

The purpose of this document is to answer frequently asked questions about the Health Insurance Exchange.

Health Insurance Exchange Frequently Asked Questions

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The purpose of this document is to answer frequently asked questions Idaho Legislators have regarding the Health Insurance Exchange. It is organized by category for ease of access and reading.

Section 1 Health Insurance Exchange

Health Insurance Exchange Overview

1. What is a Health Insurance Exchange?

- a. What
 - i. An organized marketplace for the purchase of qualified health insurance plans to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on benefits, services, price, and quality.
 - ii. Exchanges will interactively assist eligible individuals by providing individual pricing and information to possibly receive premium tax credits.
 - iii. Exchanges will direct people to appropriate Qualified Health Plan products that fit their financial requirements or direct them to the Medicaid product for which they may be eligible.
 - iv. Benefits are actuarially equal in a format that allows the member to select what they need or want.
- b. When
 - i. Beginning with an open enrollment period in October 2013, Certified Exchanges will help individuals and small employers shop for, select, and enroll in high quality, affordable private health plans that fit their needs at competitive prices.
- c. Bottom Line
 - i. By providing one-stop shopping for a qualified health plan, Exchanges will make purchasing health insurance easier and more understandable.

2. What is a Qualified Health Plan (QHP)?

- a. A qualified health plan is a health plan that
 - i. Is certified by the Exchange
 - ii. Provides the essential benefits package
 - iii. Is offered by an issuer that is
 1. Licensed and in good standing in each state in which it is offered
 2. Agrees to offer at least one silver plan and one gold plan
 3. Agrees to charge the same premium whether the plan is sold through the Exchange or outside the Exchange

4. Complies with other requirements of the Secretary of Health and Human Services and the Exchange¹

3. What are the Essential Health Benefits Requirements (EHB)?

- a. The essential health benefits package must cover the following 10 general categories of services:
 - i. Ambulatory patient services
 - ii. Emergency services
 - iii. Hospitalization
 - iv. Maternity and newborn care
 - v. Mental health and substance abuse disorder services, including behavioral health treatment
 - vi. Prescription drugs
 - vii. Rehabilitative and habilitative services and devices
 - viii. Laboratory Services
 - ix. Preventive and wellness services and chronic disease management
 - x. Pediatric services, including oral and vision care
- b. The scope of benefits is to be determined by the Secretary of HHS and equal to the scope of benefits under a typical employer-based plan. HHS has informed the states via a bulletin issued on December 16, 2011, that it will permit the states to determine a benchmark plan, however, the plan selected by states must still contain benefits in all 10 categories. Nothing shall prevent a qualified health plan from providing benefits in excess of the essential benefits package.
- c. Deductibles for plans in the small group market are limited to \$2000 individual/\$4000 family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.
- d. The levels of coverage are defined as follows:
 - i. Bronze level—Must provide coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan.
 - ii. Silver level—Must provide coverage that provides benefits that are actuarially equivalent to 70% of the full actuarial value of benefits under the plan.
 - iii. Gold level—Must provide coverage that provides benefits that are actuarially equivalent to 80% of the full actuarial value of benefits under the plan.
 - iv. Platinum level—Must provide coverage that provides benefits that are actuarially equivalent to 90% of the full actuarial value of benefits under the plan.²

Consequences of Waiting

4. Why can't we wait to make a decision on the state exchange until after the Supreme Court rules?

- a. By waiting for the Supreme Court ruling, states will jeopardize their opportunity to implement a State-based exchange, recognizing there is already urgency. Therefore a Federally-facilitated exchange will be implemented in states that defer any action until after the court's ruling.
- b. By law, a Federally-facilitated Health Insurance Exchange will be in place and operational by January 2014 for states that have not:

¹ http://www.naic.org/documents/committees_b_Exchanges.pdf

² http://www.naic.org/documents/committees_b_Exchanges.pdf

- i. Met certification requirements by 1/1/2013 or...
- ii. Implement a State-based exchange that will meet certification requirements

5. What happens if we do nothing to create a health insurance exchange?

- a. The federal government will implement a Federally-facilitated exchange for the state of Idaho.
- b. Details on the Federally-facilitated exchange are covered on page 11 of this document.
- c. The state of Idaho Medicaid system changes must be completed and ready to participate in either a certified State-based Exchange or a Federally-facilitated Exchange.

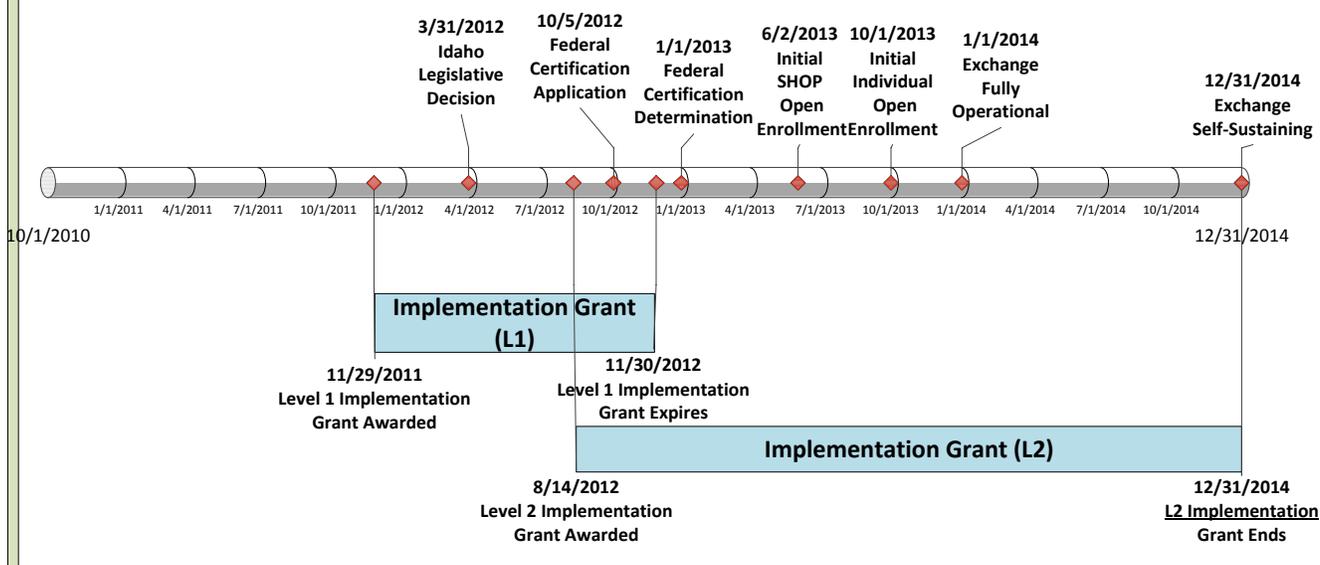
6. Don't we have plenty of time to work on this exchange since it does not start until 2014?

- a. KPMG conducted an in-depth analysis of the schedule risks for the State-based Ohio Health Insurance Exchange Project. Their findings are as follows:
 - i. "Given the scope of the IT solution and the aggressive schedule commitments of the Affordable Care Act, the implementation schedule is at significant risk.
 - ii. Based on the work required, according to the 'golden square' rule of project duration, the initiative should be implemented over a four year period.
 - 1. The Exchange project requires a total of approximately 2,500 person months.
 - 2. The golden square rule states that, to manage complexity and minimize risk, project duration should not be less than the square root of the effort – in this case, 50 months.
 - 3. From January 2012 to end of 2014, there are only 36 months.
 - iii. The golden square rule applies to projects with significant logical dependencies among the subprojects. If a way can be found to have more 'loose coupling' between the subprojects, there may be an opportunity for schedule compression and an increase in the average FTEs (Full Time Equivalent employees).
Funding constraint sets the implementation to a three year period as HIE funding runs out in December 2014."³
- b. The following is a timeline leading up to the 12/31/2014 self-sustainable exchange. Note that from the point the legislators make a decision to the Federal Certification Application date is probably 6 months. The certification criteria for a state-based exchange is published and is available upon request.

³ "KPMG State of Ohio Health Insurance Exchange Planning: Strategic Architecture Roadmap and Budget Report", September 14, 2011, pg. 6.

Health Insurance Exchange Deadlines and Funding Timeline

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Exchange Not Following the Patient Protection and Affordable Care Act (PPACA)

7. Why can't we make a state health insurance exchange that is separate from the federal rules?

- If a state does not meet the requirements defined in PPACA, the federal government will implement an exchange for the state.
- States have latitude in building a state health insurance exchange that meets their needs within the federal requirements defined in PPACA. However, qualifying employers and individuals could not access tax credits and subsidies that would otherwise be available to them.

Costs for a State-based Exchange

8. Why does it cost so much to develop the Health Insurance Exchange?

- The table starting on page 6 is a breakdown of the Level 1 Establishment Grant. It defines each core area of the health insurance exchange project by the costs, goal and overall approach. The core areas and scope aligns with an exchange that has a high likelihood of being certified by HHS.
- In order to more effectively support the population of Idaho and to meet the Federal certification requirements and requirements of the Affordable Care Act, the Idaho Health Insurance Exchange Project and resulting Implementation will be driven by these principles and priorities:
 - Establishing a state-based exchange
 - Promoting efficiency and effectiveness
 - Avoiding adverse selection
 - Streamlining access and continuity of care
 - Public outreach and stakeholder involvement
 - Public accountability and transparency
 - Financial accountability

- c. While considering the following high-level milestones:
 - i. January 2013 – Certification of Idaho Health Insurance Exchange
 - ii. June 2013 – Open enrollment begins in Idaho Health Insurance Exchange for Small Business clients
 - iii. October 2013 – Open enrollment begins for Idaho Health Insurance Exchange individuals
 - iv. January 2014 – Fully functional Idaho Health Insurance Exchange and supporting organization
 - v. December 2014 – End of Federal funding for Idaho Health Insurance Exchange implementation and supporting changes, however, it appears that money awarded through December 2014 can be spent into 2015
- d. Idaho’s approach to implementation of the exchange will consist of two major Initiatives: the Preliminary Design Initiative supported by this Level 1 Implementation Grant and the Final Implementation Initiative supported by the Level 2 Implementation Grant. The Preliminary Design Initiative will address or refine many of the functional, business, organizational and technical questions that remain.

Core Area	L1 Grant	Goal	Overall Approach
Coordination, Guidance, Direction and Support	\$2,821,616.10	Provide direction and management of the project while assuring core area interdependencies to achieve a self-sustaining, efficient, and effective Health Insurance Exchange by 2015 on time and within budget.	Throughout implementation of the exchange, Idaho will maintain executive and project leadership. Executive Leadership will consist of the Department of Health and Welfare and the Department of Insurance Directors and Deputy Directors. This will ensure continuity and integration through all parts of the Idaho Health Insurance Exchange. The Project Management Team will consist of two Project Managers, two Project Coordinators and six Project Leads. These leads will oversee and provide continuity across all Core Areas in Policy, Business Process Reengineering, Information Technology, Quality and Communications. This structure will assure early identification and immediate mitigation of risks and issues in a defined escalation process. These resources will be engaged in all of the Core Areas.
Core Area 1 – Background Research	\$455,043.20	Conduct research and analysis and regularly evaluate to inform development and implementation of the Idaho Health Insurance Exchange.	Background research on health exchanges and implications to stakeholders was started in the planning grant. In addition to these activities, research will be conducted on the populations that will interact with the exchange and the market environment that will result from various decisions across the exchange. There will be a series of reports utilized to make incremental decisions for the most efficient, effective, and sustainable Idaho Health Insurance Exchange (including a study and other research to determine the best approach for supporting an Exchange). Other background research will be associated with the respective core areas and will be reflected in that work plan.
Core Area 2 – Stakeholder Involvement	\$468,880.51	Increase stakeholder involvement and utilize the results to create the Idaho Health Insurance Exchange.	Idaho will conduct 12 stakeholder and work group meetings throughout the Level 1 Grant period to inform groups of progress and obtain feedback. The Level 1 Grant emphasis will be to focus on the needs of consumers, employees, employers, tribes, producers, insurers, and legislators through a multifaceted outreach to inform the public of services and coverage options. This will develop a strong relationship with stakeholders as a vital component of a successful exchange. This will include information sessions on the progress of the project for key leaders.

Core Area	L1 Grant	Goal	Overall Approach
Core Area 3 – Legislative and Regulatory Action	\$155,267.82	Establish sufficient State and Federal authority for the Idaho Health Insurance Exchange for its programs and operations that complies with applicable State and Federal rules and requirements.	<p>Idaho will also encourage feedback in various formal and informal processes. Stakeholders will continue to be involved in Work Groups in various core area assignments. Idaho will continue to keep stakeholders advised of progress; promote continued feedback and involvement; and design the outreach and education plan required for Core Area 11-16.</p> <p>The Legislature for the State of Idaho is scheduled to reconvene in early January 2012 and the Department of Insurance is preparing to finalize and recommend the Legislature adopt the draft Exchange enabling legislation. At this time the Idaho Health Insurance Exchange project is conducting a review and evaluation of regulations that may affect the exchange; identifying specific state requirements for the exchange; drafting the needed exchange legislation; advising the Legislators; and obtaining legislative support for the exchange legislation. As we move into the next legislative session, we will continue to research all pertinent State laws and regulations. The research will determine the steps Idaho must take to have the necessary legal authority to establish and operate an exchange that complies with Federal requirements. This will ensure the proposed and adopted legislation will permit the State to establish and operate an exchange, as well as providing for the establishment of governance and exchange structure. The research will be reviewed for input from the Governor’s Health Care Task Force, Senate Commerce and Health Committees, House Business and Health Committees, and other groups deemed necessary by executive leadership.</p>
Core Area 4 – Governance	(Combined with Core Area 3)	Establish an accountable and transparent governance structure for the Idaho Health Insurance Exchange that is staffed with competent leadership and is in compliance with applicable conflict-of-interest provisions.	<p>The enactment of an Idaho Health Insurance Exchange and the appointment of a Board of Directors will be a major milestone in the long-term success of the exchange. The Board of Directors will conform to the Federal requirements. Several alternatives have been discussed and more analysis needs to be done in specific areas. These areas are: obtaining additional stakeholder input into the process; developing a plan to hire the necessary program staff and determining on-going staffing needs; determining conflict-of-interest requirements for the governing body; and adopting the governance structure when the State adopts the Legislative authority described in Core Area 3 of this document. The exchange will be publicly accountable, transparent, and have technically competent leadership, adhering to Idaho’s conflict-of-interest requirements, with the capacity and authority to take all actions necessary to meet Federal standards, including the discretion to determine whether health plans offered through the exchange are in the interests of qualified individuals and qualified employers.</p>
Core Area 5 – Program Integration	\$393,347.71	Collaborate with the Department of Insurance and the Department of Health and Welfare (Medicaid) by clearly defining rolls and creating synergy through activities that promote program integration.	The Idaho Health Insurance Exchange project will continue collaborative planning with the State Medicaid and CHIP programs to achieve streamlined application, verification, eligibility and enrollment processes throughout the exchange. The Idaho Health Insurance Exchange’s partnership with Department of Health and Welfare

Core Area	L1 Grant	Goal	Overall Approach
Core Area 6 – Technical Infrastructure/ Information Technology	\$9,371,132.47	Define the Idaho Health Insurance Exchange architecture, including related systems, and procure the necessary components and provide a technical demonstration.	<p>(Medicaid) will focus on systems development, operational procedures, interoperability coordination, referrals and other functions deemed necessary. The Idaho Health Insurance Exchange will work closely with the Department of Insurance who will oversee the regulation and licensure of health insurance issuers, including those that offer qualified health plan coverage through the exchange. In addition, the Department of Insurance may process consumer coverage appeals and complaints. The exchange will work closely with the Department of Insurance to monitor the financial stability of insurance companies, certification of plans, rate review, State licensure, solvency, adverse selection, and market conduct.</p> <p>Idaho will use an agile approach to system development process to capture updates and changes to business and system requirement, development, testing, and implementation of exchange information technology systems. After the initial Information Technology (IT) Gap Analysis and decision making has been established, the Idaho Benefits Eligibility System (IBES) will provide Medicaid Eligibility Determination to the Idaho Health Insurance Exchange.</p>
Core Area 7 – Financial Management	\$389,758.91	Establish a financial management structure that adheres to generally accepted accounting principles, ensures sound financial management of exchange funds, complies with cost allocation requirements, and ensures long-range sustainability of the exchange as required by federal law.	<p>The Idaho Department of Health and Welfare will serve as the Grantee of Record for the Level I grant program and will manage the funds and reporting requirements. Idaho will focus on several areas of specific interest, namely: conducting a cost analysis of the different exchange models; identifying and estimating the on-going funding requirements to sustain the exchange over the long-term; identifying the cost for integrating exchange eligibility and enrollment processes; adopting and implementing generally accepted accounting requirements and ensure sound fiscal management of exchange funds; and, ensuring long-range sustainability of the exchange as required by federal law.</p>
Core Area 8 – Oversight and Program Integrity	\$212,839.42	Implement effective oversight and program integrity to prevent waste, fraud, and abuse of funds used to start up and operate the Exchange.	<p>The Idaho Health Insurance Exchange will incorporate as many of the State’s existing Waste Prevention, Fraud, Abuse, and Auditing procedures as possible into the exchange program in addition to insurance industry standard fraud and abuse procedures and adopting and implementing fiscal management procedures to ensure program integrity.</p>
Core Area 9 – Health Insurance Market Reforms	\$599,994.62	Monitor and demonstrate state compliance with and enforcement of Federal health insurance market reforms.	<p>The Idaho Health Insurance Exchange will track and monitor state legislation, regulations and implementation of health insurance market reforms by working with the Legislature, Department of Insurance and Department of Health and Welfare. Level 2 Implementation will include passing Idaho legislation or issuing appropriate regulations implementing the health insurance market reforms; stakeholder consultation on these issues; development of a plan to implement the reforms; as well as monitoring and considering enforcement of consumer protections and specific requirements that impact the exchange.</p>
Core Area 10 – Providing Assistance to	\$299,997.31	Create a system to assure that services are available and sufficient to meet the needs of individuals and	<p>Work with existing consumer assistance programs and stakeholder groups to collect and analyze data on providing exchange information, problem resolution, and</p>

Core Area	L1 Grant	Goal	Overall Approach
Individuals and Small Businesses, Coverage Appeals and Complaints		small businesses for assistance in determining eligibility, filing complaints and appeals, and providing information about consumer protections. Collection of data through consumer assistance programs on inquiries, problems, and resolutions.	intra-agency referral processes for individuals and small businesses. Stakeholder groups will be integral in developing complaint and appeal process protocols for the exchange. The Department of Insurance and Department of Health and Welfare have existing assistance programs that help residents resolve problems, answer questions, file complaints and appeals, and enrollment applications. The Idaho Health Insurance Exchange will provide this assistance through contracting entities or interagency agreements and will ensure the referral entity has capacity to provide assistance that consumers need. The exchange will build a robust capacity for providing assistance for all residents and small business owners by collaborating closely with other entities within Idaho who are carrying out these activities.
Core Area 11 – Business Operations	\$5,208,677.98	Identify Exchange markets, products, programs, and detailed system and operational requirements for Exchange Implementation.	(Details by sections of Core Area 11 below)
11-1 Health Plan Certification and Administration		Provide an automated way to certify, recertify, and decertify qualified health plans.	The Idaho Health Insurance Exchange project will develop a streamlined process and approach to certify, recertify, and decertify qualified health plans by open enrollment mid-2013.
11-2 Call Center and Toll-free Hotline		Provide meaningful assistance to individuals and small businesses by operating a call center with a toll-free hotline.	In addition to providing enrollment assistance to individuals and small businesses, the Idaho Health Insurance Exchange Call Center may facilitate outreach to consumers and answer consumer questions on how the ACA may affect individual access to health insurance. Considerations for call center activities may include collaborating with the Department of Insurance Consumer Affairs Section to jointly contract for, or to operate, a call center (since the activities are closely related).
11-3 & 4 Exchange Website and Calculator		Provide a website through which applicants and enrollees may obtain standardized comparative information on qualified health plans, apply for coverage, and enroll online (including premium tax credit and cost-sharing reductions).	The Idaho Health Insurance Exchange will maintain a website through which applicants and enrollees may obtain standardized comparative information on qualified health plans, apply for coverage, and enroll online. The exchange will provide access to an electronic calculator that allows individuals to view an estimated cost of their coverage once premium tax credits have been applied to their premiums, and the impact of cost-sharing reductions, if they are eligible. The website will also post required transparency of cost information.
11-5 Quality Rating System		Ensure a quality rating is assigned to each plan in accordance with the quality rating system that will be issued by HHS. Also, certification of qualified health plans will include consideration of quality data.	The approach for quality rating systems will be determined through an initial assessment and guidance provided by HHS.
11-6 Navigator Program		Establish a Navigator program to assist consumers in the selection and enrollment of health insurance.	The Idaho Health Insurance Exchange project will establish a Navigator program by determining Navigator grantee organizations and awarding contracts or grants to entities that will assist consumers in navigating their choices in the health insurance marketplace. This includes facilitating enrollment in qualified health plans. The Navigator program will be funded from the operational funds of the

Core Area	L1 Grant	Goal	Overall Approach
11-7 Eligibility Determinations for Exchange Participation, Advance Payment of Premium Tax Credits, Cost-Sharing Reductions, and Medicaid		Provide eligibility determinations for exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid.	exchange. Key operations of the exchange will be verifications and determinations of eligibility for qualified health plans. Key functions will include eligibility determinations for advance payment of premium tax credits; cost sharing reductions and Medicaid; and appeals of eligibility determinations for enrollment in a qualified health plan and premium tax credits and cost-sharing reductions.
11-8 Seamless Eligibility and Enrollment Process with Medicaid and Applicable State Health Subsidy Programs		Provide seamless eligibility determinations for Medicaid and CHIP programs through the exchange.	The Idaho Health Insurance Exchange will determine an individual's eligibility for Medicaid, CHIP, and other applicable state health subsidy programs. The exchange will also ensure that such individuals are seamlessly enrolled in the program for which they are eligible without need for further determination by other programs. The exchange eligibility system will be integrated with the Medicaid system since the eligibility function in the exchange has significant similarities to eligibility determinations in other programs. Steps necessary to achieve interoperability with other health and human services programs for the purposes of coordinating eligibility determinations, referrals, verifications, or other functions will be considered. The seamless eligibility and enrollment process will be carried out through the development of information technology systems in close partnership with Idaho's Medicaid program.
11-9 Enrollment Process		Facilitate plan selection for an individual who is eligible to enroll in a qualified health plan, including providing information about customized qualified health plans.	The Idaho Health Insurance Exchange will provide information about available qualified health plans that is customized according to an individual's preferences, receiving an individual's choice of plan, and providing enrollment transactions to qualified health plan issuers using applicable standards that will be set forth by HHS.
11-10 Applications and Notices		Provide a single, streamlined application, (including notices) that supports the consumer's ability to carry out enrollment through the exchange.	The Idaho Health Insurance Exchange project will implement all requirements for applications and notices consistent with Federal requirements, including facilitating the use of a single, streamlined application. Applications and notices will include mechanisms for consumers to carry out enrollment steps (screening, enrollment forms, and verifications) both in person or online. Applications and notices will facilitate the application, eligibility determination process, and enrollment of individuals into qualified health plans. The Exchange will also issue notices to facilitate program operations and communications with enrollees.
11-11 Individual Responsibility Determination		Establish a process for receiving, adjudicating, and reporting on requests for exemptions to individual responsibility requirements.	The Idaho Health Insurance Exchange will have in place a process to receive and adjudicate requests from individuals for exemptions from the individual responsibility requirements of the Affordable Care Act, and to communicate information on such requests to HHS for transmission to the IRS.
11-12 Administration Premium Tax		Perform and report on administrative activities related to premium tax credits and cost-sharing	The exchange will perform administrative activities related to premium tax credits and cost-sharing reductions. The exchange will be the first point of contact for prospective

Core Area	L1 Grant	Goal	Overall Approach
Credits and Cost-Sharing Reductions		reductions.	enrollees who will be interested in learning more about premium tax credits and for seeking assistance when needed.
11-13 Adjudication of Appeals of Eligibility Determinations		Establish a process for individuals to contest the eligibility determinations made by the exchange for premium subsidies and exchange participation.	The exchange will implement a process for processing appeals if an individual seeks to contest the eligibility determination made by the exchange for premium subsidies or exchange participation. This process will coordinate with Medicaid and CHIP programs.
11-14 Notification and Appeals of Employer Liability		Provide notifications to employers when one or more of their employees is determined to be eligible for advance payment of a premium tax credit.	The Idaho Health Insurance Exchange will notify employers when one or more of their employees is determined to be eligible for advance payment of a premium tax credit because the employer does not offer minimum essential coverage or the coverage is not affordable or does not meet the minimum value requirement. The exchange will also offer the employer an opportunity to appeal.
11-15 Information Reporting to IRS and Enrollees		Report required coverage data to the IRS and enrollees each year.	The Idaho Health Insurance Exchange will report to the IRS and enrollees each year certain information regarding the enrollee's coverage provided through the exchange.
11-16 Outreach and Education		Provide a robust education and outreach program to health care consumers about the exchange (primarily new coverage options and the benefits of purchasing health care through the exchange).	The exchange will educate consumers about the benefits of purchasing health insurance coverage through the Idaho Health Insurance Exchange, including access to health plans that meet State and Federal certification standards and access to assistance with paying their premiums and cost-sharing. This informational and educational outreach will be unique to the diverse stakeholder types in the three geographic regions of the state. The outreach will coordinate with Core Area 2, Stakeholder Involvement.
11-17 Risk Adjustment and Transitional Reinsurance		Implement and support a risk adjustment program and a transitional reinsurance program in accordance with Federal standards.	The risk adjustment program and transitional reinsurance program will meet Federal standards. Data collection will support risk adjustment and transitional reinsurance including demographic, diagnostic, and prescription drug data. Qualified Health Plans may be required to submit encounter data and therefore, will need to develop data and other systems to support risk adjustment.
11-18 SHOP Exchange specific functions		Establish and operate a Small Business Health Options Program (SHOP) Exchange that is integrated with the Individual Health Insurance Exchange.	The Idaho SHOP Exchange will facilitate the purchase of coverage in Qualified Health Plans for employees of small businesses that choose to purchase coverage through the exchange. Idaho will decide whether to merge the operations of the SHOP Exchange with the individual market exchange. Implementation will be integrated with outreach and education activities.
Total for Level One Establishment Grant	\$20,305,445		

Federally-facilitated Exchange vs. State-based Exchange

9. What does it mean to have a federal insurance exchange instead of a state-run health insurance exchange?

- a. A Federally-facilitated Exchange will perform core functions comparable to State-based Exchanges, including consultation with stakeholders.⁴ Core Functions for both a federally-facilitated or state-based exchange include:
 - i. Consumer Assistance
 1. A Federally-facilitated Exchange will work with local stakeholders through the Navigator program and other outreach efforts to educate consumers and small businesses about available options in 2014.
 - a. Education and outreach
 - b. Navigator management
 - c. Call center operations
 - d. Website management
 - e. Written correspondence with consumers to support
 - ii. Plan Management
 1. Plan selection approach (e.g., active purchaser or any willing issuer)
 2. Collection and analysis of plan rate and benefit package information
 3. Issuer monitoring and oversight
 4. Ongoing issuer account management
 5. Issuer outreach and training
 6. Data collection and analysis for quality
 - iii. Eligibility
 1. A Federally-facilitated Exchange will provide eligibility information to the applicable State agency to enroll those individuals in coverage.
 2. A Federally-facilitated Exchange will determine eligibility for qualified health plans, tax credits, cost sharing reductions, and Medicaid and CHIP eligibility based on modified adjusted gross income.
 3. State Medicaid and CHIP programs will not be required to contribute to the costs associated with the Federally-facilitated Exchange, including the costs associated with a Federally-facilitated Exchange making a Medicaid or CHIP determination. However, State Medicaid and CHIP programs will have to transfer information and cases to, and accept information and cases from, the Federally-facilitated Exchange; the costs of establishing, testing and maintaining those interfaces will be shared between the State Medicaid and CHIP programs and the Federally-facilitated Exchange, consistent with current cost allocation rules.⁵
 4. HHS has provided additional help to States to build and maintain a shared eligibility service that allows for the Exchange, the Medicaid agency, and the CHIP agency to share common components, technologies and processes to evaluate applications for insurance affordability programs. This includes enhanced funding under Medicaid and opportunities for other State programs to reuse the information technology (IT) infrastructure without having to contribute funding for development costs related to shared services. This additional help is available to defray State costs related to establishing an efficient and effective shared eligibility service regardless of whether a Federally-facilitated Exchange or a State-based Exchange is operating in a State.⁶

⁴ CCIIO Conference Presentation, September 19-20, 2011

⁵ CCIIO Questions and Answers, November 29, 2011

⁶ IBID

5. Eligibility under a Federally-facilitated Exchange or a State-based Exchange Section 155.305 of the proposed rule on Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers proposes that the Exchange will make eligibility determinations for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program, where applicable, based on modified adjusted gross income (MAGI). The Exchange Eligibility proposed rule does not distinguish between a State-based Exchange and a Federally-facilitated Exchange in this regard. Based on comments to the Exchange Eligibility proposed rule, however, HHS intends to modify this original proposal in the final rule to permit additional options for determining eligibility under a State-based and Federally-facilitated Exchange.⁷
6. In response to comments to the Exchange Eligibility proposed rule, HHS is planning to revise the options that are available for the responsibility for the determination of eligibility under a Federally-facilitated Exchange to include the following:
 - a. The Federally-facilitated Exchange will conduct initial assessments of applicants for Medicaid and CHIP eligibility based on MAGI, as part of the determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions. However, the State Medicaid and CHIP agencies make final Medicaid and CHIP determinations under this option. In order to ensure an optimal consumer experience, a State electing this option would agree to make these determinations consistent with general guidelines and the terms of an agreement established between the State and the Federally-facilitated Exchange to ensure that applicants are not required to submit redundant documentation and that timeliness standards are met.
 - b. Alternatively, if a State does not choose to retain Medicaid and CHIP eligibility determinations as set out in paragraph “a” above, the Federally-facilitated Exchange may determine Medicaid and CHIP eligibility using State eligibility rules and standards in conjunction with determining eligibility for advance payments of the premium tax credit and cost-sharing reductions,⁸ including:
 - i. Accept applications
 - ii. Conduct verifications of applicant information
 - iii. Determine eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs
 - iv. Connect Medicaid and CHIP-eligible applicants to Medicaid and CHIP
 - v. Conduct redeterminations and appeals
- iv. Enrollment
 1. Enrollment of consumers into Qualified Health Plans
 2. Transactions with Qualified Health Plans
 3. Transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions
- v. Financial Management
 1. User fees
 2. Financial integrity
 3. Support of risk adjustment, reinsurance, and risk corridor programs
 4. HHS can charge issuers user fees to run the Federally-facilitated Exchange
- vi. Advance Payments of the Premium Tax Credit in the Federally-facilitated Exchange
 1. Individuals enrolled in coverage through either a State-based Exchange or a Federally-facilitated Exchange may be eligible for tax credits, including advance

⁷ IBID

⁸ IBID

payments. Additionally, neither the Congressional Budget Office score nor the Joint Committee on Taxation technical explanation discussed limiting the credit to those enrolled through a State-based Exchange.⁹

- b. Federally-facilitated Exchange will make decisions where Exchanges have flexibility, including areas such as network adequacy and marketing.
- c. HHS will look to State standards to harmonize rules inside and outside of the Exchange.
- d. HHS will solicit input from States when running the Federally-facilitated Exchange.
- e. Coordination with State Insurance Departments
 - i. A Federally-facilitated Exchange will operate in States electing not to pursue a State-based Exchange. To the greatest extent possible, HHS intends to work with States to preserve the traditional responsibilities of State insurance departments when establishing a Federally-facilitated Exchange. Additionally, HHS will seek to harmonize Exchange policy with existing State programs and laws wherever possible.
 - 1. For example, Qualified Health Plans (QHP) that will be offered in the Federally-facilitated Exchange must meet State licensure and solvency requirements and be in good standing in the State (section 1301(a)(1)(C) of the Affordable Care Act). Accordingly, States continue to maintain an important responsibility with respect to health plans licensed and offered in their State, regardless of whether the Exchange is Federally-facilitated or fully State-based.
 - ii. With respect to review of network adequacy, which is commonly a responsibility of State insurance departments or State health agencies in consultation with State insurance departments, HHS would rely on the State for advice and recommendations regarding network adequacy standards where HHS is operating a Federally-facilitated Exchange. Network adequacy standards must ensure enrollees a sufficient choice of providers, consistent with HHS regulations. It is expected that if a State has not adopted such a standard, HHS would develop it for the purposes of the Federally-facilitated Exchange using a commonly recognized and accepted standard such as the National Association of Insurance Commissioners (NAIC) Network Adequacy Model Act.
 - iii. Similarly, HHS is also currently working to determine the extent to which activities like the review of rates and benefit packages are already conducted by State insurance departments and how these responsibilities could be recognized as part of the certification of QHPs by a Federally-facilitated Exchange. For example, most States (including Idaho) currently have an effective rate review program in place and HHS will rely on such processes to the extent practicable and where legally permissible.
 - iv. In States with a Federally-facilitated Exchange, HHS will also apply existing State standards on marketing materials, assuming issuers will be required to convey information about premiums, benefits and cost sharing that flow from data used for plan approval, and complaints. HHS will work with States to utilize existing processes for consumer complaints as efficiently as possible to the extent practicable.
- f. Pursuant to the federal goal to preserve the traditional responsibilities of State insurance departments when establishing a Federally-facilitated Exchange, HHS is planning to establish one or more working groups with representatives from State insurance departments to start working through issues related to plan management functions.
- g. Successful operation of the Federally-facilitated Exchange will depend on successfully harmonizing State and HHS workflows so that the annual QHP certification process can be effectively completed in time to adequately support open enrollment including preparation and release of an insurance web portal.¹⁰

⁹ CCIIO Questions and Answers, November 29, 2011

¹⁰ CCIIO Questions and Answers, November 29, 2011

- h. In 2012 and 2013, grant funding is available until it is clear that a Federally-facilitated Exchange will operate in the State.

10. What are the benefits of a Federally-facilitated Exchange?

- a. Health and Human Services (HHS) will look to State standards to harmonize rules inside and outside of the Exchange.
- b. HHS will solicit input from States when running the Federally-facilitated Exchange.
- c. A Federally-facilitated Exchange will make decisions where Exchanges have flexibility, including areas such as network adequacy and marketing.
 - i. A state can choose a hybrid of the federally-facilitate exchange. This would combine state designed and operated business functions with federally designed and operated business functions.
 - ii. Examples of such shared business functions could include eligibility and enrollment, financial management, consumer assistance and health plan management systems and services.

11. What are the benefits of a federally certified state-run exchange?

Benefit 1: Prevent a Federally-Run Exchange for Idaho

- Sec. 1321(b) of the PPACA state the following (paraphrased): “If a State is not an electing State Exchange, or the Secretary determines, on or before January 1, 2013, that an electing State will not have any required Exchange operational by January 1, 2014; or has not taken the actions the Secretary determines necessary to implement the other requirements set forth in the standards or requirements; the Secretary shall establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.”
- Therefore, the benefit of a federally certified state-run exchange is that it would prevent the federal government from implementing an exchange for Idaho.

Benefit 2: State Flexibility

- **Navigator Role**
 - It would enable Idaho to develop the best way to implement the requirements of a federally certified state-run exchange. There is some flexibility in the “how” of each of the “what” (requirements). A good example is the role of the navigator. The requirements are:
 - “(A) conduct public education activities to raise awareness of the availability of qualified health plans;
 - (B) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402;
 - (C) facilitate enrollment in qualified health plans;
 - (D) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage; and
 - (E) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange or Exchanges.”
 - It is up to each state to determine the details for each of the five responsibilities.

- A state exchange would give maximum opportunity and flexibility to design a required navigator program in such a way as to maintain insurance producer licensure standards and requirements for people selling, soliciting or negotiating insurance and recognizing the valuable role that producers play (see e.g. 45 CFR 155.220(a) and (b))
- **Preserve Competition and Choices in the Market to the Maximum Extent**
 - A state exchange can elect to be:
 - an open and competitive market (such that any plan that meets the minimum criteria of having the Essential Health Benefits, cost sharing limits, metallic levels of actuarial value can be sold in the Exchange, etc.); Idaho policymakers have encouraged an open competitive market to allow all health carriers that meet the basic criteria to participate; or
 - a federal exchange could choose to follow an “active purchaser” model and limit consumer choices.
- **Combined Risk Pools**
 - Establish separate exchanges & risk pools or combine individual and small employer exchange and risk pools into one – Idaho would decide.
 - A state can also elect up until plan years beginning Jan. 2016 to define small employers as from 2 to 50 employees, as is the current state definition, rather than up to 100 employees.

Benefit 3: Reinsurance and Risk Adjustment (45 CFR part 153)

- If the state operates an exchange, then the state must also set up a transitional reinsurance program for the individual market; the state has the option to do a reinsurance program under a federally-facilitated exchange (ACA § 1341).
- Risk adjustment program – the state can operate this if there is a state exchange (ACA § 1343).
- (Note the temporary Risk Corridor program is a federal program with no state option – ACA § 1342).

Benefit 4: Cost of an Exchange

- The Exchange must be self-sustaining after Jan. 1, 2015.
- The exchange can be funded by assessments or fees.
- Local control over how much this is and how it is assessed is preferable.

Benefit 5: Minimize Complexity & Duplication

- A state exchange could elect to meet only the minimum criteria mandated by the ACA and associated regulations, most of which are not finalized, and thus additional state flexibility may be afforded.
- A state exchange could more easily and likely rely upon existing state insurance regulation functions rather than duplicating those efforts.
- Examples include: rate review, the process of certification of health plans (noted above), making sure that network adequacy is sufficient (45 CFR § 155.1050), and consumer assistance, e.g. toll free hotline, complaints, etc.

Benefit 6: Flexible and Adaptable

- A state exchange would also be more flexible / adaptable after the initial set-up, even though significant changes would likely require notice to HHS.

Department of Health and Welfare's Role in the Exchange

12. Why does the Department of Health and Welfare have to work on the health insurance exchange?

- a. Health and Welfare has the technical expertise and knowledge of two major systems, Idaho Benefit Eligibility System (IBES) and Medicaid Management Information System (MMIS) that will provide critical and timely information to an Exchange. This includes the tight integration of several programs, models, automated systems, and infrastructure to ensure continuity in information and data.
- b. Outsourcing the development of an Exchange would be far more costly than utilizing IDHW's expertise and their availability of obtaining technical resources.

Section 2 Medicaid Readiness

1. What is meant by Medicaid Readiness?

- a. New Medicaid requirements, which are separate federal requirements than those for an Exchange, are changing the current way in determining eligibility for health coverage.
- b. These requirements also state that eligibility must be completed in real time and information from IBES to the Exchange must also be shared in real-time.
- c. These new Medicaid requirements also state that these new changes must be implemented and operational for integration to a Federal or State Exchange.

2. What is the difference between the health insurance exchange and Medicaid Readiness as it relates to the exchange?

- a. Medicaid Readiness is the requirement to have all federal required changes (mentioned above), be completed and ready to connect to either a Federal or State Exchange. Thus the term "Medicaid Readiness".
- b. The Health Insurance Exchange has separate federal requirements that require a seamless integration with multiple federal and state systems, such as Medicaid Eligibility. The term "Program Integration" is used as it relates to the Exchange.

3. Why does it cost so much to develop a Medicaid Readiness system?

- a. The requirements in the Affordable Care Act completely change Medicaid as we know it today. Although modernized, our rules engines, notification system, interface structure, on-line customer options, 24x7-infrastructure, and all budget-unit calculations must be reconfigured to meet the new regulations for Medicaid. A significant re-design of IDHW's entire Medicaid program, systems, and infrastructure will have to be performed.

4. What happens if we do nothing related to Medicaid Readiness?

- a. If our Division of Medicaid does not prepare to interface with either a state or federal exchange, then Idaho runs the risk of having its federal match rate reduced to a lower rate such as 50/50 instead of the current rate of 70/30.

Section 3 Other Resources

This bibliography will provide resources that may contribute to our understanding of health insurance exchanges. This is not meant as an extensive list, but more of an overview for legislators.

1. Overview of Health Care Reform

Document Title	Document Description	Document Link
"Explaining Health Care Reform: Questions About Health Insurance Exchanges" / Kaiser Family Foundation	"This summary provides responses to questions about the purpose and function of exchanges and how they relate to the regulation of the insurance market."	www.kff.org/healthreform/upload/7908-02.pdf
"Explaining Health Reform: Eligibility and Enrollment Processes for Medicaid, CHIP, and Subsidies in the Exchanges" / Kaiser Family Foundation	Provides explanations of different provisions in the law. The enrollment system for Medicaid, CHIP, and subsidies in the exchange must be consumer-friendly, coordinated, simplified, and technology enabled. Summarizes the various positions in the law that address these goals.	www.kff.org/healthreform/upload/8090.pdf
Patient Protection and Affordable Care Act of 2009: Health Insurance Exchanges / National Association of Insurance Commissioners	Lists the provisions in the Patient Protection and Affordable Care Act relevant to the health exchanges in the form of a chart, highlighting key features, applicability, and effective dates.	www.naic.org/documents/committees_b_Exchanges.pdf
Private Health Insurance Provisions in PPACA (P.L. 111-148) / U.S. Congressional Research Service.	Provides an in-depth analysis and explanation of the health insurance exchanges described in the Patient Protection and Affordable Care Act. Explains the essential health benefits package, qualified health plans, eligibility for individuals and small businesses, as well as premium and cost-sharing subsidies as they relate to the exchange.	http://assets.opencrs.com/rpts/11-148_20100415.pdf

2. Guide to the Health Insurance Exchanges—the Basics

Document Title	Document Description	Document Link
"Illustrating Health Reform: How Will Coverage Work?"	Easy to understand YouTube video explaining how coverage will work in Health Reform	http://healthreform.kff.org/the-basics.aspx
"A Guide to Health Insurance Exchanges?"	Overview of an exchange and common questions	http://www.kaiserhealthnews.org/stories/2011/march/30/exchange-faq.aspx
"The Uninsured, A Primer: Key Facts About Americans Without Health Insurance" October 2011	Addresses who are the uninsured, how lack of insurance affects access to health care, financial implications of lack of coverage and more.	http://www.kff.org/uninsured/upload/7451-07.pdf
"How People Get Coverage Under the Affordable Care Act"	An easy to read flow chart describing the individuals' experience in the exchange.	http://healthreform.kff.org/the-basics/access-to-coverage-flowchart.aspx

3. States' Activities Implementing Health Insurance Exchanges

Document Title	Document Description	Document Link
State Actions to Implement Health Insurance Exchanges/ National Conference of State Legislatures. Updated 12/2011	Provides a comprehensive table detailing state actions in implementing reform, including introduced bills and laws.	http://www.ncsl.org/default.aspx?TabId=21388
"Overview of Massachusetts Health Reform: Exchange Design Issues & Lessons Learned" / National Conference of State Legislatures	Slides. Slides give a brief overview of the Commonwealth Choice and Commonwealth Care program, including its subsidized and non-subsidized options. Provides statistics on the successes and shortcomings of the exchange. Lessons learned stress the importance of campaigning, communication and collaboration, consolidating legacy problems, and more.	www.ncsl.org/portals/1/documents/health/Exchanges_KingsdaleLS10.pdf
"The Utah Health Exchange: Ten Lessons Learned from the Utah Experience" / National Conference of State Legislatures	Slides. Provides guidelines for implementing exchanges based on experience with the Utah Health Exchange. Documents the timeline of events involved in the Utah exchange, demonstrates the functions on its Web site, and compares the Utah model with the Massachusetts Connector.	www.ncsl.org/portals/1/documents/health/Exchanges_ClarkeLS10.pdf

4. Issues to Consider

Document Title	Document Description	Document Link
A State Policymakers' Guide to Federal Health Reform: Part I, Anticipating How Federal Health Reform Will Affect State Roles / National Academy for State Health Policy	Identifies broad areas of focus in current state reform efforts, asking "will [federal] reform support or impede progress toward existing state health system improvement goals?"	http://www.nashp.org/sites/default/files/Policymakers%20Guide%20Part1.pdf

5. Related Web Sites

Document Title	Document Description	Document Link
GPO Access	The Federal Register is the official daily publication for rules, proposed rules, and notices of Federal agencies and organizations.	www.gpoaccess.gov/fr
Healthcare.gov	The official government Web site that provides information to consumers on the Patient Protection and Affordable Care Act.	www.healthcare.gov
Massachusetts Health Connector	Official Web site for the Massachusetts Health Exchange.	www.mahealthconnector.org/portal/site/connector
National Association of Insurance Commissioners	Provides information on health reform with an added focus on the role of the NAIC in creating many of the standards and methodologies required in the law.	www.naic.org
National Conference of State Legislatures	Provides updated information on state actions. Go to Health Reform Implementation, or search for "insurance exchanges".	www.ncsl.org
Centers for Consumer Information and Insurance Oversight	The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many provisions of the Affordable Care Act. The site provides information on programs and initiatives as well as resources.	http://cciio.cms.gov/