

Health Insurance Exchange Task Force Recommendations

Insurance Plan and Market Organization

Co-chair, Randy Moses, Division of Insurance

Co-chair, Eric Matt, Office of the Governor

Objectives:

- Make recommendations regarding the methods and rules under which insurance agents can participate in the placement of coverage through the exchange.
- Carrier certification process and role of the Division of Insurance
- Recommend standards for marketing of products within the exchange for agents and carriers
- Recommend method for employers and employees to enroll and purchase health insurance in an exchange
- Recommend requirements for network adequacy within and outside exchange
- Outline the ways in which adverse selection can occur

Description	Recommendation
<p>Defined contribution plans offer employers a way of fixing costs by providing a set monetary contribution for employee health plans. Employers have then allowed employees the choice among benefit levels with any extra costs with plan options borne by the employee. With defined contribution it is also possible to set up through the exchange an employee choice model, whereby the employee/dependent can choose among plans offered by various insurers. A form of employee choice is required under the PPACA exchange rules.</p>	<p>IPMO 1: The exchange should provide to employers that choose to offer defined contribution plans to eligible employees the option of choosing either an employee choice or an employer choice method of enrollment into the exchange.</p>
<p>Most employers do not offer health insurance to employees on a defined contribution basis but rather on a defined benefit basis. Under this method, employers choose the benefit plan(s) and pay a set percentage of contribution toward the employee/dependent premium. Under a defined benefit model, employer contributions may vary based upon premium increases and based upon the employer's choice of plan design. Allowing this option will be</p>	<p>IPMO 1a: In addition to the defined contribution model, employers should also be provided with the option of a defined benefit plan. With this option, the employer could choose the benefit structure(s) for the employees with the employer contribution set as a percentage of premium as opposed to a defined contribution amount.</p>

<p>helpful in providing employers a benefit structure they and their employees are familiar with.</p>	
<p>One of the populations with a higher incidence of being uninsured is part-time workers. In addition, South Dakota, as a state, has the highest percentage of those holding multiple jobs. With an employee choice premium payment module, premiums for part-time employees can be aggregated for payment to individual market carriers. This would offer a method for assisting those part-time employees for those employers wishing to contribute even a small amount toward those employees' health insurance.</p>	<p>IPMO 2: The exchange should offer employers the option to provide part-time employees, who are not eligible for coverage under the employer's health benefit plan, the option of enrollment in and contribution to coverage for those part-time employees in the American Health Benefit Exchange.</p>
<p>Under PPACA exchanges must certify health plans in order for those plans to be offered through the exchange. The function of reviewing the policies and the rates for compliance is a function currently performed by the Division of Insurance. Maintaining that function within the Division of Insurance avoids duplication of effort.</p>	<p>IPMO 3: The exchange should rely on existing state filing processes for certification of health plans and deem plans and rates, which are approved by the Division of Insurance for use in the exchange, as certified.</p>
<p>Adverse selection occurs whenever people make insurance purchasing decisions based upon their own knowledge of their insurability or likelihood of making a claim on the insurance coverage in question. Adverse selection results in higher premiums for everyone. The formation of exchanges creates unique challenges to control adverse selection. The areas listed are those that were identified as possessing potential for adverse selection.</p>	<p>IPMO 4: The exchange and the health insurance market outside the exchange should be structured so that adverse selection is minimized. Areas of potential adverse selection that should be addressed include: employers having the option to be in the exchange; employee choice defined contribution plans; plan design differentials inside/outside the exchange; favorable commission or other agent compensation arrangements outside v. inside exchange; differential networks or differential network adequacy requirements inside/outside the exchange; grandfathered v. non-grandfathered plans; self-funded plans; association and out-of-state trusts being subject to lesser regulatory standards; low attachment points for small employer self-funded plans; wrapping; and premiums being paid by third parties. Wrapping should not be prohibited but rather insurers should be allowed to inquire about wrapping during the application process and to make rating adjustments accordingly.</p>
<p>Some states such as Massachusetts have merged their individual and small group markets into a single market. Therefore the products that are purchased and the premiums charged do not vary whether it is an individual or small group. This may not be advisable as it removes group enrollment principles that mitigate</p>	<p>IPMO 5: The formation of an exchange should not result in the merging of the individual and small group health insurance markets. A single exchange can facilitate enrollment for both the individual and small group markets but the markets should remain distinct from a rating, risk pooling, marketing, and regulatory standpoint.</p>

<p>adverse selection for small employer plans and requires carriers that are not and never have been in a market to dramatically change their operations to fit a single merged marketplace. Creating a single exchange to facilitate enrollment for both individuals and small groups does not require the merging of those markets as purchases in those markets can be kept separate and distinct within the exchange.</p>	
<p>Under current South Dakota law, insurers wishing to offer network plans in this state must follow network adequacy requirements. Those requirements include having sufficient numbers and types of medical providers in the network so as to provide services for the benefits provided under the health insurance coverage. There are also requirements for consumer disclosure of networks as well as requirements for coverage when the network is inadequate. The recommendation would be to apply the same current network adequacy requirements for coverage offered through the exchange.</p>	<p>IPMO 6: The exchange should follow the same network adequacy rules that currently apply to the individual and small group health insurance markets.</p>
<p>There are numerous marketing standards in place that affect the manner in which health insurance is sold in this state. Those standards include, among other things, prohibitions against misrepresentations in advertising and solicitation, licensing of agents and insurers, and use of consumer disclosures. The recommendation would be to apply those same requirements to marketing via the exchange.</p>	<p>IPMO 7: The exchange should follow the same regulatory framework that currently applies to the marketing of health insurance.</p>
<p>Selling insurance through the exchange will require specific knowledge that a health insurance agent will not normally have in the course of that agent's health insurance business. Exchange transactions will have unique features that are not present in the outside marketplace. Agent training through a continuing education credit will help ensure agents selling through the exchange have the training necessary to properly assist those that are enrolling into the exchange.</p>	<p>IPMO 8: The exchange should require agents, as a condition of selling health insurance through the exchange, to complete one hour of continuing education dedicated to the exchange. The one hour should be part of, and not in addition to, the current continuing education hours required for licensing in this state.</p>

Outreach and Communication

Co-chair, Secretary Kim Malsam-Rysdon, Dept. of Social Services

Co-chair, Secretary Doneen Hollingsworth, Dept. of Health

Objectives:

- A. Outreach/Public Education: Develop outreach and education plan for SD’s Health Care Exchange
- B. Navigators: Develop recommendations for implementing navigator program in SD
- C. Communication Strategies: Recommend strategies for parts of the exchange such as the call center and website to assist targeted populations

Description	Recommendation
<ul style="list-style-type: none"> • Key messages include that there will be an individual mandate to purchase insurance, the exchange is coming, key implementation dates, the state’s position on building an exchange, and information on what the federal law says. • Need to keep information simple and focused on basic aspects of the federal law. • Existing website to be used for educational purposes in a consumer friendly format. • Develop frequently asked questions. • Leverage existing search functionality, external links. • Site to be integrated in a way that will support provision of general information now and be the exchange portal in the future. • Navigators will also help raise awareness once they are in place. 	<p>O&C A1: Raising general awareness of future health care reform should start now using the state’s existing health reform website. This website should be marketed as South Dakota’s source for unbiased information about the federal health care law and how South Dakota intends to comply with the law.</p>
<ul style="list-style-type: none"> • Target audiences for education and outreach efforts for SD’s exchange include the uninsured, small business owners, tribal members (including tribal leaders and IHS). • The detailed plan should develop a “toolkit” for outreach to include educational materials and information that key messengers, including insurance agents, government agencies, navigators and community agencies, can use for each target audience. 	<p>O&C A2: Once specifics about SD’s Health Care Exchange are available, specific outreach should be targeted to certain groups.</p>

<ul style="list-style-type: none"> • The detailed plan should include performance metrics and evaluation plan to ensure the outreach plan is effective. 	
<ul style="list-style-type: none"> • Navigators shall not sell, solicit or negotiate the purchase of health insurance. • The exchange should determine minimum annual education requirements for navigators. • Navigators will need to carry professional liability insurance. • The exchange shall include a qualification process for navigator programs. 	<p>O&C B1: Navigators will need to meet certain federal requirements.</p>
<ul style="list-style-type: none"> • The RFP should include the considerations in recommendation B1. • The RFP should require that applicants for navigator programs demonstrate capacity to use the technology associated with the exchange and communicate with a variety of target audiences on different levels. • Multiple entities could be selected as navigator programs in the state, depending on the response to the RFP. Individuals may also be considered for navigator services. • Define navigators' role in the private market. • Address common myths about health insurance, health reform and the exchange. 	<p>O&C B2: SD should select Navigator Programs through a Request for Proposals (RFP) process.</p>
<ul style="list-style-type: none"> • Address common myths about health insurance, health reform and the exchange. 	<p>O&C C1: The existing state health reform website should transform from providing general awareness to serving as the site of the exchange website so that consumers have one place to go to access information about health care reform and the exchange.</p>

Operations and Finance Subcommittee Objectives

Chair, Lt. Governor Matt Michels

Co-chair, Rachel Byrum, Bureau of Finance and Management

Objectives:

1. Resources and Capabilities
2. Technical Infrastructure
3. Regulatory or Policy Actions and Legislation
4. Finance
5. Business Operations

Description	Recommendation
<u>Resources and Capabilities</u>	O&F 1
<ul style="list-style-type: none"> • Evaluate staffing requirements and job descriptions for <ol style="list-style-type: none"> 1. Technology support, including maintenance of a web portal; 2. Eligibility determinations for the exchange, CHIPS, Medicaid and * individual mandate; 3. A consumer hotline; 4. Navigators; 5. Accounting and Auditing; and 6. Plan certification; 	O&F 1a: Details are within the recommended cost model proposal.
<ul style="list-style-type: none"> • Evaluate multi-state exchange infrastructure 	O&F 1b: Direction should be to plan and cost a State-based Exchange. As multi-state options evolve, SD can consider the options based on cost-benefit relative to the State-based Exchange plan/costs.
<ul style="list-style-type: none"> • Evaluate whether existing state staff can be used to perform the above functions or if new staff must be hired to perform the work. 	O&F 1c: A combination of existing staff and new staff should perform exchange functions as outlined in the recommended cost model proposal.
<ul style="list-style-type: none"> • Evaluate whether each exchange function (see above) should be performed within state government or by a private service provider. 	O&F 1d: Initially considering outsourcing for such functions as the web portal for eligibility and enrollment; and insourcing such functions as the call center.
<ul style="list-style-type: none"> • Evaluate Exchange demand based on survey results. 	O&F 1e: Demand should be based on an approximate high volume of 320,000 and an approximate low volume of 193,000.
<ul style="list-style-type: none"> • Reporting and analytics job description 	O&F 1f: Details are within the recommended cost model proposal.

<ul style="list-style-type: none"> Marketing and Communications 	<p>O&F 1g: Will follow the Outreach and Communication Subcommittee Recommendations. Navigant has included details in the recommended cost model proposal.</p>
<ul style="list-style-type: none"> Administrative Functions of the SHOP 	<p>O&F 1h: Assuming one front door sourced portal as part of overall portal (health plans will sell to both individual and small groups market). There will be no broker/commissioning by the Exchange as it will operate as a facilitator model.</p>
<p><u>Technical Infrastructure</u></p>	
<ul style="list-style-type: none"> Evaluate infrastructure technology models for the operation of a South Dakota Exchange 	<p>O&F 2a: Navigant has presented components of Exchange. Initial recommendation based on current capability analysis is to secure a RFP for third party web portal (eligibility and enrollment interfaces) and selectively insource functions like call center, and reporting, to expand and build on current state capabilities.</p>
<ul style="list-style-type: none"> Evaluate whether existing systems can be used to implement the model or if new systems must be purchased, and evaluate which technology to purchase and how much it costs. 	<p>O&F 2b: Will be based upon information provided in Navigant’s final report. Subject to BIT’s review and approval.</p>
<ul style="list-style-type: none"> Evaluate whether information technology services should be performed by the state or if those services should be contracted out to a private vendor. <ul style="list-style-type: none"> If the state will run the web portal, evaluate designs for a web portal, taking into account ease of use, user privacy considerations, and adequate security measures. Investigate the cost and adequacy of running a web portal through a private vendor. 	<p>O&F 2c: Will be based upon information provided in Navigant’s final report and subject to BIT’s review and approval.</p>
<ul style="list-style-type: none"> Evaluate system requirements, including: <ul style="list-style-type: none"> Online comparison of qualified health plans. Online application and selection of qualified health plans. Premium tax credit and cost-sharing reduction calculator functionality. Request for assistance. Linkages to other State health subsidy programs and other health and human services programs as appropriate. Capturing data in the enrollment process. 	<p>O&F 2d: Exchange users should be able to submit an online application that will tell them if they qualify for Medicaid or premium subsidies and then allow them to compare multiple qualified health plans. Exchange cost planning will seek to implement eligibility to support Medicaid, and leverage technology architecture that supports Exchange implementation, but also adaptability for future program eligibility. The Exchange should have to ability to generate reports required by PPACA, etc. The current Medicaid/CHIP enrollment systems need technology upgrades or replacement for Exchange interface and will require additional research and funding.</p>

<ul style="list-style-type: none"> ○ Submitting relevant data to HHS for later use in information reporting. ○ Capacity to generate information reports to enrollees. 	
<ul style="list-style-type: none"> ● Evaluate security needs. 	O&F 2e: Exchange will handle all security relating to HIPAA and individual privacy laws.
<ul style="list-style-type: none"> ● Call center service technology and telephony 	O&F 2f: The call center should be centralized expanding upon existing state hardware and software.
<ul style="list-style-type: none"> ● Data exchange and integration 	O&F 2g: O&F 2a: Assuming the Exchange will be the primary eligibility and enrollment data interchange.
<ul style="list-style-type: none"> ● Recommend updating security to specifically call out “privacy” 	O&F 2h: Exchange will ensure all security relating to HIPAA and individual privacy laws are met.
<u>Regulatory or Policy Actions and Legislation</u>	O&F 3
<ul style="list-style-type: none"> ● Recommend legislation and/or regulations as necessary to implement exchange functions and provide oversight authority to appropriate departments or quasi-governmental organizations. <ul style="list-style-type: none"> ○ Recommend a governing body structure that ensures public accountability, transparency, and prevention of conflict of interest. 	<p>O&F 3a: Legislation is not recommended at this time.</p> <p>The Governor will recommend a governing body structure which will be in compliance with the final federal regulations.</p>
<ul style="list-style-type: none"> ● Recommend a method for the Division of Insurance to certify health plans that complies with the requirements for a “qualified health plan” as set forth in the 2009 health reform legislation. 	O&F 3b: New or existing Division of Insurance staff should certify plans using existing policies and procedures.
<ul style="list-style-type: none"> ● Recommend a standardized application that will determine whether an applicant is eligible for subsidies to purchase insurance through the exchange, for Medicaid, or for CHIP. 	O&F 3c: The Exchange should utilize a standard application that will collect the necessary data in order to determine various eligibilities.
<u>Finance</u>	O&F 4
<i>Accounting and Finance</i>	
<ul style="list-style-type: none"> ● Recommend accounting and auditing standards needed to comply with PPACA (Patient Protection and Affordable Care Act) and any other appropriate accounting standards i.e. GAAP, etc. 	O&F 4a: The Exchange should follow accounting and auditing standards that comply with PPACA and those related to its governance structure.
<ul style="list-style-type: none"> ● Evaluate accounting functions and evaluate whether software should be developed or purchased to perform these functions. <ul style="list-style-type: none"> ○ If software should be purchased, recommend appropriate software. 	O&F 4b: If the Exchange is part of state government, it should utilize the existing accounting system. If it is not, the appropriate software should be purchased.

<ul style="list-style-type: none"> Recommend the method that will be used to finance the exchange in a self-supporting manner i.e. fees, assessments to insurance companies, or other methods. 	<p>O&F 4c: No recommendation at this time. Further analysis needs to be done to determine the impact on the market, insurance carriers, and employers.</p>
<ul style="list-style-type: none"> Evaluate cost allocation between the Exchange grants, Medicaid Federal Financial Participation (FFP), and other funding streams as appropriate. 	<p>O&F 4d: Exchange will become front end portal for Medicaid and CHIP eligibility, as well as, establish data sources to support participant eligibility and enrollment process. Exchange does not include costs to replace Medicaid and DSS enrollment system (ACCESS). Navigant recommends that costs be looked at holistically across Medicaid and Exchange to ensure a single picture of cost-budget allocation.</p>
<p><u>Business Operations</u></p>	<p>O&F 5</p>
<p><i>Transparency</i></p>	
<ul style="list-style-type: none"> Develop a recommended model for reporting information to the public that complies with PPACA and South Dakota open records statutes. 	<p>O&F 5a: The Exchange should have employee reporting specialists and Exchange technology infrastructure should be designed to comply with federal and state laws.</p>
<ul style="list-style-type: none"> Develop a recommendation for reporting required information to the Department of Health and Human Services. 	<p>O&F 5b: The Exchange should have employee reporting specialists and Exchange technology infrastructure should be designed to generate necessary reports.</p>
<p><i>Processes</i></p>	
<ul style="list-style-type: none"> Evaluate standard processes and workflows for each process performed by the exchange. <ul style="list-style-type: none"> Enrollment <ul style="list-style-type: none"> Providing customized plan information to individuals based on eligibility and QHP data. Submitting enrollment transactions to QHP issuers. Receiving acknowledgments of enrollment transactions for QHP issuers. Submitting relevant data to HHS. 	<p>O&F 5c: As part of the ability to compare multiple qualified health plans, Exchange users should be able to view customized plan information. After Exchange users choose a plan, enrollment transactions should be submitted to the qualified health plan. The qualified health plan should be responsible for billing and payment.</p>
<ul style="list-style-type: none"> Evaluate Medicaid/CHIP roles and responsibilities related to eligibility determination, verification, and enrollment. <ul style="list-style-type: none"> Identify challenges with Medicaid/CHIP program integration processes, strategies for mitigating those issues and timelines for completion. 	<p>O&F 5d: If an Exchange user is determined Medicaid/CHIP eligible they should be directed to the current Medicaid/CHIP enrollment systems.</p>
<ul style="list-style-type: none"> Evaluate whether all plans that meet qualifying standards should be part of the exchange or whether plans should bid to 	<p>O&F 5e: All plans that meet qualifying standards should be part of the Exchange.</p>

become a part of the exchange (plan bidding)	
<ul style="list-style-type: none"> Investigate and recommend premium credit and cost sharing assistance models 	O&F 5f: The Exchange will handle premium credit calculations based on HHS regulations.
<ul style="list-style-type: none"> Recommend a system to rate the quality of plans offered on the exchange so shoppers can compare plans as they shop the web portal 	O&F 5g: Exchange will handle consumer-lead plan rating based on HHS regulations. Methodology for ratings will come from future HHS regulations.
<ul style="list-style-type: none"> Recommend a process for requests for exemptions. 	O&F 5h: Exchange Board of Appeals
<ul style="list-style-type: none"> Recommend a process for employer appeals with appeals of individual eligibility. 	O&F 5i: Exchange Board of Appeals
<ul style="list-style-type: none"> Recommend a process for providing relevant information to QHP issuers and HHS to start, stop, or change the level of premium tax credits and cost-sharing reduction. 	O&F 5j: Exchange will be able to calculate premium credit calculations and adjustments based on HHS regulations.
<ul style="list-style-type: none"> Recommend a process to verify/resolve inconsistent information provided to Exchange by applicants (e.g. income, citizenship). 	O&F 5k: The Exchange technology infrastructure should interface with the necessary databases to verify information provided to the Exchange. Will connect to Federal HUB, other state agencies, and nationally recognized data sources.
<ul style="list-style-type: none"> Possible add-Process and management for agents (tracking registered, activity, and commissions) – dependent on decisions from other committees 	O&F 5l: The Exchange should not be involved with broker commissioning.
<ul style="list-style-type: none"> Recommend a decision and information support system for Navigators and Exchange Consumers. 	O&F 5m: Exchange will handle decision support for consumer. Additional decision support interfaces will be developed pending finalized Navigator role.
<ul style="list-style-type: none"> Recommend adding model and process for managing employer registering and/or product selection, contributions, and employee enrollment – dependent on employer choice/employee choice decision from other sub committees 	O&F 5n: The Exchange should allow employer registration and/or product selection, contributions, and employee enrollment.