other data sources that may capture information that may be used to determine eligibility.

Recipients of both Medicaid and CHIP are required to report changes that can have an effect on eligibility. Medicaid eligibility is reassessed at the time changes are reported, and coverage changes are made as appropriate. The DHCP program, however, allows for 12 months of continuous eligibility. This means that once an applicant has been determined eligible, their coverage is effective for 12 months, regardless of any change in circumstances (e.g., income, family status, offer of employer-sponsored insurance).

Similar to Medicaid, eligibility for premium subsidies and the amount of the subsidy for coverage available through the Exchange will not be set for a continuous 12-month period. Rather, as an individual's or family's circumstances change during the year, their eligibility for Exchange subsidies, and the subsidy amount, needs to be re-evaluated and adjusted to reflect the changed circumstances.

This difference in eligibility rules between Medicaid, DHCP and the Exchange has important ramifications, for both the State and for Delawareans who will be receiving subsidized coverage through the Exchange.

The Exchange needs to establish a process that allows for adjustments to eligibility during the year to account for mid-year changes in status. Given that an individual who is eligible for Medicaid is not eligible for premium subsidies through the Exchange, it will be necessary for the State to capture these

[1] Under current law, legal residents who have resided in the United States for less than five years are not eligible for Medicaid. However, these legal residents will be eligible for subsidized coverage through the Exchange.

mid-year changes in eligibility to assure the State is enrolling Delawareans in the appropriate health coverage program.

For people receiving premium subsidies through the Exchange, updating their eligibility status will have important financial ramifications. If the premium subsidy provided to the enrollee exceeds the amount for which he or she is eligible, the enrollee will be responsible for re-paying the federal government for the excess amount. The potential premium subsidy reimbursement is $600 for an individual and $3,500 for a family.

3.1.2 Options for Delaware

Delaware has already established a single application form that is used to determine eligibility for Medicaid and DHCP (which are both administered by Division of Social Services – or DSS). The application can be completed online through the ASSIST portal, manually on paper and mailed to DSS, filled out and dropped off at any of the 19 State Service Centers located across the State, or completed electronically in the State Service Centers with the assistance of an eligibility field worker.

Although there is a single application and eligibility determination process, there are instances in which some families have one or more children covered by Medicaid while other children in the household are covered by DHCP. Medicaid eligibility differs based on the age of the child. Infants up to age 1 are eligible for Medicaid if their family income is no greater than 185% of FPL. Between 185%-200% of FPL, infants are eligible as part of the DHCP expansion. Children up to age 5 are eligible for Medicaid if family income is no greater than 133 percent of the federal poverty level (FPL), while children ages 6 to 19 are eligible for Medicaid if family income is no greater than 100 percent FPL. DHCP covers children who are not otherwise eligible for Medicaid with income up to 200 percent FPL.

The Exchange will provide premium subsidies to individuals and families with income up to 400 percent FPL. The amount of the premium for which an individual or family will be responsible is based on the applicant's FPL percentage and income. The tables below show the monthly premiums for various incomes and two family sizes, individual and family of four, based on the 2011 FPL standards.

Table 3-1. Exchange Premiums for Individual Coverage (household size = single)

Percent of FPL	Annual income ($)	Premium as percent of income	Member's share of monthly premium ($)
133	14,484	3.0	36
150	16,335	4.0	54
200	21,780	6.3	114
250	27,225	8.05	183
300	32,760	9.5	259
350	38,115	9.5	302
400	43,560	9.5	345

Table 3-2. Exchange Premiums For Family Coverage (household size = four)

Percent of FPL level	Annual income ($)	Premium as percent of income	Member's share of monthly premium ($)
100	29,726	3.0	74
150	33,525	4.0	112
200	44,700	6.3	235
250	55,875	8.05	375
300	67,050	9.5	530
350	78,225	9.5	619
400	89,400	9.5	708

The ACA requires all state Medicaid programs to expand eligibility to include all non-elderly, non-pregnant individuals with income at or below 133 percent FPL who were previously ineligible for Medicaid. With an additional 5 percent income disregard, the FPL eligibility threshold will be effectively expanded to include individuals and families with modified adjusted gross income at or below 138 percent FPL. This expansion with MAGI up to 138 percent FPL will essentially eliminate "split families" in which some children are covered by Medicaid and other children are covered by DHCP. However, with Exchange-based subsidies available to families with income up to 400 percent FPL, there will be families with income between 138 percent and 200 percent FPL in which the parents may be covered through the Exchange and the children are covered by DHCP.

Because the State has already established a single application for all public assistance programs including Medicaid and DHCP, it only needs to modify a single application for the coverage expansions that will take effect in 2014, rather than consolidate multiple application forms. The State needs to evaluate whether it is feasible to expand existing State eligibility staff to support not only the expansion of Medicaid, but also the establishment of the Exchange.

Another consideration that they state will need to evaluate when assessing the additional staff required to support the expanded eligibility requirements under the MAGI rules is how to assist in the transition of recipients who experience a life event that would cause them to no longer be eligible for Medicaid and need to transition to federal subsidies through the Exchange. It is important through stakeholder outreach activities, that DHSS works actively with the MCO partners in the State, as they develop plans to offer inside of the Exchange, to encourage the commercial carriers to maintain the same provider networks inside and outside of the Exchange; as well as offering as private insurers, similar plans inside of the Exchange (including similar cost-sharing and benefit coverage). To the extent that this can be achieved, the State may better equip navigators to find the right product for recipients to ensure continuity of care.

The State is planning on reviewing the current eligibility rules for Medicaid and DHCP to determine the extent to which these rules differ and whether the rules should be adjusted so that they are consistent across all programs. Federal guidance on the eligibility determination methodology for the Medicaid expansion and subsidized coverage through the Exchange, which is scheduled to be released shortly, needs to be incorporated.

As the State works on modifying its eligibility systems to support the Exchange, the potential financial liability for consumers that receive excess premium subsidies will also need to be addressed. This may require the eligibility systems to include robust income data matching functionality, as well as a process for consumers to provide updated information during the plan year regarding income or household composition that could affect their eligibility for, and the amount of, premium subsidies through the Exchange.

The State needs to evaluate whether the changes required to support MAGI and meet the eligibility interface requirements to support the Exchange can be supported by the existing eligibility mainframe or if a replacement of the existing eligibility system is required. Either option needs to be considered within the context of the mid-2013 implementation date by which the eligibility system needs to be available in order to process applications by October 1, 2013 for coverage that will take effect starting on January 1, 2014.

Finally, the State should continue to monitor the work of other states and the "Early Innovator" grantee states as they develop or modify eligibility systems for use by the Exchanges.[2] As the State is aware, the Early Innovator states received funding from the federal government to support the development of "cost-effective consumer-based technologies and models for insurance eligibility and enrollment for

[2] Seven states or consortia of states—Kansas, Maryland, Massachusetts, New York, Oklahoma, Oregon, and Wisconsin—were awarded approximately $241 million in total through the Early Innovator grant program. Since the announcement in February 2011, Oklahoma and Kansas have opted out of the program and returned the grant.

Exchanges."[3] The intent is for these states to develop IT models that can be adopted and tailored for use by other states.

3.2 Adjudication of Appeals Pertaining to Eligibility Determination

For Individuals and families who are determined ineligible for premium subsidies or who disagree with the level of subsidy for which they have been determined eligible, the Exchange needs to establish a process to handle complaints and appeals. The manner by which Delaware chooses to determine eligibility for the Exchange will likely influence the decision as to how best to handle complaints and appeals pertaining to eligibility.

Currently, the Medicaid program and the DHCP program utilize separate in-house staff to handle eligibility appeals. For both programs, information on appeal rights is included in the notice of determination that is sent to an applicant who is denied enrollment. If the applicant disagrees with the decision, the case is initially reviewed by a case worker. If resolution is not achieved, the case is forwarded to a supervisor for his/her review. The supervisor meets with the applicant, and if this meeting does not resolve the issue, the applicant can request a fair hearing before an administrative law judge. In Delaware, most of the appeals volume for the Medicaid program involves eligibility for long-term care, which will not be affected by the Exchange.

3.2.1 Options for Delaware

The manner by which appeals of eligibility are handled may depend on the process and the entity that determines eligibility for the Exchange. If Delaware's Exchange leverages the Medicaid program's eligibility system and staff, it may be cost-effective and administratively efficient to have Medicaid staff handle appeals of eligibility. As the State looks to establish a no wrong door approach with regard to eligibility for all medical assistance programs, instituting a centralized eligibility appeals process may also be worth pursuing. In addition, given the reality that some individuals will move between the Exchange and the Medicaid program over the course of a year as their circumstances change, the activities of these programs need to be closely coordinated.

The Exchange could set up its own appeals process, with Exchange staff accessing the eligibility system to review information submitted by the applicant and the federal and State data sources used to determine eligibility. Regardless of the approach taken, the Exchange needs to adopt an appeals process, either independently or through an existing appeals process.

3.3 Determining Eligibility for Exemptions from the Individual Mandate

An individual may be exempt from the individual mandate to obtain and maintain health coverage due to coverage being unaffordable, the individual's religious beliefs or personal hardship. The Exchange will be responsible for certifying exemptions and verifying information submitted by an applicant and

[3] US Department of Health and Human Services, Office of Consumer Information and Insurance Oversight, *Cooperative Agreements to Support Innovative Exchange Information Technology Systems*, October 29, 2010.

information obtained from federal and State data sources. The Exchange will also need to report information to the IRS for those individuals who receive an exemption from the mandate.

If an individual's household income is less than the filing threshold for federal income taxes or if the required contribution for health coverage exceeds eight percent (8 percent) of household income for the calendar year, coverage is considered unaffordable and the individual will not be subject to a tax penalty.

Individuals may also file for an exemption based on religious beliefs or a hardship exemption if circumstances affect their ability to obtain and/or maintain coverage. Determination of eligibility for these exemptions will require coordination with, at minimum, the IRS and HHS.

3.3.1 Options for Delaware

The Exchange needs to establish a process to certify exemptions from the individual mandate in compliance with guidance to be issued by the federal government. The adjudication of these requests for exemption will likely require the development of both web-based and paper-based applications that allow individuals to submit information necessary to determine whether the applicant qualifies for an exemption.

3.4 Determining Eligibility of Businesses and Employees

The ACA limits the size of businesses (i.e., number of employees) that may purchase coverage through the Small Business Health Options Program (SHOP) Exchange to firms with 50 or fewer fulltime employees, but also provides the State with the option to expand the small group market to firms with up to 100 employees in 2014. The federal health care reform law requires an expansion of the small group market to businesses with up to 100 employees by January 1, 2016 and allows the Exchange to offer coverage to larger groups (i.e., firms with more than 100 employees) in 2017 and beyond. Delaware is in the process of evaluating whether it will expand the market from its current limit of 50 employees to 100 employees before it is required to do so in 2016.

In addition to the upper limits on the size of firms that may purchase coverage through the Exchange, the State may expand the definition of small groups to include sole proprietors or self-employed individuals. Currently, Delaware regulations are consistent with this definition. The definition of employer, under Section 1304 of the ACA, includes the following:

> (b) EMPLOYERS.—In this title:
>
> (1) LARGE EMPLOYER.—The term ''large employer'' means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 101 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.

> (2) SMALL EMPLOYER.—The term ‘‘small employer’’ means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 1 but not more than 100 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year.
>
> (3) STATE OPTION TO TREAT 50 EMPLOYEES AS SMALL.—In the case of plan years beginning before January 1, 2016, a State may elect to apply this subsection by substituting ‘‘51 employees’’ for ‘‘101 employees’’ in paragraph (1) and by substituting ‘‘50 employees’’ for ‘‘100 employees’’ in paragraph (2).

Regardless of the size of firms that are allowed to purchase coverage, the Delaware Exchange needs to establish a process to verify, at a minimum, the following information:

1. The company is, in fact, a legitimate business;
2. The employer meets Delaware's definition of small group; and,
3. Employees qualify for employer-sponsored insurance.

Information obtained from the employer needs to include, at a minimum, the employer's name and address, the employer's federal identification number, a roster of employees, and, possibly, payroll records or other documentation to verify that the employees meet the minimum requirements for participation in the employer's health insurance offering (e.g., each eligible employee works, on average, at least 30 hours per work).

The Delaware Exchange may also need to verify that the employer meets the current participation requirements of 100 percent for groups with three or fewer employees and 75 percent for groups with more than three employees. That is, for the smallest groups (i.e., three or fewer employees), all of the employees must participate in the purchase of employer-sponsored insurance or have a valid waiver (e.g., covered through a spouse's policy, Medicare, Medicaid); and for groups with more than three employees, at least 75 percent of eligible employees must take-up the offer of employer-sponsored insurance or have a valid waiver.

Carriers may also have contribution requirements, which require an employer to contribute a minimum dollar amount or percentage toward the employees' purchase of insurance. Minimum employer contributions of 50 percent of the monthly premium for individual coverage are currently required by some health insurers in the Delaware marketplace.

3.4.1 Options for Delaware

Employer and employee verifications are currently conducted in the market, either directly by health insurers or by brokers that handle this for other health insurers in the small group market. The Delaware Exchange needs to document the manner by which the health insurers verify that the employer qualifies to purchase coverage in the small group market, that the employees are eligible for coverage and that the employer meets applicable participation and contribution requirements.

To allow an employer to complete one application and meet one set of eligibility standards, the Delaware Exchange needs to develop a standard eligibility process that applies to all health carriers participating on the Exchange. In developing this application process for small employers, the Exchange should consult with the carriers operating in the market to determine the extent to which their processes are comparable and how they may differ.

If the Exchange were to allow each carrier to use its own application form and verification process for employers and employees purchasing through the SHOP Exchange, certain employers could be determined eligible to purchase coverage from a sub-set of health carriers through the Exchange, but not from all of the SHOP Exchange's health carriers. Employers might also need to submit different types of information to satisfy the verification processes used by the Exchange's health carriers. The recently released NPRM indicates that CMS will require Exchanges to use a standard method for verifying employer and employee eligibility across all carriers participating in the Exchanges.

The Exchange also needs to determine how it will administer the eligibility verification process, including whether Exchange staff will handle eligibility verifications in-house, the extent to which agents and brokers will be responsible for conducting these verifications, and the role of the health insurers in the verifications. The Delaware Division of Revenue may also be leveraged as part of the process of eligibility verification as they currently require businesses to provide the number of employees and payroll information in order to receive a business license.

With regard to participation and contribution requirements that may apply to coverage purchased through the SHOP Exchange, Delaware will likely need to apply a consistent standard across all health insurers. As with the employer and employee verification process, setting a uniform standard across all carriers operating in the Delaware Exchange will allow employers to meet one standard and complete one application.

These rules and procedures need to be developed in close consultation with the carriers participating in the Exchange. In addition to establishing consistency across carriers operating within the Delaware Exchange, consideration should be given to the manner by which these various standards apply to group coverage purchased outside the Exchange.

A few key questions to consider:

- How are employer and employee verification currently conducted in Delaware's small group market?
- Do the major health carriers collect similar information and use a common set of procedures to verify employers and employees?
- Can the Exchange leverage existing processes and develop a standard application form?
- Who will be responsible for carrying out these verifications?
- What role, if any, will brokers and agents play?
- Are there existing federal and/or State data sources that can be leveraged to enable online verification of employers and/or employees?

3.5 Assistance to Small Employers for Premium Assistance Tax Credits

To qualify for a small business tax credit in 2014, businesses with fewer than 25 employees who pay an average annual wage of less than $50,000 must contribute at least 50 percent of the premium for employee-only coverage purchased through the Exchange. The tax credits will be available to each eligible small business for up to two years. While the Exchange will not determine eligibility for the small business tax credit, it needs to coordinate with the IRS to verify employer eligibility for these tax credits and report enrollment information to the federal government.

Information on the availability of the employer premium assistance tax credits need to be posted on the Exchange website and otherwise made available (e.g., pamphlets and brochures) to employers and other interested parties. Call center staff, navigators, and brokers and agents need to be able to respond to inquiries regarding the tax credits or direct inquiries to individuals and entities that can respond.

3.5.1 Options for Delaware

At a minimum, the Exchange needs to make available information on the employer premium assistance tax credit program and support Delaware businesses in applying for those credits. This may include information, and possibly an electronic application, available to businesses via the Exchange website, as well as hard copy information and application materials. The Exchange will likely need to provide information to the IRS on those employers that are participating in the premium subsidy tax credit program.

Because these tax credits are limited to eligible employers that purchase coverage through the Exchange and are not available to employers that do not use the SHOP Exchange in 2014 and beyond, Delaware could use this exclusive arrangement to attract small employers to the Exchange. The Exchange could promote the availability of tax credits for small employers as part of a broader marketing campaign and could provide more focused outreach and assistance to employers who may be eligible for these tax credits.

Guidance from the federal government on the specific requirements of the Exchange with regard to the employer tax credit should be forthcoming. After reviewing this guidance, Delaware's Exchange needs to determine how it can best implement this program and support Delaware businesses that may be eligible for the tax credit.

4 Enrollment and Disenrollment

The Exchange needs to facilitate health plan selection for an individual or family who is eligible to enroll in a QHP, as well as for employees of employers who choose to purchase coverage through the SHOP Exchange. This facilitation will include:

- Providing a summary of benefits in a standardized manner about the QHPs available to allow for a comparison of health plans from the carriers participating in the Exchange;
- Generating plan choice information that can be customized based on the individual's eligibility and personal preferences;
- Calculating premiums and out-of-pocket limits for each QHP;
- Processing an individual's health plan choice and transferring enrollment data to the selected health carrier for the applicable QHP;
- Notifying CMS of the health plan selected by the enrollee to facilitate payments of the advanced premium tax credit and the applicable cost sharing reduction; and
- Facilitating payment of premiums.

This process will involve significant coordination and communication with the health carriers offering QHPs through the Exchange and the federal government for individuals eligible to receive premium subsidies and reduced cost sharing. The section below reviews the functionality and processes that the Delaware Exchange needs to establish to facilitate enrollment in QHPs for the individual market and the small group market (SHOP Exchange).

4.1 Information on Qualified Health Plans

The Exchange needs to provide information, via the web and hard copy, on the benefits covered under each of the QHPs so that potential enrollees can compare the health plans' benefits and services. At a minimum, the information should include a basic overview of the major services covered (e.g., physician office visits, inpatient care, outpatient surgery, prescription drugs, etc.) and the point-of-service cost sharing for each service; a link or source to obtain more detailed information (i.e., evidence of coverage); and other information on the health carriers, as required by the ACA.[4]

All QHPs offered through the Exchange must cover the "essential health benefits" required pursuant to Section 1302 (b) of the ACA. The health plans will be grouped into five coverage tiers or categories based on their actuarial value: Platinum (90 percent), Gold (80 percent), Silver (70 percent), Bronze (60 percent), and a Catastrophic or high deductible health plan (HDHP). The HDHP plans will only be available to individuals under the age of 30 or individuals who have a certification of exemption from the individual mandate, based on affordability.

[4] Section 1311 (e) (3) (A) of the ACA requires QHPs to submit to the Exchange, the federal Secretary of HHS, and the State Insurance Department the following information: claims payment policies and practices; periodic financial disclosures; enrollment and disenrollment data; number of claims denied; rating practices; cost-sharing and payments for out-of-network coverage; enrollee and participant rights; and other information "as determined necessary by the Secretary."

Structuring the market and grouping the health plans by their actuarial values – which is a summary measure of the percentage of allowed medical claims that are paid by the insurer – will allow consumers to evaluate comparable health plans offered by the health carriers participating in the Exchange. However, because actuarial value is not understood by most consumers and much health insurance vernacular is not well understood, the Exchange needs to develop tools and use terminology that is meaningful and understandable to the Exchange's customers.

4.1.1 Options for Delaware

The manner by which health plan information is provided to Exchange consumers should take into account the health insurance literacy of the people who will be purchasing coverage through the Exchange. As is true for most people across the country, most people in Delaware have never actually shopped for health insurance as an individual purchaser. Unlike other types of insurance (e.g., auto, homeowners, life), health insurance is not typically purchased by an individual.[5] In Delaware, insurance is either provided through State-federal programs, like the Delaware Medicaid and DHCP programs, or provided by an employer to their employees.

In developing the website and hard copy information that describes the QHPs' benefits, the Delaware Exchange could leverage the expertise and experience of health insurers, brokers and agents, and other entities and organizations that deal directly with consumers in the Delaware health insurance marketplace, particularly the individual market and small group market. There are also local and national consumer organizations with experience working with low and moderate income residents who may provide insight into effective means of communicating information to these groups of people.

Health insurers typically prepare a summary of benefits that provides an overview of the covered benefits and the cost sharing that applies to the major services. The Exchange needs to standardize this information across carriers to allow individuals and families to compare health plans in a uniform fashion. The Delaware Exchange also need to provide consumers with access to more detailed information on the QHPs, as well as access to information on the performance of the health carriers.

Additional information provided to potential enrollees might include a "provider look up" capability to enable an individual to enter his/her doctor's name or a hospital's name on the Exchange's website or to inquire through the Exchange's customer service unit and determine which of the health plans include the doctor or hospital in their respective provider network.

The Exchange needs to provide consumers with information on the health carriers offered through the Exchange. The specific types of information to be made public will be developed by HHS, but will include claims payment policies and practices, financial disclosures, enrollment and disenrollment, denied claims, rating practices, out-of-network coverage and cost sharing, and enrollee rights. The Delaware Exchange may choose to add to the federal disclosure requirements.

[5] Based on 2009 data from the US Census Bureau's Current Population Survey, released in August 2010, direct purchase of health insurance by Delawareans represented roughly 6 percent of all people under age 65 covered by private health insurance. Across the United States, the direct purchase of health insurance comprised roughly 8.5% percent of all privately insured individuals under age 65.

The ACA also requires the Exchange to rate QHPs offered in each benefit level (i.e., Platinum, Gold, Silver, Bronze, and Catastrophic) on the basis of quality and price. This information needs to be provided to potential enrollees and displayed on the Exchange website. Enrollee satisfaction survey results for plans with more than 500 enrollees in the previous year must also be posted on the Exchange's website and provided to consumers.

A key decision for the Delaware Exchange affecting the information provided to consumers and the assistance consumers may require to make informed decisions is the number of health plans offered and the extent to which health plans vary (e.g., point-of-service cost sharing, types of plans: HMO, PPO, Indemnity) within each benefit level. The ACA provides flexibility with regard to the plans offered and the cost sharing within the parameters of actuarial value set by the ACA and the inclusion of the essential health benefits.

On the one hand, dictating the specifics regarding the amounts and types of cost sharing for each service within each benefit level might help focus consumers' decision making on premiums, provider networks (i.e., hospitals and physicians), quality of service, and reputation of the carrier. On the other hand, an overly standardized approach may stifle creativity in the market and reduce a consumer's ability to trade off one type of cost sharing (e.g., an upfront deductible, lower cost sharing after the deductible) for other types of cost sharing (e.g., no upfront deductible, higher co-payments) within the same benefit level.

While standardizing benefits may be desirable from the perspective of helping consumers navigate what can be a confusing process, being overly prescriptive and micromanaging the health plan designs within the Exchange may result in products that are out of sync with the market and may stifle innovation. The extent to which benefits are standardized will be an important decision for the Delaware Exchange.

4.2 Generating Customizable Plan Choice Information

As noted above, it is projected that the vast majority of Delawareans seeking coverage through the Exchange will be purchasing health insurance for the first time. To help people make informed decisions, the Exchange needs to provide these consumers with actionable information and decision support tools that enable them to customize their shopping experience and narrow their search to QHPs that best meet their needs. Identifying the criteria that is most important to individuals and families and establishing a means by which consumers can narrow their choices to QHPs that best meet their needs, much like consumers today narrow their choices for various products, will be a key to the Exchange's success.

At a minimum, the Exchange needs to provide consumers with a means by which they can sort QHPs by premiums and out-of-pocket costs (see cost calculator discussion below). With QHPs available in five different levels or tiers (i.e., platinum, gold, silver, bronze and catastrophic), there will likely be a wide range of benefit designs. Consumers may want to sort their choices by deductible level, cost sharing for physician office visits, cost sharing for inpatient admissions, the quality rating of the health plan, or any number of variables that consumers may find useful.

The recent NPRM includes a requirement that insurers participating on the Exchanges provide and regularly update a database that includes providers in their network. Delaware's Exchange may want to use these files to help consumers customize their search for those health plans that include their physician

or nearby hospital. The ability to narrow searches will be particularly important if there are multiple carries offering a large number of QHPs on Delaware's Exchange.

4.2.1 Options for Delaware

A number of private sector vendors have developed health plan selection and consumer decision support tools that the State might review to determine whether they can provide the Delaware Exchange with a means by which consumers may be provided customizable plan choice information. The Exchange might consider issuing a request for information (RFI) or otherwise establishing a process that would allow Delaware's Exchange to evaluate the capabilities of the various vendors in the marketplace.

In addition, the federal government is in the process of soliciting private sector vendors to assist the Center for Consumer Information and Insurance Oversight (CCIIO) with the development of tools that support plan choice by consumers purchasing coverage through the federally-facilitated Exchanges. The State should also monitor the activities of other states, including Early Innovator states that have been provided federal grants to develop prototypes and the IT infrastructure needed to operate Exchanges.

4.3 Calculating Premiums and Out-of-Pocket Limits

Each Exchange needs to supply consumers with a cost calculator that provides an estimate of the total cost of coverage, including premiums and point-of-service cost-sharing, taking into account both the advanced premium tax credits as well as any cost sharing reduction that may apply to the applicant. At a basic level, the cost calculator would enable an individual to compare health plans based on annual premiums and maximum out-of-pocket expenses, which will vary based on the applicant's income and FPL.

A more advanced cost calculator might allow an applicant to enter member-specific information on expected health care utilization (e.g., office visits, prescription drugs, outpatient care, inpatient admissions, etc.), which can then be used to generate potential member costs for the various health plans offered through the Exchange. This would require linking benefit designs (i.e., deductibles, co-pays, co-insurance) for the various health plans offered through the Exchange to a tool that is capable of generating member-specific cost estimates.

4.3.1 Options for Delaware

As with consumer decision support tools (discussed in the preceding section), there are a number of private sector vendors that have developed cost calculators. The State may choose to evaluate to these vendors to determine whether they can provide the Delaware Exchange with a means by which consumers may be provided customizable plan choice information. The Exchange might consider issuing a RFI or otherwise establishing a process that would allow Delaware to evaluate the capabilities of the various vendors in the marketplace.

The federal government is also soliciting private sector vendors to provide CCIIO with a cost calculator that consumers may use to estimate their total cost of coverage. It is important for Delaware to monitor the activities of other states, including Early Innovator states, to identify vendors that these states and CCIIO may use to provide this capability.

4.4 Processing an Individual's Health Plan Choice

Having provided the consumer with information on the QHPs available through the Exchange; and the decision support tools to help them narrow their health plan choice; the Exchange needs to process an individual's health plan choice. Delaware's Exchange needs to notify the issuer of the QHP selected by the individual, notify CMS to facilitate payments of advance premium tax credits and cost sharing reductions, if applicable, and process the issuer's response to the Exchange enrollment transaction.

4.4.1 Options for Delaware

The State has a number of options with regard to the manner by which it processes enrollment. The availability of private sector enrollment systems that are already in place across the country provides Delaware with a range of choices. Delaware's Exchange will want to establish a process to evaluate the capabilities of the various systems that are currently in the market, as well as enrollment systems being developed by CCIIO and other states' Exchanges. Criteria in the evaluation of enrollment systems will be greatly influenced by the extent to which the Delaware Exchange chooses to be involved in premium billing. Delaware could choose to use a third-party administrator to coordinate premium billing and aggregate premiums from multiple payers (e.g., individuals, employers, employees, federal government).

The Exchange might also consider making available a health risk assessment (HRA) tool to allow an individual to provide a limited amount of personal health information that might then be shared with the carrier selected by the applicant to enable the carrier to determine whether the new enrollee might benefit from care management or disease management programs. Given that many of the people enrolling through the Delaware Exchange will be new to the insurers and likely to be newly insured, putting in place an HRA may be an added value that the Exchange can bring to the market.

4.5 Facilitating Payments of the Premium and the Application of the Advanced Premium Tax Credit

The ACA and the recently released NPRM establish the following requirements relating to billing, collecting and aggregating premiums, which could vary between the individual and small group markets.

With regard to the individual market, the Exchange has three options as it relates to its role in premium payment administration:

1. No active role in premium processing;
2. Facilitate the payment of premiums by enrollees by creating an electronic pass through without directly retaining any payments; or
3. Establish a payment option whereby the Exchange collects premiums from multiple sources and submits a reconciled aggregated sum to the QHP issuers.

Regardless of the options elected, the Exchange needs to establish a process for consumers who wish to pay premiums directly to the health insurer.

For the SHOP Exchange, the requirements include:

- Accepting payment of an aggregated premium by an employer;

- Facilitating through electronic means the collection of premium payments, which could include the Exchange acting as a simple pass-through or the Exchange collecting and distributing premiums to the QHP issuers; and
- Developing a single monthly bill for all QHPs in which an employer's employees are enrolled and processing a single monthly payment from the employer.

The employee choice model offered by Delaware's SHOP Exchange, and the extent to which an employer's employees are allowed to select from among the QHPs and health insurers offered through the Exchange (discussed further below), will affect the capabilities of the premium payment process that the Exchange needs to establish. With the NPRM requiring all SHOP Exchanges to offer employers the option of allowing their employees to select from at least a sub-set of QHPs and health carriers, the Delaware Exchange needs to establish a means by which an employer will receive a single bill that covers all health plans selected by its employees.

4.5.1 Options for Delaware

As noted above, there are a number of vendors in the market touting enrollment and premium billing solutions that the Delaware Exchange will want to evaluate to determine which provides the most robust and cost-effective means by which the Exchange can facilitate health plan premium billing and collection. Delaware should be able to leverage work already completed or underway in other states for their Exchange IT solutions with regard to enrollment systems and premium billing and collection processes, as well as systems being procured by the federal government.

4.6 Plan Choice for Employers and Employees in the SHOP Exchange

The manner by which employers, and ultimately employees, may purchase coverage will be one of the more important policy decisions for the Delaware Exchange, and will likely determine the ultimate success of the SHOP Exchange. Key policy decisions include participation requirements, contribution requirements, and the number and types of health plans from which employees may choose. Each is discussed briefly below.

4.6.1 Participation Requirements

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 three or fewer employees is typically required to enroll all of his/her employees in the group's health plan, unless an employee is covered under another plan (e.g., spousal coverage, coverage as a dependent under a parent's health plan, Medicaid, Medicare). For groups of four 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.

4.6.2 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 offering coverage to a group.

Employers unable or unwilling to contribute at least 50 percent of the premium are not offered group insurance by the carrier.

The participation and contribution requirements protect against adverse selection and the risk of bad debt. Adverse selection describes 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; while younger and healthier individuals may choose to go without coverage or opt for a more limited health policy.

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 Delaware Exchange will be whether the participation and contribution requirements that apply to employers purchasing coverage outside of the Exchange will apply to employers purchasing coverage through the Exchange. In addition to whether the Exchange will establish participation and contribution requirements, the Exchange needs to determine the manner by which these requirements will be calculated.

In today's health insurance marketplace, health insurers do not allow small employers to offer their employees a choice of health insurers. This means that the participation and contribution requirements apply to a single carrier. Under an employee choice model that may be available through the Exchange (discussed further below) the employer may offer employees a number of health plans from a range of health carriers.

The Exchange could require an employer to meet participation and/or contribution requirements, and a minimum percentage of employees would need to purchase coverage as part of the group through the Exchange. However, if these employees are allowed to choose coverage from multiple health insurers, the employer may not meet the participation requirements for each (or any) of the health insurers if employees opt for coverage from multiple health insurers.

4.6.3 Options for Delaware

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 could be developed, listed below are four options that Delaware may consider. These models are not necessarily mutually exclusive, in that the Exchange may choose to allow employers to select from two or more purchasing options.

4.7 Employer Purchasing Models

4.7.1 One Carrier, One Plan

The one carrier, one plan model reflects the traditional way that employers, particularly small employers, purchase insurance. The employer selects a carrier and a health plan, and his/her employees are allowed

to enroll in the plan. The Exchange platform could be used by the employer (aided, perhaps, by an agent/broker) to compare health plans, assess premium contribution options, and select a carrier and health plan for his/her employees.

Table 4-1. 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 could be set for the entire group.

4.7.2 One Carrier, Multiple Plans

Under the one carrier, multiple plan purchasing model, the employer would select a health carrier and allow his/her 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.

Table 4-2. 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 percent 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, the employer's premium contribution is pegged at 70 percent of the cost of the Silver plan.

The employee could opt for the Silver plan, or 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 reduce the employee's monthly premium. The employer's share of the cost is fixed, while the employee's amount varies depending on the plan the employee selects. The table below shows how this defined contribution option might be structured for an individual employee.

Table 4-3. Employee Contributions under Single Carrier Model ($)

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 and the same rates apply to all individuals and families that enroll in coverage. Under list bill rating, premiums are set for each individual and family that enrolls in coverage.

Take, for example, an employer with two employees, a 60-year-old and a 20-year-old. Under composite rating, the insurer quotes a premium for single coverage that applies to both employees (e.g., $400 per month per employee or $800 in total). Using a list bill method, the premium charged might still total $800 for both employees, but the amount charged the older employee would be higher than the amount charged the younger employee (e.g., $200 for the 20-year-old and $600 for the 60-year-old). If employees are able to select from among a number of different plans through the Exchange, premiums need to reflect the enrollment choices of individual employees.

4.7.3 All Carriers, One Plan Level

Under the all carriers, one plan level purchasing model, the employer would select a plan level (i.e., Platinum, Gold, Silver, or Bronze) and allow his/her employees to select from any of the health carriers offering QHPs in that level. The table below illustrates how this might be structured.

Table 4-4. 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

The employer selects the Silver Level plan and the employees may choose from any of the health carriers that offer a Silver Level plan through the Exchange. The employer could set its premium contribution as a percentage of the cost of a specific plan (e.g., 70 percent of the cost of Carrier B's Silver plan). If the employee selects Carrier B's Silver plan, the employee would pay 30 percent 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 amount will vary depending on which carrier the employee selects. The table below shows how this might work for an individual employee.

Table 4-5. Employee Contributions under Plan Level Model ($)

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 described above.

4.7.4 All Carriers, All Plans

Under the all carriers, all plans 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 percent of any plan's premium), could be set based on the premium of a particular plan offered by a specific carrier (e.g., 70 percent of the Silver Level Plan offered by Carrier B), or the employer could provide employees with a flat dollar

amount and allow them to use the employer's contribution to purchase any health plan offered through the Exchange. The table below illustrates how this might be structured.

Table 4-6. 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 offered through the Exchange, premiums would 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. The Exchange needs to evaluate the advantages and disadvantages of each purchasing option, and determine which model will work best for Delaware's employers, employees, residents, and insurers.

4.8 Premium Billing, Collection and Remittance

The need for the SHOP Exchange to administer premium billing, collection, and remittance 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, an employer purchasing coverage through the Exchange would likely need to pay multiple health carriers for the different health plans selected by the 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 within the Exchange, the employer would need to deal with various 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 by the health carrier or through a broker.

In light of those administrative challenges, the Exchange will likely be the most 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, Consolidated Omnibus Budget Reconciliation Act (COBRA) notification, etc. In addition, the Exchange may be responsible for administering the premium tax credits program for eligible small employers that employ low wage workers. This responsibility might also be better coordinated through a centralized process established by the Exchange.

5 Information and Outreach

5.1 Customer Service and Call Center

As part of its plan to provide assistance to individuals and small businesses, Delaware's Exchange must operate a toll-free number to respond to requests for assistance from consumers. The call center must be able to respond to the specific needs of the individual, employers, and employees, such as inquiries related to eligibility, plan selection, premiums, tax credits, appeal status, and availability of providers in the different health plans offered through the Exchange, as well as enable callers to access the services of navigators and brokers. The call center needs to be operational no later than October 1, 2013 to support customers during the initial open enrollment. However, Delaware may want to launch the call center earlier in the third quarter of 2013 to answer preliminary questions regarding the enrollment process, the website, and consumer information requirements.

In addition to the call center, the Delaware Exchange may also want to establish an online help center that would allow individuals, employers, and employees to ask questions and receive answers in real time through the Exchange website. The online help center could also provide guidance for navigators and brokers when they have questions on behalf of the consumers they serve or need further clarification on product offerings or Exchange operations.

5.1.1 Options for Delaware

The State has a few options to consider for establishing the Exchange call center. A review of existing public resources, it was noted that the Delaware Division of Social Services (DSS) operates two separate call centers that provide information and assistance to clients and the public. The DSS Change Report Center is focused on processing changes to a client's case information and only receives calls of this nature, and would most likely not be expandable to meet the needs of the Exchange. The Customer Support Call Center provides front-line client support and information and assists with some case management functions. Delaware does not have a centralized customer support process and, outside of the information available on the State's website and the Delaware Application for Social Services and Internet Screening Tool (ASSIST) portal, does not operate an online help center.

Other options include collaborating with neighboring states or innovator states to share call center resources. This may reduce costs by sharing resources and gaining operational efficiencies. There are also several private exchange solutions that include both technical infrastructure and operational services as a complete solution package.

6 Exchange Website

Delaware's Exchange needs to establish and maintain a website through which applicants and enrollees may obtain standardized comparative information on QHPs, apply for coverage, and complete enrollment online. The website needs to post required transparency information. In addition, the Exchange website must provide access to an electronic calculator that allows individuals to view an estimated cost of their coverage once tax credits have been applied to their premiums, and the impact of cost-sharing reductions, if applicable.

The website must be easily navigable and conform to Americans with Disabilities Act standards for accessibility. In addition to the general features described above, the website must also:

- Enable navigators and brokers to assist individuals and employers in completing enrollment and renewals;
- Enable identity verification;
- Allow carriers to manage benefits, submit products for certification, and receive enrollment and network selection data and premium payments;
- Allow employers to set up accounts, select plans by tiers, carriers, or products, apply contribution arrangements, and pay premiums; and,
- Track employer tax credits.

The web portal will serve as a central point of access for individuals and employers to obtain information on commercial health insurance available through the Exchange, compare health plans, enroll in coverage, make premium payments, and update their account during the year. In addition, the website needs to make it possible for individuals to apply for an exemption from the individual mandate. The site needs to include, at a minimum, the following functionality:

- Streamlined process for individuals and families to apply for subsidized health coverage, including Medicaid, DHCP, and premium subsidies available through the Exchange;
- Seamlessly link visitors to the eligibility engine, allow individuals and families to enter information online, and determine their eligibility for all health coverage programs;
- Direct individuals determined eligible for Medicaid or DHCP to DMMA to complete the enrollment process; and
- Have individuals found eligible for coverage through the Exchange – whether or not they are eligible for premium subsidies and reduced cost sharing – continue on Delaware's Exchange website to evaluate their health plan options and continue with the enrollment process.

The eligibility engine will determine whether an individual or family is eligible for coverage through the Exchange, and whether the individual or family qualifies for premium subsidies and reduced cost sharing. The eligibility engine will do this by processing the following information:

- Name, address, and date of birth of each individual who is to be covered by the plan (i.e., if the individual is applying for family coverage, data on each member to be covered by the plan must be entered into the system);
- Social security number and information on the enrollee's immigration status;
- Modified adjusted gross income;
- Family size; and,
- Availability of employer-sponsored insurance, including:
    - Name, address, and employer identification number (if available) of the employer; and
    - Whether the applicant is a fulltime employee and is offered minimum essential coverage.

If the employer offers minimum essential coverage, the lowest cost health plan offered by the employer and the enrollee's share of the premium for the applicable rate basis type (i.e., single, single plus one, family) needs to be provided to determine whether the employee's share of the premium is "affordable."[6]

For legal residents who are not offered employer-sponsored insurance, with income between 138 percent and 400 percent FPL, the Exchange website (or rather the business process that runs behind the Exchange website) needs to be able to receive data from the eligibility engine to then calculate the premium subsidies and reduced cost sharing for which an individual or family may be eligible. The Exchange needs to be able to generate rates (or otherwise obtain rates from the carriers in real time) for all health plans, apply the appropriate premium subsidy and cost sharing reduction, and display that information for the eligible individual/family.

In addition to generating premiums and cost sharing reductions, the Exchange website needs to display benefit summaries to allow a consumer to compare health plans. This will likely include both a summary plan description that captures the major benefits and applicable cost sharing, as well as a link to more detailed information for each health plan offered through the Exchange.

The website needs to provide a cost calculator that provides an estimate of the total cost of coverage, including premiums and point-of-service cost-sharing (discussed above). Additional website functionality might include the provider look-up tool, as well as an HRA tool to allow an individual to enter a limited amount of personal health information that might then be shared with the health carrier selected by the applicant to enable the health carrier to determine whether the new enrollee might benefit from care management programs.

The website needs to display comparative information on the health carriers and health plans offered through the Exchange. The specific types of information to be made public will be developed by HHS, but will include claims payment policies and practices, financial disclosures, enrollment and disenrollment, claims denied, rating practices, out-of-network coverage and cost sharing, and enrollee rights. The Delaware Exchange may choose to add to the federal disclosure requirements.

[6] Employer-sponsored insurance is considered affordable if the employee's share of the premium is no more than 9.5 percent of the applicant's MAGI, and the health plan has an actuarial value of at least 60 percent.

The ACA requires the Exchange to rate QHPs offered in each benefit level (i.e., Platinum, Gold, Silver, Bronze, and Catastrophic) on the basis of quality and price. This information needs to be provided to potential enrollees and displayed on the Exchange website. Enrollee satisfaction survey results, for plans with more than 500 enrollees in the previous year, must also be posted on the Exchange's web site.

The Exchange website must also contain information, and most likely an online application, for people to apply for an exemption from the requirement to obtain and maintain health coverage (i.e., the individual mandate). People may be eligible for an exemption from the mandate based on affordability (i.e., the cost of coverage is more than 8.0 percent of their MAGI), religion, member of an Indian tribe, or personal hardship, based on criteria to be determined by the Secretary of HHS. A process to handle these applications, as well as an appeals process, must also be established by the Exchange (see the previous discussion for additional details on these Exchange responsibilities).

6.1.1 Options for Delaware

The ASSIST web portal and screening tool allows individuals to learn about potential benefits that might be available to them, supply information for screening about possible eligibility for many public programs, and complete an application for further processing. The ASSIST is currently being enhanced to re-platform its technology infrastructure and include additional programs for screening. While the ASSIST performs some elements needed of an Exchange, it would need additional enhancements to satisfy all required functionality, including a provider directory, quality ratings, and detailed financial information. The impact of those enhancements in terms of time and resources is unknown at this time.

As mentioned in the Enrollment and Disenrollment section, there are a number of private sector vendors that have developed private exchange solutions, including a fully functioning web portal that the State may choose to evaluate to determine whether they can provide the Delaware Exchange with a full service web portal that can meet the federal requirements. The Exchange might consider issuing a RFI or otherwise establishing a process that would allow Delaware to evaluate the capabilities of the various vendors in the marketplace. Other options, as with other components of the Exchange, include leveraging solutions from Early Innovator states and/or waiting to leverage the federal Exchange solution.

7 Exchange Financing

7.1 Financial Management and Risk Management

The Exchange will act as a conduit for premium payment transactions, including payment processing and tracking, application of premium tax credits, and management of premium aggregation from multiple sources (e.g. employer, individual, spouse's employer). In addition, the Exchange will be responsible for tracking delinquent payments, administering the tax credits and cost-sharing reductions that were determined previously, and facilitating the exchange of data among various State and federal systems. Many of the financial functions required of the Exchange will directly depend on financial determinations calculated as part of the eligibility process.

The ACA requires the development of a number of financial and risk management capabilities and functions, including:

- Risk management;
- Premium payment administration; and
- Financial sustainability.

The risk management requirements are intended to develop solutions to smooth out or spread risk. The primary processes may include: administration of a reinsurance program; the receipt, processing, and payment of high risk claims that reach the assigned attachment point; and the measurement, reporting, and analytics of financial performance across the commercial markets, for health plans sold inside and outside the Exchange.

Delaware insurers are currently allowed to set premiums in the individual and small group markets based, in part, on the health status of applicants or small employer groups; are allowed to raise premiums if individuals or small group members become ill; and are not required to accept all applicants for coverage in the individual market (i.e., no guaranteed issue requirement).

Under the federal health care reform law, medical underwriting will no longer be allowed in the individual and small group markets. In 2014, health insurance policies in these markets will be guaranteed issue using a modified community rating system to set premiums. Premiums will still vary, primarily based on the age of the applicant; however, the health status of individuals or groups will not be a factor in the development of premiums.

These changes in the rating rules will mean that individuals and small employers who are currently unable to purchase insurance or who are effectively priced out of the market due to health status or pre-existing condition may be able to purchase coverage. It will also mean that individuals and small employers who have coverage today may see their premiums adversely affected, due to the inclusion in the individual and small group market risk pools of people who had previously been denied coverage due to their medical conditions. For example, people covered in Delaware's federally-administered high risk pool (i.e., the Pre-existing Condition Insurance Plan) will be able to purchase coverage through the Exchange and will become part of the individual market risk pool.

The law recognizes that these changes to the individual and small group markets' rules may cause risk selection problems for some insurers. To mitigate the impact of these changes, the health care reform law includes three mechanisms to address risk selection and provide some financial protection for insurers:

1. Transitional reinsurance program for the individual market in each state;[7]
2. Risk corridors in the individual and small group markets;[8] and
3. Risk adjustment to transfer funds among health plans that offer coverage in the individual and small group markets based on the relative health status of their enrollees.[9]

These provisions of the health care reform law are designed to address the adverse risk selection problems that may result from the switch to a guaranteed issue, modified community rating system. Each is briefly described below. These risk mitigation provisions will not apply to "grandfathered" plans.[10]

7.1.1 Reinsurance

For the first three years of the Exchange (January 1, 2014 to December 31, 2016), the State is required to establish a reinsurance program for the individual market. A reinsurance entity will collect payments from insurers in all markets (i.e., the individual and group markets, as well as from third party administrators) and make reinsurance payments to the insurers in the individual market to cover the costs of high-risk individuals. The Secretary of HHS, in consultation with the National Association of Insurance Commissioners and the states, will develop guidelines and the methodology for the transitional reinsurance program. The Secretary of HHS will also provide the methodology used to determine how much insurers are to contribute to the reinsurance program.

Risk Corridors

The Secretary of HHS is required to establish a national risk corridors program for QHPs in the individual and small group markets that will be effective in 2014 through 2016. If a health plan's "allowable" (i.e.,

[7] Section 1341 of the ACA.

[8] Section 1341 of the ACA.

[9] Section 1341 of the ACA.

[10] Many provisions of the ACA apply to all health plans, both those in existence on March 23, 2010, when the ACA was signed into law, (or "grandfathered plans") and new health plans. However, some provisions apply only to new health plans, exempting existing plans from making changes. Grandfathered plans that people purchase on the individual market are exempt from provisions such as a ban on preexisting condition exclusions and bans against annual limits on coverage.

All grandfathered plans are exempt from certain requirements so long as employers do not significantly lower their premium contributions to employee plans and plans do not increase people's cost-sharing requirements beyond certain limits. Grandfathered plans do not have to comply with the following provisions:

- Offering an essential benefit package in the individual and small group markets in 2014;
- Eliminating cost-sharing for preventive services;
- Reporting on quality improvement activities; and
- Guaranteeing access to emergency, pediatric, and ob-gyn services.

Health plans can retain grandfathered status if the changes they make do not reduce the comprehensiveness of the plan.

non-administrative) costs in the individual and small group markets exceed 103 percent of total premiums (excluding administrative costs), the Secretary of HHS will make payments to the health plan to defray the excess costs. Conversely, if a plan's non-administrative costs are less than 97 percent of total premiums (excluding administrative costs); the health plan needs to pay a portion of the excess premiums to the Secretary of HHS. Recently released proposed rules for the risk corridors program suggests that this provision will apply only to QHPs sold through the Exchange.

7.1.2 Risk Adjustment

Finally, Delaware will be required to establish a risk-adjustment program for the individual and small group markets. The risk adjustment program will assess charges on health plans with enrollees of lower than average risk and make payments to health plans with enrollees of higher than average risk.

The premium payment administration requirements, which are discussed above, include processes relating to the billing, collecting, aggregating, transmitting, reporting, and reconciling insurance premium payments from multiple sources, including individuals, employees, employers, and the federal government.

7.2 Financial Sustainability Requirements

The financial sustainability requirements relate to the need for the Exchange to be financially self-sustaining by 2015. This will require Delaware to establish a means to support the operations of the Exchange once federal funds are no longer available (i.e., the end of the first year of operations).

The creation, development, and operation of the Delaware Exchange will require the preparation of a comprehensive financial management plan to ensure successful implementation. The Exchange will be responsible not only for managing federal grant funds, but also establishing a financial sustainability plan for 2015 and beyond. It is critical that the Exchange develop a financial management system that offers integrity and a thoughtful and detailed approach to maintain credible spending, revenue, and accounting streams.

As required by federal regulations, the Exchange is required to have adequate financial management systems and provide efficient and effective accountability and control of all property, funds, assets, and related grants and cooperative agreements. The development of a budget for the Exchange needs to include:

- Staff salaries and benefits;
- General administrative services;
- Consultants and professional support;
- Facility costs;
- Maintenance;
- IT and communication;
- Marketing and outreach;
- Eligibility, enrollment and premium billing services; and,

- Evaluation plan and enforcement of the individual mandate and appeals.

Some of these functions may be outsourced and others may be performed in-house. Federal guidance indicates that Medicaid eligibility determination systems will be eligible for an enhanced federal matching rate of 90 percent for system design and development and 75 percent for ongoing maintenance. A cost allocation methodology needs to be developed to determine the federal portion of the design and build costs and the State obligation for these costs. In a State Medicaid Director letter issued by on August 10, 2011, clarification was provided that if states choose to replace existing integrated eligibility systems with enhanced funding, cost allocation is not required for other public assistance programs that leverage the technology infrastructure developed to support Medicaid and the Exchange. Lastly, the Exchange needs to establish and execute financial controls and audit protocols to ensure the validity and appropriateness of all financial transactions occurring within the Exchange.

8 Certification, Recertification, and Decertification

The Exchange will offer health plans in five benefit levels: Platinum, Gold, Silver, Bronze, and Catastrophic. 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 (not including member cost sharing), expressed as a percentage of the total medical claims incurred for a standard population.

Platinum plans will cover 90 percent of the cost of care, which means a person enrolled in a Platinum level plan, on average, would pay ten percent of the cost of health care through co-payments, co-insurance and other types of cost sharing. The health plan's premiums would cover the rest of the cost of care.

Gold plans will cover 80 percent, Silver plans will cover 70 percent, and Bronze plans will cover 60 percent. Catastrophic plans, which are HDHPs, will also be available to individuals under 30 years of age and to people who are exempt from the insurance mandate due to affordability.[11]

The law requires participating insurers to offer at least one plan at the Gold and Silver levels. An important policy decision for Delaware will be whether the Exchange will require insurers that wish to participate to offer health plans in all of the other coverage tiers (i.e., Platinum, Bronze and Catastrophic).

Another key decision for Delaware's Exchange will be the extent to which benefits are standardized within each benefit level (e.g., the amount of cost sharing for different services, and the types of plans offered – HMO, PPO, Indemnity). The federal law and NPRM provide some flexibility with regard to the plans offered and the cost sharing, within the actuarial value parameters set by the law and the essential health benefits requirements.

8.1.1 Essential Health Benefits

The federal law requires the Exchange to offer QHPs in the coverage tiers described above, and those plans must cover essential health benefits. The terms "qualified" and "essential health benefits" will be further defined by the Secretary of HHS. The law[12] does, however, enumerate 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

[11] A HDHP offered through the Exchange must cover all of the essential health benefits, as determined by the Secretary of HHS, but may have larger up-front deductibles and a lower actuarial value than the Bronze level plans. In 2010, HDHPs could have deductibles of $5,950 (individual) and $11,900 (family).

[12] Section 1302 of the Patient Protection and Affordable Care Act (ACA).

- 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 may require that health plans cover additional benefits or services. For coverage sold through the Exchange, the federal law requires that the cost of any mandated benefits that exceed the federally-defined essential health benefits must be paid for by the State.

An initial review of Delaware insurance mandates identified a few potential services that may not be considered essential health benefits; however, Delaware needs to complete a complete review of the federal essential health benefits, once it is issued, 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 purchased through the Exchange.

While the law imposes new regulatory requirements on all health insurers, health plans offered through the Exchange must also meet additional requirements, including marketing standards, network adequacy, accreditation, and quality improvement programs. The Exchange may certify plans for participation only if it "determines that making available such health plan through such Exchange is in the interests of qualified individuals and qualified employers in the State or States in which such Exchange operates."[13]

The law also requires health insurers that are seeking certification as QHPs to submit to the Exchange justification for any premium increase prior to implementation of the increase and to "prominently post such information on their websites."[14] The Exchange is to take this information, along with information and recommendations provided by the DOI relating to patterns or practices of excessive or unjustified premium increases, into consideration when determining whether to make such health plan available through the Exchange.[15]

Health insurers will also be required to submit and make public information to the Exchange, the DOI, and the Secretary of HHS, including:

- Claims payment policies and practices;
- Periodic financial disclosures;
- Data on enrollment and disenrollment;
- Data on the number of claims that are denied;

[13] Section 1311 (e) (1) of the ACA.

[14] Section 1311 (e) (2) of the ACA.

[15] Jost, T.S., *Health Insurance Exchanges and the Affordable Care Act: Eight Difficult Issues*, The Commonwealth Fund, September 2010.

- Data on rating practices;
- Information on cost-sharing and payments with respect to any out-of-network coverage;
- Information on enrollee and participant rights; and
- Other information as determined appropriate by the Secretary.

Given the Exchange's ability to offer premium subsidies to low and moderate income individuals and families, insurers offered through the Exchange will likely have access to a large group of new consumers. This heightens the responsibility of Delaware's Exchange to establish a fair and open certification process for all QHPs.

8.1.2 Options for Delaware

Because the ACA requires the Exchange to offer QHPs, Delaware needs to establish a process and selection criteria to solicit health plans from insurers. There are three basic options or selection processes available: 1) any qualified plan; 2) selective contracting agent; or 3) active purchaser.

1. Any Qualified Plan: under this model, Delaware's Exchange would establish threshold criteria, perhaps no greater than the minimum standards outlined in the ACA and the federal regulations, and offer all QHPs that meet the threshold criteria. Under this option, Delaware's Exchange acts as an impartial source of information; provides structure to the market to enable consumers to compare health plans based on relative value; administers premium subsidies; and serves, essentially, as a broker of health insurance.
2. Selective Contracting Agent: this approach requires the Exchange to play a bit more of an active role in the marketplace. Delaware's Exchange may exert some influence in the market through contracting with a limited number of carriers offering a select group of health plans, or by requiring that health carriers and health plans meet certain cost and/or quality metrics above and beyond the federal minimums. The Exchange might solicit plans based on plan design parameters or preferred plan types.
3. Active Purchaser: this approach would require the Delaware Exchange to act more like a purchaser of health insurance; much like an employer establishes and purchases health benefits on behalf of its employees. This model is predicated on the Exchange covering a large and broad risk pool that enables carriers to offer competitively-priced plans. Initially, it will be difficult for the Delaware Exchange to act as an active purchaser, due to the fact that the carriers will be required to establish premiums based on numerous unknown factors (e.g., the number of people purchasing coverage through the Exchange, health status of enrollees, demographic characteristics, etc.).

Because the Exchange will provide access to affordable coverage for tens of thousands of newly insured Delawareans, carriers offered through the Delaware Exchange will likely have exclusive access to a sizeable population. This heightens the responsibility of the Exchange to establish a fair and open health carrier and health plan selection process, regardless of the decision to offer any qualified plan, to act as a selective contracting agent, or to be an active purchaser.

9 Network Adequacy Standards

Section 1311 of the ACA directs the Secretary of HHS to establish network adequacy standards for health insurers seeking certification of their QHPs that may be offered by the State's Exchange. However, the recently released NPRM largely defers this responsibility to the State's Exchange to "ensure that enrollees of QHPs have a sufficient choice of providers."[16] The proposed rule provides Delaware with the ability and responsibility to establish network adequacy standards that fit the geography, demographics, local patterns of care, and market conditions.

9.1 Options for Delaware

Currently, there are no network adequacy standards in effect in Delaware, and no standards or requirements that DOI enforces or monitors as part of its licensing and review process. As a result of the proposed federal rule, assuming there are no significant changes that occur when the proposed rule is finalized, Delaware has significant latitude in establishing these standards. The State could adopt network adequacy standards that apply only to QHPs sold through the Exchange, or Delaware could opt to adopt standards for all health plans licensed for sale in the State. The State might also consider adopting different standards for managed care plans compared to preferred provider plans or indemnity plans.

A first-line decision for Delaware is which entity or agency will be responsible for developing the standards. With DOI responsible for regulating the health insurance market in Delaware and the likelihood that a Delaware Exchange will have little, if any, regulatory authority, directing DOI to develop these standards may be the preferred approach. The National Association of Insurance Commissioners has developed a Managed Care Plan Network Adequacy Model Act that the State may consider as it begins developing these network adequacy standards.

9.2 Rate Review and Approval

Section 1311 (e) (2) of the ACA requires an Exchange to consider rate increases in determining whether to make a health plan available:

[16] Department of Health and Human Services, 45 CFR Parts 155 and 156, Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans, "Establishment of Exchange network adequacy standards (§155.1050)," pages 106–108.

> (2) Premium Considerations.—The Exchange shall require health plans seeking certification as qualified health plans to submit a justification for any premium increase prior to implementation of the increase. Such plans shall prominently post such information on their websites. The Exchange shall take this information, and the information and the recommendations provided to the Exchange by the State under section 2794(b)(1) of the Public Health Service Act (relating to patterns or practices of excessive or unjustified premium increases), into consideration when determining whether to make such health plan available through the Exchange. The Exchange shall take into account any excess of premium growth outside the Exchange as compared to the rate of such growth inside the Exchange, including information reported by the States.

Section 1003 of the ACA provides for a program of grants to help the State improve rate review and reporting process. In July 2010, the federal government awarded the Delaware DOI a $1million grant to improve the rate review process.

According to CMS, an effective rate review system:

- Receives sufficient data and documentation concerning rate increases to conduct an examination of the reasonableness of the proposed increases.
- Considers the factors below as they apply to the review:
    - Medical cost trend changes by major service categories
    - Changes in utilization of services (i.e., hospital care, pharmaceuticals, doctors' office visits) by major service categories;
    - Cost-sharing changes by major service categories;
    - Changes in benefits;
    - Changes in enrollee risk profile;
    - Impact of over or under estimate of medical trend in previous years on the current rate;
    - Reserve needs;
    - Administrative costs related to programs that improve health care quality;
    - Other administrative costs.
    - Applicable taxes and licensing or regulatory fees;
    - Medical loss ratio; and
    - The issuer's capital and surplus.
- Determines the reasonableness of the rate increase under a standard set forth in State statute or regulation.
- Posts either rate filings under review or preliminary justifications on their websites; or post a link to the preliminary justifications that appear on the CMS website.
- Provides a mechanism for receiving public comments on proposed rate increases.

- Reports results of rate reviews to CMS for rate increases subject to review.

9.2.1 Options for Delaware

The State needs to determine the role, if any, of Delaware's Exchange in reviewing proposed rates, compared to the role of DOI. The NPRM issued in early July indicates that an Exchange "may receive this information (i.e., rate review data) from the State DOI or DHSS, if applicable, to satisfy its obligation to receive such a justification."[17] With the Delaware Exchange likely serving as a facilitator of QHPs, and not as a regulator or selective contracting agent, the Exchange will likely defer responsibility for conducting rate reviews and approvals to DOI, who handles this responsibility for Delaware's broader individual and small group markets.

[17] Department of Health and Human Services, 45 CFR Parts 155 and 156, Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans, "Subpart K—Exchange Functions: Certification of Qualified Health Plan," pages 96–104.

10 Consumer Assistance

10.1 Role of Navigators and Brokers

The Exchange must provide assistance to individuals and small businesses that will include:

- Assisting people in determining eligibility for health coverage;
- Helping people enroll in the appropriate health coverage;
- Helping individuals and businesses file insurance grievances and appeals;
- Providing information on consumer protections; and,
- Collecting data on inquiries and problems, as well as their resolution.

If the Delaware Exchange is to attract a sufficient volume of individuals, families, and small businesses, it needs to develop a multi-pronged outreach, education, enrollment, and consumer assistance program. Such an effort might include a wide array of organizations and individuals, including Exchange staff, social service agencies, schools, community-based advocacy organizations, faith based organizations, private employers, business groups, hospitals, community health centers, physicians, health insurers, paid media, and public service announcements.

In addition to establishing a website, a customer service unit, call center, and facilities to provide consumer assistance, the Exchange needs to work with outside entities that can provide assistance to individuals and employers. The ACA requires the Exchange to establish a grant program for navigators who will be responsible for:

- Conducting public education activities to raise awareness of the availability of QHPs through the Exchange;
- Distributing "fair and impartial" information concerning enrollment and the availability of premium subsidies and cost-sharing reductions;
- Facilitating enrollment in QHPs;
- Referring people to the appropriate agency or agencies if they have questions, complaints, or grievances; and
- Providing information in a culturally and linguistically appropriate manner.

Navigators are entities such as trade, industry, and professional associations; chambers of commerce; faith-based and community based organizations; brokers; and other groups that have established or can readily establish relationships with employers, employees, consumers, or self-employed individuals. Federal law prohibits health insurers from serving as navigators and prohibits navigators from receiving "direct or indirect payments" in connection with the enrollment of an individual or an employee in a QHP. HHS has made clear that this provision does not prevent brokers from serving as navigators within the Exchange; however, while brokers may serve as navigators or brokers within the Exchange and brokers outside of the Exchange, they may not serve as both brokers and navigators within the Exchange.

The Exchange needs to establish a selection process for awarding grants to navigators. Community based groups that currently help with outreach and enrollment for Medicaid, DHCP, and other public assistance programs may be prime candidates to become Delaware Exchange navigators. In addition, the Exchange needs to expand outreach efforts beyond these groups to reach people who normally are not eligible for public assistance programs (i.e., individuals and families with income up to 400 percent FPL).

In addition to navigators, the Delaware Exchange needs to determine the role for brokers and how they might be utilized to help consumers. In determining the appropriate role that brokers and navigators may play in the operation of the Delaware Exchange, a number of key issues are worth considering. These include, but are not limited to, the following:

- What type of assistance is currently provided by various organizations, and how might the Exchange involve these groups in its outreach, education, and enrollment efforts?
- What should be the role of navigators and should navigators be credentialed or licensed? If so, which entity should handle credentialing?
- What is the current role of brokers in the individual and small group markets, and how can the Exchange best leverage brokers' expertise?
- How are brokers compensated today, and what type of broker compensation model might the Exchange establish?
- What should be the role of insurers with regard to outreach, education, and enrollment?
- How can providers, hospitals, community health centers, and other front-line entities support outreach and enrollment efforts?
- What types of information will people need to help them make informed decisions?
- How should the Exchange structure the health benefits that will be available to individuals and small businesses?
- Will the outreach, education and enrollment needs of individuals differ from the needs of small employers and their employees?

Establishing an effective, efficient, and sustainable outreach, education, and enrollment effort will be one of the more important initiatives undertaken by Delaware's Exchange. Determining how best to leverage the expertise of health insurance brokers, community-based organizations, health centers, and other key groups, and proactively including these individuals in the outreach and enrollment program will be critical to the success of the Exchange.

11 Correspondence and Notifications

The Exchange will be responsible for notifying a number of different entities when decisions are reached on pending issues. On the individual level, the Exchange must communicate verification of eligibility for Medicaid, DHCP, premium tax credits, and cost sharing reductions, in addition to relaying final decisions on individual appeals. On the employer level, the Exchange must notify employers of employees' eligibility for advanced premium tax credits where the employer does not provide minimum essential coverage or coverage is deemed unaffordable. The Exchange must also notify carriers of premiums and tax credits to be applied to individual and group coverage, ratings of plans submitted to the Exchange, and certification status of submitted plans.

As noted under the Eligibility section, there are a number of instances in which the Exchange needs to communicate with or send notification to various federal and State agencies, including, but not limited to, HHS, IRS, DHS, the Delaware Department of Revenue, various divisions under DHSS, and DOI.

The communication responsibilities of a fully-functioning Exchange are significant, even if these requirements have not been fully articulated by HHS at this time. The Exchange must facilitate communication and notification for a number of different entities including individuals, employers, health plans, and State and federal agency partners.

12 Regulatory Functions

12.1 Monitoring and Evaluation of the Exchange

Ensuring the quality of both the products offered through the Exchange and the overall Exchange user experience will be critical to the Exchange's success. As such, the Exchange must monitor plan transactions and Exchange operations, comparing the Exchange operational performance to predetermined baseline indicators in order to quantifiably measure service delivery execution. To inform this measurement, the Exchange will oversee implementation of enrollee and Exchange user satisfaction surveys.

Additionally, the Exchange will be required to administer a number of functions on an as needed basis. For example, in the instance where an individual or employer submits a complaint, appeal request, or formal grievance, the Exchange must track the submission through to a resolution.

13 Oversight and Program Integrity

Oversight and program integrity is designed to protect the Delaware Exchange planning and establishment expenditures, as well as provide for ongoing monitoring and oversight of the program. There are four main areas that the Exchange needs to address as part of its oversight and program integrity efforts:

1. Fraud, Waste, and Abuse: The Exchange needs to seek to prevent fraud, waste, and abuse through a variety of methods, including streamlining enrollment and minimizing acquisition expenses. Polices need to be implemented to prevent and detect fraud, waste, and abuse, and to promote financial integrity.
2. Eligibility Determination and Post-enrollment Audits: The Exchange needs to implement a robust audit strategy by creating audit criteria and protocols using a series of data sources from Exchange partners and stakeholders.
3. Availability of Commercial Insurance: The Exchange needs to work with health insurers and other key stakeholders (e.g., navigators, brokers, agents, employers) to develop processes and procedures to determine whether an applicant and/or an enrollee has available employer-sponsored insurance.
4. Coordination with Insurers: The Exchange needs to coordinate and share information with health insurers to ensure appropriate coordination of benefits, if applicable, and to ensure that individuals, families, and employees are enrolled in the appropriate health program.
5. Opportunities for Disruption in the Commercial Markets: The Exchange needs to work with health insurers, DOI, and other key stakeholders to develop processes and protocols that seek to minimize unintended disruption to the commercial health insurance markets. This includes, but is not limited to, enforcement and monitoring of off-cycle enrollment, underwriting requirements, and verification of "groups," as that term applies to the small group health insurance market.

13.1.1 Options for Delaware

The Exchange needs to coordinate its program integrity protocols and procedures with insurers that participate on Delaware's Exchange, as well as DOI and key stakeholders, including navigators, brokers, agents, and employers.

The Exchange needs to combat fraud, waste, and abuse within its financial management system, as well as with the processing of data, information, and funds that flow through the Exchange. The strategy developed for program integrity needs to incorporate the different methods necessary for audit of the Exchange's financial management system, as well as oversight and monitoring of Exchange participants, including insurers, navigators, brokers, employers, and consumers. To assure the Exchange is capable of sharing relevant data for program integrity, monitoring, and oversight, one of the first activities will be to complete data sharing agreements and establish ongoing coordination activities between the Exchange and its partners and key stakeholders.

An additional priority is to develop program integrity provisions that ensure that individuals, families, employers, and employees are appropriately enrolled in coverage for which they are eligible. Because the Exchange will determine eligibility for people purchasing coverage in the health insurance markets (individual and small group markets, initially), it will be incumbent upon the Exchange to protect the program and the insurers that participate in the Exchange, and minimize the opportunity for individuals to "game" the system or otherwise engage in improper activities. The Exchange needs to develop these program integrity provisions through evaluation of enrollee and provider audit strategies currently in place for the Medicaid and DHCP programs, as well as audit procedures utilized by insurers in the Delaware market.

Although much of the Medicaid and DHCP audit strategies are designed to oversee the provider community, there are protocols and criteria for review of Medicaid and DHCP enrollees that may be adapted and tailored for Exchange purposes. In addition, there are likely to be program integrity policies and procedures in the commercial health insurance market that will prove useful and appropriate for use by the Exchange.

14 Security

Given the sensitive nature of the information that is shared through the Exchange, there are a number of security measures that must be in place to protect all Exchange users. These measures include individual and entity identity management and various levels of access control, including authentication procedures and any necessary firewalls to protect electronic transactions. Specifically, the Exchange must comply with all requirements of the Health Insurance Portability and Accountability Act (HIPAA), and include mechanisms and redundancies to protect both personal identification information and protected health information.

While the federal health care reform law does not explicitly discuss identity access management (IAM), CMS does describe the need for consumers that purchase coverage through the Exchange to be able to establish accounts, along with user identity descriptions and passwords. These privacy and security requirements implicitly necessitate the integration of an IAM solution. Delaware's Exchange must be able to trust the identities of users requiring access and easily administer user identities efficiently and effectively. IAM solutions are based on user and access rights management through an integrated, efficient, and centralized infrastructure. This concept combines business processes, policies, and technologies that enable organizations to:

- Provide secure access to any resource;
- Efficiently control this access;
- Respond to changing relationships; and
- Protect confidential information from unauthorized users.

When implementing any technology that provides access to protected information, the following questions should be considered:

- Have the different user roles been considered and are they included in the identity management process?
- How will identities be verified, ensuring the user is who they claim to be, and evaluated for risk and access purposes?
- What level of authentication strength is required?
- Are there national or State-level regulatory requirements or technical standards with which the Exchange needs to be in compliance?
- After authentication, what is the process for credentialing these individuals?
- How often will credentialed individuals need to be re-authenticated?

Exchanges are subject to privacy and security requirements and are subject to civil monetary penalties for infractions as under HIPAA. HIPAA security standards and electronic transaction rules would also apply, although the NPRM provides the State with flexibility to create a more "appropriate and tailored" standard with regard to privacy. The proposed rule may require the Exchange to adopt privacy policies that conform to the Fair Information Practice Principles.

14.1.1 Options for Delaware

Delaware's Department of Technology and Information (DTI) is using Oracle Identity and Access Management Suite as the foundation for its identity management infrastructure. Delaware leverages its identity management infrastructure to offer secure citizen services online. Delaware is well equipped to deliver citizen services while helping to protect personal data.

Appendix A: Acronyms

Acronym	Stands For:
ACA	Patient Protection and Affordable Care Act
ASSIST	Delaware Application for Social Services and Internet Screening Tool
CCIIO	Center for Consumer Information and Insurance Oversight
CMS	Centers for Medicare and Medicaid Services
COBRA	Consolidated Omnibus Budget Reconciliation Act
DOI	Delaware Department of Insurance
DHR	Delaware Department of Human Resources
DHS	United States Department of Homeland Security
DHSS	State of Delaware Department of Health and Social Services
DMMA	Division of Medicaid and Medical Assistance
DSS	Delaware Division of Social Services
FPL	federal poverty level
HDHP	high deductible health plan
HHS	United States Department of Health and Human Services
HIPAA	Health Information Portability and Accountability Act
HRA	health risk assessment
IAM	identity access management
IRS	Internal Revenue Service
IT	information technology
MAGI	modified adjusted gross income
NPRM	Notice of Proposed Rulemaking
PCG	Public Consulting Group
QHP	qualified health plan
RFI	request for information
SHOP	Small Business Health Options Program