C.L. "BUTCH" OTTER
GOVERNOR

Considerations for a State-based vs. Federally-Facilitated Health Insurance Exchange

MANAGEMENT OF HEALTH PLANS AND COVERAGE OPTIONS IN THE EXCHANGE

	In a state-based exchange, each state would determine the specific criteria for plan certification and participation within broad federal regulations and would maintain local authority over managing plans in the exchange.	**In the federal exchange,** the federal government would decide the criteria for plan certification and participation in the exchange and would lose regulatory authority over plans in the exchange. Specifically, in the federal exchange:
<u>Plan participation, certification and management</u>	• Each state-based exchange would determine the criteria for certifying Qualified Health Plans (QHP), the certification process, and which plans are eligible to participate in the exchange. Account management and oversight for QHP issuers would be provided locally through its exchange.	• The federal government would determine the criteria for certifying Qualified Health Plans (QHP), the certification process, which plans are eligible to participate in the exchange, and provide oversight for QHP issuers . Account management for QHP issuers would be provided by federal "Account Managers."
<u>Ongoing oversight</u>	• Each state-based exchange would review rates, rate increase justifications, policy forms, benefit levels, actuarial plan values, and compliance with market reforms. Each state-based exchange would maintain local authority for oversight for accreditation, market conduct, adequacy of plan-level rate and benefit data, and proposed changes in services/networks, ownership, mergers, or acquisitions.	• The federal government would review rates, rate increase justifications, policy forms, benefit levels, actuarial plan values, and compliance with market reforms. They would also assess accreditation, market conduct, adequacy of plan-level rate and benefit data, and proposed changes in services/networks, ownership, mergers, or acquisitions.
<u>Adequacy of benefits</u>	• Each state-based exchange would be responsible for confirming that QHPs meet its criteria for coverage of essential health benefits.	• The federal government would be responsible for confirming that QHPs meet the criteria for coverage of essential health benefits based on each state's choice or default plan.

EXCHANGE NAVIGATORS/BROKERS/ASSISTORS

Agents, brokers, and community organizations are eligible to provide Navigator/Broker/Assistor services to help citizens find, compare and enroll in coverage options in the exchange.

	In a state-based exchange, each state would determine who is best positioned to serve as navigators/agents/brokers/assistors in the exchange, based on local experience. A navigator serves as a guide to provide individuals and families with the information necessary to determine which health insurance plan best fits their needs and then help them enroll in the plan of choice. Navigators are not licensed insurance producers. The Affordable Care Act requires all state exchanges to fund navigators. Specifically, in a state-based exchange:	**In the federal exchange,** the federal government would determine who will serve as navigators/agents/brokers/assistors for plans in the exchange. Specifically, in a federal exchange:
<u>Standards:</u>	• Each state's exchange would establish requirements and provide oversight of local standards regarding which individuals and organizations can provide navigator/broker/assistor services and what training may be required.	• The federal government would set and oversee the standards and roles regarding which individuals and organizations can provide navigator/agent/broker/assistor services in each state.
<u>Financing:</u>	• A state-based exchange would establish the payment and financing structures by which navigators/brokers/assistors would be paid in the individual state.	• The federal government would choose the payment and financing structures for navigator/agent/broker/assistor services in each state.
<u>Timeline:</u>	• The state-based navigator programs would be established by October 1, 2013.	• The federal navigator programs would be established by October 1, 2013.

FINANCING

In a state-based exchange, the Legislature and the Governor would approve and select the appropriate level of funding for the start-up costs of a state-based exchange. The source of funds is grants from the Department of Health and Human Services. The $20.3 million grant awarded to Idaho in November 2011 has been extended by HHS and, with spending authority from the Legislature, can be used to finance implementation of a state-based exchange. Idaho has more flexibility in how we finance this exchange; these are our options: Since December 11, 2012, when Governor Otter made his declaration choosing a state-based exchange for Idaho, a few vendors have indicated various pricing plans to implement an exchange. In one proposal, there are no upfront costs for an "exchange in a box" concept. Ongoing costs would be structured to allow the private entity (vendors) to meet development and ongoing expenses through the use of a per-member per-month fee. Another proposal would be to share developed infrastructure from other states to reduce the upfront costs of implementation in Idaho to $20-$25 million. The goal and belief is that ongoing costs for operation of Idaho's state-based exchange will be less expensive than a federally facilitated exchange. The bigger issue is what is best for Idaho citizens for the long term. A state-based exchange would hire Idaho citizens.	In the federal exchange, the federal government would determine the sources and methods for financing the exchange. HHS issued a proposed regulation on November 16, 2012 that set a fee for the federally facilitated exchange based on the average of all state-based exchanges' estimated fees. The approximate fee would be 3 ½% of state's written health insurance premiums written in its exchange.

CUSTOMER SERVICE AND APPEALS

All exchanges (whether state or federally-facilitated) are required to provide a toll-free number, website, and in-person assistance for individuals, as well as information that is accessible to people with disabilities and those with limited English proficiency.

Operations:	• Each state-based exchange would design and operate customer services to best meet the needs of its consumers, small businesses, insurers, navigators/brokers/assistors, and other stakeholders.	• The federal government would design and operate customer services, which may be provided from a location outside of the state and centralized with customer services for other states participating in the federal exchange.
Consultation:	• Each state-based exchange would conduct ongoing, broad stakeholder engagement to ensure services best meet the local needs of its customers.	• The federal government would conduct exchange-related consultations with stakeholders.
Services:	• Each state-based exchange would streamline and coordinate customer service with the Department of Human Services to support services across both public programs and commercial products.	• The federal government would provide customer service separately from the state's Department of Human Services. This may increase administrative complexity particularly for families with members enrolled in public and private coverage, compared to the state-based exchange providing these services directly.
Customer satisfaction:	• Each state-based exchange would develop and implement a rating system and enrollee satisfaction survey designed to reflect the priorities of its citizens.	• The federal government would develop and implement a rating system and enrollee satisfaction survey which would likely be standard across all states in which the federal exchange is operating.
Outreach:	• Each state would plan and implement a comprehensive outreach program to meet its needs.	• The federal government would conduct an outreach and education program to promote enrollment in the exchange.
Appeals:	• Each state would have jurisdiction to collect, analyze and resolve enrollee complaints.	• The federal government would collect, analyze and resolve enrollee complaints.

ELIGIBILITY

	In a state-based exchange, advance premium tax credits and Medicaid eligibility determinations would be seamlessly integrated into one system.	**In the federal exchange,** advanced premium tax credit determinations would be done in a federal system, while Medicaid determinations would be done through a State system. The interactions between the systems would be complicated and create additional administrative work for both clients and the State.
<u>Eligibility determination</u>	• In a state-based exchange, eligibility for advanced premium tax credits (subsidies) and Medicaid would be determined through one unified process by the state exchange.	• The federal government would determine eligibility for commercial exchange options, including eligibility for advanced premium tax credits.
	• Each state's Medicaid eligibility system and infrastructure would determine eligibility for Medicaid. The system would seamlessly integrate with premium tax credits/cost sharing reductions in the exchange, minimizing administrative complexity, particularly as families move between public and private programs.	• The federal government would make the initial Medicaid eligibility assessment, based on federal requirements and the state's income eligibility standards. Data and information would be passed to the Department of Human Services of each state to make final eligibility determinations. This adds an additional time, complexity, and opportunities for people to drop out of the process.
	• It will be easier to determine an individual's eligibility for all coverage options and connect them with the most appropriate program, because the determination will be done on one system.	• The federal government will not do assessments or determinations for non-MAGI Medicaid (e.g., disabled) or other state-funded health care programs. This disjointed approach to eligibility determinations will make it more difficult to connect people with their best coverage options.
<u>Customer experience</u>	• A state-based exchange would have a single, consolidated notice for all household members—even when parents have private coverage and children have Medicaid.	• The federal government would send multiple notices for household members if household members are eligible for different programs.
	• A state-based exchange would have coordinated program administration for households in which some family members receive Advance Premium Tax Credits (APTC) and others receive Medicaid.	• The federal government would have multiple points of contact for households when some family members receive Advance Premium Tax Credits (APTC– through the federal exchange) and other receive Medicaid (State). This will require many families to update all of their information twice through two systems.

COMPARING PLANS IN THE EXCHANGE

In a state-based exchange, options to compare plans in the exchange would be based upon local expertise, innovation and infrastructure for measuring and reporting the cost and quality of services provided by health care providers and health plans. This includes opportunities to go beyond minimum federal requirements to utilize state-specific cost, quality, and customer service information to address local needs.	**In the federal exchange,** the federal government would determine what data categories and sources are provided in the exchange and would decide which data are used to calculate the value of QHPs.