WISCONSIN OFFICE of HEALTH CARE REFORM

Office of Health Care Reform

Exchange: Solicitation of Comments

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1. State Exchange Planning and Establishment Grants

1. What factors are States likely to consider in determining whether they will elect to offer an Exchange by January 1, 2014? To what extent are States currently planning to develop their own Exchanges by 2014 (e.g., become electing States) versus choosing to opt-in to an Exchange operated by the Federal government for their State? When will this decision be made? Can planning grants assist in identifying and assessing relevant factors and making this decision?

2. To what extent have States already begun to plan for establishment of Exchanges? What kinds of activities are currently underway (e.g., legislative, regulatory, etc.)? What internal and/or external entities are involved, or will likely be involved in this planning process?
    a. What kinds of governance structures, rules or processes have States established or are they likely to establish related to operating Exchanges (e.g., legal structure (such as placement in State agency or nonprofit organization), governance structure, requirements relating to governing board composition, etc.)?
    b. To what extent have States begun developing business plans or budgets relating to Exchange implementation?

3. What are some of the major factors that States are likely to consider in determining how to structure their Exchanges (e.g. separate or combined individual Exchanges and SHOP Exchanges; regional or interstate Exchanges; subsidiary Exchanges, State agency versus nonprofit entity)? What are the pros and cons of these various options?

4. What kinds of factors are likely to affect States' resource needs related to establishing Exchanges?
    a. What is the estimated range of costs that States are likely to incur during the upcoming year (e.g., calendar 2010 through calendar 2011) for each of the major categories of Exchange activities? Which of these expenses are fixed costs, and which costs are variable?
    b. To what extent do States have existing resources that could be leveraged as a starting point for Exchange operations (e.g. existing information technology (IT) systems, toll-free hotlines, websites, business processes, etc.)?.
    c. For what kinds of activities are States likely to seek funding using the Exchange establishment and planning grants?

5. What kinds of questions are States likely to receive during the initial planning and start-up phase of establishing Exchanges? How can HHS provide technical assistance, and in what forms, in helping States to answer these questions?

2. Implementation Timeframes and Considerations

1. What are the key implementation tasks that need to be accomplished to meet Exchange formation deadlines and what is the timing for such tasks? What kinds of business functions will need to be operational before January 1, 2014, and how soon will they need to be operational?

2. What kinds of guidance or information would be helpful to States, plans, employers, consumers, and other groups or sectors as they begin the planning process?

3. What potential criteria could be considered in determining whether an electing State is making sufficient progress in establishing an Exchange and implementing the insurance market reforms in Subtitles A and C of Title I of the Affordable Care Act? What are important milestones for States to show they are making steady and sufficient progress to implement reforms by the statutory deadlines?

4. What other terms or provisions require additional clarification to facilitate implementation and compliance? What specific clarifications would be helpful?

3. State Exchange Operations

1. What are some of the major considerations for States in planning for and establishing Exchanges?

2. For which aspects of Exchange operations or Exchange standards would uniformity be preferable? For which aspects of Exchange operations or Exchange standards is State flexibility likely to be particularly important?

3. What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, (etc.), to ensure adequate accounting and tracking of spending, provide transparency to Exchange functions, and facilitate financial audits? What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new standalone Exchange IT systems?

4. What are the tradeoffs for States to utilize a Federal IT solution for operating their Exchanges, as compared to building their own unique systems to conform to the current State environment? For what kinds of functions would it make more sense for States to build their own systems, or modify existing systems?

5. What are considerations for States as they develop web portals for the Exchanges?

6. What factors should Exchanges consider in reviewing justifications for premium increases from insurers seeking certification as QHPs? How will States leverage/coordinate the work funded by the rate review grants to inform the decisions about which plans will be certified by QHPs?

7. To what extent are Territories likely to elect to establish their own Exchanges? What specific issues apply to establishing Exchanges in the Territories?

8. What specific planning steps should the Exchanges undertake to ensure that they are accessible and available to individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

9. What factors should the Secretary consider in determining what constitutes as wasteful spending (as outlined in Section 1311 (d)(5)(B))?

4. Qualified Health Plans (QHPs)

1. What are some of the major considerations involved in certifying QHPs under the Exchanges, and how do those considerations differ in the context of individual and SHOP State Exchanges, subsidiary Exchanges, regional or interstate Exchanges, or an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange?

2. What factors should be considered in developing the Section 1311(c) certification criteria? To what extent do States currently have similar requirements or standards for plans in the individual and group markets?

    a. What issues need to be considered in establishing appropriate standards for ensuring a sufficient choice of providers and providing information on the availability of providers?
    b. What issues need to be considered in establishing appropriate minimum standards for marketing of QHPs and enforcement of those standards? What are appropriate Federal and State roles in marketing oversight?

3. What factors are needed to facilitate participation of a sufficient mix of QHPs in the Exchanges to meet the needs of consumers?
    a. What timeframes and key milestones will be most important in assessing plans' participation in Exchanges?
    b. What kinds of factors are likely to encourage or discourage competition among plans in the Exchanges based on price, quality, value, and other factors?

4. What health plan standards and bidding processes would help to facilitate getting the best value for consumers and taxpayers?

5. What factors are important in establishing minimum requirements for the actuarial value/level of coverage?

6. What factors, bidding requirements, and review/selection practices are likely to facilitate the participation of multiple plans in Exchanges? To what extent should the Exchanges accept all plans that meet minimum standards or select and negotiate with plans?

7. What are some important considerations related to establishing the program to offer loans or grants to foster the promotion of qualified nonprofit health plans under CO-OP plans? How prevalent are these organizations today? What is the likely demand for these loans and grants? What kinds of guidance are they likely to need from HHS and what legislative or regulatory changes are they likely to need from States?

8. Are there any special factors that are important for consideration in establishing standards for the participation of multi-State plans in Exchanges?

9. To what extent are States considering setting up State Basic Health Plans under Section 1331 of the Act?

5. Quality

1. What factors are most important for consideration in establishing standards for a plan rating system?
    a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?
    b. Are the measures and standards that are being used to establish ratings for health plans in the Medicare Advantage program appropriate for rating QHPs in the Exchanges? Are there other State Medicaid or commercial models that could be considered?
    c. How much flexibility is desirable with respect to establishing State-specific thresholds or quality requirements above the minimum Federal thresholds or quality requirements?

2. What are some minimum standards or other factors that could be considered with respect to establishing quality measurement and improvement thresholds or quality requirements that should be met by QHPs? What other strategies, including payment structures, could be used by plans to improve the practices of plan providers?

6. An Exchange for Non-Electing States

1. How can the Federal government best work to implement an Exchange in States that do not elect to establish or are unable to establish their own Exchanges?

2. Are there considerations for an Exchange operated by the Federal government on behalf of States that do not elect to establish an Exchange that would be different from the State-run Exchanges?

7. Enrollment and Eligibility

1. What are the advantages and issues associated with various options for setting the duration of the open enrollment period for Exchanges for the first year and subsequent years? What factors are important for developing criteria for special enrollment periods?

2. What are some of the key considerations associated with conducting online enrollment?

3. How can eligibility and enrollment be effectively coordinated between Medicaid, CHIP, and Exchanges? How could eligibility systems be designed or adapted to accomplish this? What steps can be taken to ease consumer navigation between the programs and ease administrative burden? What are the key considerations related to States using Exchange or Medicaid / CHIP application information to determine eligibility for all three programs?

4. What kinds of data linkages do State Medicaid and CHIP agencies currently have with other Federal and State agencies and data sources? How can the implementation of Exchanges help to streamline these processes for States, and how can these linkages be leveraged to support Exchange operations?

5. How do States or other stakeholders envision facilitating the requirements of Section 1411 related to verification with Federal agencies of eligibility for enrollment through an Exchange?

6. What are the verification and data sharing functions that States are capable of performing to facilitate the determination of Exchange eligibility and enrollment?

7. What considerations should be taken into account in establishing procedures for payment of the cost-sharing reductions to health plans?

8. Outreach

1. What kinds of consumer enrollment, outreach, and educational activities are States and other entities likely to conduct relating to Exchanges, insurance market reforms, premium tax credits and cost-sharing reductions, available plan choices, etc., and what Federal resources or technical assistance are likely to be beneficial?

2. What resources are needed for Navigator programs? To what extent do States currently have programs in place that can be adapted to serve as patient Navigators?

3. What kinds of outreach strategies are likely to be most successful in enrolling individuals who are eligible for tax credits and cost-sharing reductions to purchase coverage through an Exchange, and retaining these individuals? How can these outreach efforts be coordinated with efforts for other public programs?

9. Rating Areas

1. To what extent do States currently utilize established premium rating areas? What are the typical geographical boundaries of these premium rating areas (e.g., Statewide, regional, county, etc.)? What are the pros and cons associated with interstate, statewide, and sub-State premium rating areas? What insurance markets are typically required to utilize these premium rating areas?

2. To the extent that States utilize premium rating areas, how are they established? What kinds of criteria do States and other entities typically consider when determining the adequacy of premium rating areas? What other criteria could be considered?

10. Consumer Experience

1. What kinds of design features can help consumers obtain coverage through the Exchange? What information are consumers likely to find useful from Exchanges in making plan selections? Which kinds of enrollment venues are likely to be most helpful in facilitating individual enrollment in Exchanges and QHPs?

2. What kinds of information are likely to be most useful to consumers as they determine whether to enroll in an Exchange and which plans to select (within or outside of an Exchange)? What are some best practices in conveying information to consumers relating to health insurance, plan comparisons, and eligibility for premium tax credits, or eligibility for other public health insurance programs (e.g., Medicaid)? What types of efforts could be taken to reach individuals from diverse cultural origins and those with low literacy, disabilities, and limited English proficiency?

3. What are best practices in implementing consumer protections standards?

4. Given that consumer complaints can be an important source of information in identifying compliance issues, what are the pros and cons of various options for collecting and reporting Exchange-related complaints (e.g., collecting complaints at the Federal level, versus at the State or Exchange level)?

11. Employer Participation

1. What Exchange design features are likely to be most important for employer participation, including the participation of large employers in the future? What are some relevant best practices?

2. What factors are important for consideration in determining the employer size limit (e.g., 50 versus 100) for participation in a given State's Exchange?

3. What considerations are important in facilitating coordination between employers and Exchanges? What key issues will require collaboration?

4. What other issues are there of interest to employers with respect to their participation in Exhchanges?

12. Risk Adjustment, Reinsurance, and Risk Corridors

1. To what extent do States and other entities currently risk-adjust payments for health insurance coverage in order to counter adverse selection? In what markets (e.g., Medicaid, CHIP, government employee plans, etc.) are these risk adjustment activities currently performed? To the extent that risk adjustment is or has been used, what methods have been utilized, and what are the pros and cons of such methods?

2. To what extent do States currently collect demographic and other information, such as health status, claims history, or medical conditions under treatment on enrollees in the individual and small group markets that could be used for risk adjustment? What kinds of resources and authorities would States need in order to collect information for risk adjustment of plans offered inside and outside of the Exchanges?

3. What issues are States likely to consider in carrying out risk adjustment for health plans inside and outside of the Exchanges? What kinds of technical assistance might be useful to States and QHPs?

4. What are some of the major administrative options for carrying out risk adjustment? What kinds of entities could potentially conduct risk adjustment or collect and distribute funds for risk adjustment? What are some of the options relating to the timing of payments, and what are the pros and cons of these options?

5. To what extent do States currently offer reinsurance in the health insurance arena (e.g. Medicaid, State employee plans, etc.) or in other arenas? How is that reinsurance typically structured in terms of contributions, coverage levels, and eligibility? How much is typically taken in and paid out? Is the reinsurance fund capped in any way?

6. What kinds of non-profit entities currently exist in the marketplace that could potentially fulfill the role of an “applicable reinsurance entity” as defined in the Act?

7. What methods are typically used to determine which individuals are deemed high-risk or high cost for the purposes of reinsurance?

8. What challenges are typically used to determine which individuals are deemed high-risk or high cost for the purposes of reinsurance?

9. How do other programs (e.g., Medicaid) use risk corridors to share profits and losses with health plans or other entities? How are the corridors defined and monitored under these programs? What mechanisms are used to collect and disburse payments?

10. Are there non-Federal instances in which reinsurance and/or risk corridors and/or risk adjustment were used together? What kinds of special considerations are important when implementing multiple risk selection mitigation strategies at once?

13. Comments Regarding Economic Analysis, Paperwork Reduction Act, and Regulatory Flexibility Act

1. What policies, procedures, or practices of plans, employers and States may be impacted by the Exchange-related provisions in Title I of the Affordable Care Act?
    a. What direct of indirect costs and benefits would result?
    b. Which stakeholders will be affected by such benefits and costs?
    c. Are these impacts likely to vary by insurance market, plan type, or geographic area?

2. Are there unique effects for small entities subject to the Exchange-related provisions in Title I of the Affordable Care Act?

3. Are there unique benefits and costs affecting consumers? How will these consumer benefits be affected by States' Exchange design and flexibilities and the magnitude and substance of provisions mandated by the Act? Please discuss tangible and intangible benefits.

4. Are there paperwork burdens related to the Exchange-related provisions in Title I of the Affordable Care Act, and, if so, what estimated hours and costs are associated with those additional burdens?

14. Comments Regarding Exchange Operations

1. What other considerations related to the operations of Exchanges should be addressed? If your questions related to the operations of Exchanges have not been asked, or you would like to add additional comments, you may do so here.