



Recommendations on Health Insurance Exchange Design

The Patient Protection and Affordable Care Act (ACA) outlines a set of federal requirements for Health Insurance Exchanges (Exchanges), and encourages states to establish a state Exchange or participate in a regional Exchange to implement ACA. Instead of imposing a highly prescriptive regulatory model, it provides flexibility so states can respond to the unique needs and circumstances of their respective populations.

The following paper outlines key issues facing states and Molina's recommendations to guide exchange design decisions in a manner that addresses the unique circumstances of the low-income individuals who will receive health insurance exchange-based subsidies while maximizing the value and expertise offered by health plans and providers that have traditionally served Medicaid and CHIP.

Principles for Health Care Reform

Molina believes that states should give substantial weight to the special circumstances of low-income populations as they design and implement health care reform and health insurance exchanges. Health plans that have traditionally served Medicaid have vast experience in delivering effective health programs and benefit packages for low-income populations that make them uniquely qualified to play a significant role under health reform. States should leverage the success and expertise of such health plans by maximizing their use and availability for this population.

With respect to low-income families and individuals, Molina recommends the following health care reform design principles:

- Individuals receiving subsidized coverage should have access to health plans with experience serving culturally diverse, low-income populations.
- States should recognize the unique social and health care needs of low-income populations and design coverage options that address their special circumstances.
- States should be committed to providing the highest quality of care and adopt coverage approaches that have proven effective for low-income populations.
- Low-income individuals should have access to affordable coverage with the lowest possible premiums and finely tuned cost sharing.
- State health care reform strategies should promote continuity of care, stable coverage, and the same health plan options for family members.
- **States should understand that forcing culturally diverse, low-income populations into largely commercial health insurance exchanges will result in care disruption and higher costs of health care for these populations.**

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Exchange Participation

Managed care

Issue: What flexibility should Medicaid health plans have with respect to participation in the exchange?

Position: Health plans that have traditionally served Medicaid clients should be encouraged but not required to participate in state exchanges. More specifically, health plans that have been awarded Medicaid contracts and otherwise meet federal exchange plan requirements should be presumptively approved for exchange participation.

Rationale: Health plans whose roots are in Medicaid have tremendous experience in serving low-income populations, and so are well-equipped to serve state exchange participants, the majority of whom will be low- or moderate-income. While such health plans bring unique advantages to the exchange, some community-based plans may perceive capacity or mission-based constraints that are inconsistent with exchange participation; in these circumstances such a plan should not be required to participate. However, an established health plan in Medicaid that has demonstrated commitment to serving low-income populations and meets federal essential requirements for exchange participation should be approved for participation.

Qualified health plans

Issue: What approach should States take in certifying qualified health plans (QHPs)?

Position: States should be selective in certifying QHPs to ensure that QHPs meet high quality standards and meet the state's strategic objectives. States should require QHPs to be accredited by the National Committee for Quality Assurance (NCQA). States should prioritize selecting exchange plans with experience and demonstrated commitment to serving low-income populations and communities.

Rationale: State exchanges need to ensure that consumers have access to quality, affordable health insurance options. To best meet the needs of low and moderate income consumers, states should establish requirements that QHPs meet high quality standards, including NCQA accreditation, at affordable prices. In the context of the process of certifying QHPs, developing mechanisms to ensure that plans with experience and commitment to community-based care is essential to adequately serving exchange consumers. States have a responsibility to their populations to ensure that any plan they certify as a QHP meets high quality standards. This is a unique opportunity for states to achieve meaningful progress towards a quality-centered, value-oriented health care system.

Benefit packages

Issue: What flexibility should QHPs have in designing benefit packages?

Position: QHPs should offer a standardized set of benefit packages through the exchange. States should seek the input of QHPs in the design of the standardized benefits.

Rationale: For many exchange participants, and especially lower-income participants, standardization of benefits will simplify the process and lead to more effective choices. In addition, adverse selection will be easier to combat with more standardized benefit packages. Federal standards for QHP benefits include essential health services but otherwise are standardized only by being defined by actuarial value, which is flexible and subject to interpretation. States should provide clearer direction to plans about benefit packages required for each tier of coverage.

Brokers

Issue: What role should agents and brokers have in the exchange?

Position: State exchanges need to ensure that brokers don't steer healthy people to plans outside of the exchange, or the exchange will suffer and become financially unstable. There should be total transparency as to broker and agent fees or commissions included or added onto rates so consumers can make an informed choice as to their use.

Rationale: States need to prevent adverse selection within the exchange. Risk adjustment mechanisms are imperfect and cannot completely compensate for differential risk. The exchange design must ensure that steering of healthy individuals outside the exchange or less healthy into the exchange does not occur.

Administration and Governance

Publicly administered

Issue: What type of entity should administer an exchange?

Position: The exchange should be a public entity. Where feasible, the state Medicaid agency should administer the exchange in collaboration with state insurance regulators.

Rationale: The work of an exchange to qualify health plans and to coordinate between federally-funded subsidized insurance and state Medicaid and CHIP programs is more appropriate for a public entity, not an independent non-profit. State Medicaid agencies have a deep understanding of the needs of a low-income population and can help to manage the expected high level of churn among programs. Further, most state Medicaid agencies have established procurement practices for managed care plans.

Governing board

Issue: Who should be represented on the governing board?

Position: Regardless of the administering entity, a governing board should include mandatory participation by state Medicaid agency leadership.

Rationale: An exchange will not succeed unless it is closely coordinated with the Medicaid program. Medicaid agency participation in exchange governance will ensure that design and implementation decisions are integrated with Medicaid policy, and will provide a mechanism to represent the viewpoint of low-income individuals who make up a large segment of the exchange population.

Advisory board

Issue: Who should be represented on the advisory board?

Position: A broad cross-section of industry and consumer stakeholder groups should be represented on the advisory board. Consumer stakeholder groups should include individuals representing low-income individuals and Medicaid beneficiaries.

Rationale: Health insurance exchanges are new endeavors and will benefit from the advice of a range of industry experts to help shape design decisions. It is essential that this advisory input include groups representing low-income individuals given the importance of the exchange to new health insurance options for such individuals.

Structure

Geographic scope

Issue: What geographic areas should exchanges cover?

Position: Exchanges should be statewide, with allowances for insurers to serve regional subareas (e.g. certain counties), rather than the entire state. In a state that implements a regional approach, regions should be defined to conform to any existing regional structure for Medicaid.

Rationale: In most states a statewide exchange will be a more cost effective solution than regional exchanges, due to economies of scale. However, allowing QHPs to serve a subarea of the state will maximize consumer choice and allow the exchange to benefit from the participation of insurers that do not have a statewide presence.

Individual and small group market

Issue: How should states structure exchanges with respect to the individual and small group markets?

Position: Exchanges should be separate for the individual and small group markets.

Rationale: Although there may be some administrative justifications for combining individual and small-group exchanges, for many important issues there will be very different considerations for the two exchanges. In particular, marketing and outreach for individuals is very different than for groups, and existing distribution channels and networks in group markets may not be well-positioned to adapt to serve low-income individuals who will purchase individually through the exchange.

Large group employers

Issue: Should large employers be allowed to participate in the exchange in 2017?

Position: States should not allow large employers to participate in the exchange in 2017.

Rationale: The long-term goal of the exchange should be a stable risk pool and insurance that meets the needs of consumers that access exchange-based subsidies. Individuals and small groups are the markets that need the assistance of the exchange and the states should concentrate on making those markets work efficiently and in close coordination with the state Medicaid program.

Functions, Responsibilities, and Standards

Eligibility determination

Issue: What role should exchanges play in eligibility determinations?

Position: State exchanges will be required to embrace the “no wrong door” approach to eligibility determinations and to ensure this work is integrated smoothly with the state Medicaid agency eligibility processes. To the extent feasible, state exchanges should contract with state Medicaid agencies to ensure an efficient and integrated approach to eligibility. Exchanges should have an annual eligibility determination and open enrollment process, and state Medicaid agencies should adopt similar rules to the extent allowed by federal regulations.

Rationale: Ensuring that eligibility policy is coordinated with the state Medicaid agency is another reason for ensuring Medicaid leadership for the exchange. To minimize “churn,” the eligibility process both for exchange subsidies and Medicaid should be annual and should result in continuous 12-month eligibility.

Plan selection – Market organizer

Issue: What role should exchanges play in selecting qualified health plans?

Position: Exchanges should be “selective contractors” and be selective in certifying QHPs.

Rationale: As discussed above, state exchanges need to ensure that consumers have access to quality, affordable health insurance options. To best meet the needs of low and moderate income consumers, states should establish requirements that QHPs meet high quality standards at affordable prices. They should encourage competition amongst Medicaid and commercial carriers and only select those who meet these high standards, including NCQA accreditation.

Premium Administration

Premiums

Issue: What role should exchanges play in collecting premiums?

Position: State exchanges, rather than health plans, should collect premiums and interface with health plans providing coverage to individuals who qualify for premium and other cost-sharing subsidies.

Rationale: It is administratively simpler to consolidate subsidy calculation and premium collection responsibilities under one entity, rather than having insurers individually collect and report on premiums.

Adverse Selection

Issue: How can exchanges protect against adverse selection?

Position: It is critical for state exchanges to protect themselves from adverse selection through appropriate regulations and use of robust risk adjustment tools. Most importantly, insurers operating inside and outside of the exchange must be operating under the same rules and standards. States should monitor marketing activities of insurers closely to prevent selective marketing of non-exchange plans that could cause adverse selection.

Rationale: Adverse selection will make participation in the exchange less attractive to insurers, which would result in fewer choices and higher prices for consumers. Any variance in rules between the exchange market and the outside market may be exploited by plans seeking to acquire low-risk members.

Conclusion

State decisions about coverage options will have major implications on the success of the state's health insurance market. As states move forward with legislative and regulatory activity surrounding the development of Basic Health Programs and health insurance exchanges, Molina will be a voice for the low-income population. With over 30 years of experience providing quality health care to those who depend on government assistance, we are uniquely positioned to provide guidance and operational support to states as they prepare for the largest expansion of the nation's health care system in over four decades.