Overview of Health Benefit Exchange

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

HEALTH BENEFIT EXCHANGE KEY RESPONSIBILITIES

Eligibility

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

Outreach, Enrollment, and Customer Service

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

HEALTH BENEFIT EXCHANGE KEY RESPONSIBILITIES (cont.)

Health Plan Selection, Evaluation, and Management

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

HEALTH BENEFIT EXCHANGE KEY RESPONSIBILITIES (cont.)

Enforcement of Individual Mandate and Federal Reporting

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