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Health Benefit Exchange Planning Services

Narrative Summary

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- Department of Human Services, including the Medicaid Department and the Department of Health Special Populations
- Information Technology Department
- Members of the North Dakota State Senate and House of Representatives

Stakeholder contributions were included from representatives of consumer groups, small businesses, health plans, agents/brokers, and trade groups.

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Section 1: Project Overview

This initial report provides a great deal of research, data, and reference information that can be used as needed for North Dakota to determine the best path for the state to meet its obligations under the Patient Protection and Affordable Care Act (ACA) with regard to a Health Benefit Exchange (HBE).

Performing due diligence could be a useful step to provide the intelligence needed for the next level of business and fulfillment decisions. This step would provide the content necessary for more precise estimates of cost, time, resources, and exchange take-up rates that would be needed to build and maintain a sustainable HBE.

Summary of Deliverables Provided

1. Research Report distributed in increments throughout the project, on September 30, 2011, October 18, 2011, and October 31, 2011;
2. Comprehensive Report that includes a summary of all content provided to date;
3. Demographic Model that estimates HBE take-up rates and allows for flexibility to run a range of scenarios; and a
4. Startup and Operating model that benchmarks costs by core area against other states.

Project Background

The ACA as passed in March 2010, introduces many changes to the health landscape¹. Among these is the creation for Health Insurance Exchanges or also known as Health Benefit Exchanges (the term “HBE” will be used throughout the document), that are designed to create new competitive private health insurance markets. Federal law defines important aspects of an exchange’s role and authority but leaves considerable flexibility—and responsibility—to the states. One of the options available to states is to forego entirely the option of developing an exchange at the state level, and instead choose to connect with a federally operated exchange.

The exchanges are intended to provide a competitive marketplace for individuals and small employers seeking coverage. Purchasers of insurance are able to compare and select from a range of competing qualified health plan (QHP) products through a website, or in consultation with an agent, broker, advisor, or navigator.

The exchange will also be responsible for serving as a no-wrong-door entry point for those seeking insurance, depending upon their income. As such, the exchange will determine eligibility for federal subsidies and for coordinating the enrollment process with Medicaid and other government-sponsored coverage programs. The exchanges will be the sole means by which eligible individual purchasers and small businesses will be able to access federal subsidies to assist in paying for coverage.

¹ H.R.3590: *The Patient Protection and Affordable Care Act*. 111th Cong., 2nd Sess. (2010).

The ACA requires that the federal Department of Health and Human Services (HHS) define an essential benefits package. The scope of the benefits in this essential package is to equal the scope of benefits provided under a “typical employer plan,” which remains to be determined by HHS.

The ACA also requires that exchanges offer a choice of plans to be available at five levels of comprehensiveness, four of which will be based on actuarial value of the essential benefits package. Actuarial value is calculated as the average share of covered health expenses reimbursed by the health plan, for a typical population. These levels include:

- Platinum: Coverage at 90% of actuarial value
- Gold: Coverage at 80% of actuarial value
- Silver: Coverage at 70% of actuarial value
- Bronze: Coverage at 60% of actuarial value
- Catastrophic: A high-deductible plan available to people under age 30 and to people who qualify for an exemption (because other coverage is not affordable) from the ACA mandate to obtain coverage.

The Center for Consumer Information and Insurance Oversight (CCIIO) made available planning grants for one million dollars to fund states’ initial exploration of the unique requirements of an HBE for their state. This preliminary funding was intended to fund the research and planning to design this new marketplace and to establish how their exchanges will be operated and governed².

Forty-nine states, plus the District of Columbia, applied for these grants, including North Dakota³.

As authorized by HB1126, in August, 2011, the North Dakota Insurance Department (NDID) issued a Request for Proposal (RFP) for a contractor to “research several issues regarding exchange planning in North Dakota, taking into consideration the unique characteristics of North Dakota’s insurance market.” This project is intended to provide data, analysis, and intelligence that can assist North Dakota with developing an HBE solution that fits the state’s unique needs.

Project Scope

The project began in September 2011, with a goal of providing a summary of key findings by the interim legislative session beginning on November 7, 2011. HTMS provided a broad survey of content within this condensed timeline, including:

- Demographic modeling to estimate participation in the HBE;

² “Affordable Insurance Exchanges”. The Center for Consumer Information and Insurance Oversight.
<http://ccio.cms.gov/programs/exchanges/index.html>

³ “Creating a New Competitive Marketplace: Health Insurance Exchange Establishment Grants Awards List”.
www.healthcare.gov.

- Start-up and operational cost estimates, benchmarked against other states;
- Demographic research on the population of North Dakota;
- Insurance market analysis summarizing the nature of the marketplace and how it compares with other states;
- A round of stakeholder engagements, connecting with constituent groups, including health plans, providers, consumer groups, and small businesses (this effort is not to be confused with stakeholder outreach conducted by a different firm);
- Context, pros, and cons on a range of governance, business, and operational issues related to the HBE; and,
- Additional market questions as defined in the RFP.

Detailed findings on all of these items were submitted in a PowerPoint presentation and are discussed in narrative form in this document.

Scope Limitations

Timeline Work was performed in a compressed time frame so as to maximize the level of content available for a special session of the legislature scheduled for November 2011.

Limited modeling As defined in the project budget and scope, intensive actuarial modeling was not performed. Instead, HTMS' project team performed high level demographic and financial modeling, using estimates and assumptions from national and other state models. In all cases, these external benchmarks were interpreted and adjusted as to be relevant to the context of North Dakota.

Health Benefit Exchange focus While there are many provisions of healthcare reform that will impact the healthcare marketplace in which exchanges will be operating, HTMS only took into account those provisions which directly impact an HBE.

Rates It is important to note that there will be many changes in the marketplace taking place at the same time as the development of exchanges. For instance, Adjusted Community Rating (ACR) requirements impose rating rules that include restriction of age rating to a 3:1 ratio, removal of health status underwriting, and the elimination of gender rating, each of which has the likelihood of increasing premium rates as a whole. These composite rate increases could be accentuated by any expansion in the breadth of mandated benefits (precise definition around Essential Health Benefits is due to be released in 2012). It is important to note that these described increases refer to the market as a whole and could vary between individuals and small groups. Because adjustments will be simultaneous to the launch of exchanges, rate increases could be associated with exchanges from a public perspective.

Section 2: Research Findings

2.1 North Dakota Demographics

The following section summarizes key demographic characteristics of North Dakota. In addition to describing North Dakota's population and implications for the development of North Dakota's Exchange, many of these figures were utilized as inputs in the development of the demographic model, described in a separate section. There were multiple sources of data available for many of the figures presented here. In each case, an attempt was made to present the data that is most relevant to the goals and boundaries of this project.

Highlights and Key Findings

Population: As of 2010, the state of North Dakota has a population of 672,591 people. By way of comparison, the city of Brooklyn, one of the five boroughs that combine to make New York, has a population of 2.6 million people, or 3.85 times more people than the state of North Dakota. This factor influences the size of the population that the cost of an exchange can be distributed across, and indicates why there may be no best exchange solution that fits all states.

Medicaid: North Dakota has the lowest Medicaid enrollment in the country, estimated at 69,400 in 2010. Yet, due to changes in the Medicaid rules as a result of the ACA, North Dakota is one of the states expecting a higher growth rate of 44% by 2019, compared with a national estimate of 27.4% for this same period.

Uninsured: According to the 2010 U.S. Census, approximately 11% of the population, or 70,800 state residents, are uninsured. Of these people, 52,100 are under 400% of poverty level, and are therefore eligible for subsidies through the exchange.

Representation: Although Native Americans reflect 5.4% of the state's population they represent 18% of the state's uninsured. As such, addressing the uninsured in the state may require understanding some of the particular barriers to coverage faced by this population.

General Population Demographics

According to the latest census data, there are 672,591⁴ residents of North Dakota. The population grew 4.7%⁵, from 2000 to 2010, and many believe that rate will increase over the next ten years due to growth in the oil and gas industry. This makes North Dakota among the smallest states from a population perspective; North Dakota's requirements for an exchange could be quite different from larger, more populous states. A smaller

⁴ US Census Bureau, 2010 Census

⁵ US Census Bureau, 2010 Census and Census 2000

marketplace may be able to sustain only a smaller number of insurers. In addition, the cost of a state-level exchange is distributed across fewer individuals.

North Dakota's population tends to be similarly aged to the rest of the country. 425,243⁶ are aged 18-64. North Dakota has the same percentage of people aged 18-64 as the nation does, at 63%⁷. Many states have a similar percentage of people in this age range; for example, Pennsylvania, South Dakota, California and New York all have between 59-63% of their populations aged 18-64⁸.

North Dakota tends to have a highly educated population. Twenty eight percent of the population age 25 and over has a bachelor's degree or higher in North Dakota, while only 19% of all US citizens do⁹.

People in North Dakota are more likely to have a job than those in other parts of the country. The median household income is \$48,670¹⁰ and the unemployment rate among people ages 20-64 in North Dakota was 3.2% in 2010¹¹. North Dakota's unemployment rate is significantly smaller than many other states and the national average. In 2010, the US had an unemployment rate of 9.6%, California had a rate of 12.5%, New York's unemployment was 8.4% and South Dakota had a 4.6% rate¹².

North Dakota's population on the whole is wealthier than that of the United States as a whole. Only 14% of North Dakota's population is under federal poverty level (FPL), compared to 20% of the population as a whole. North Dakotans are not only less likely to be poor, but they are also more likely to earn at higher income ranges. 37% of the North Dakota population compared to 32% of the US population have incomes greater than 400% of FPL (See Table 2.1).¹³

⁶ US Census Bureau, 2010 Census

⁷ US Census Bureau, 2010 Census

⁸ US Census Bureau, 2010 Census

⁹ US Census Bureau, 2010 American Community

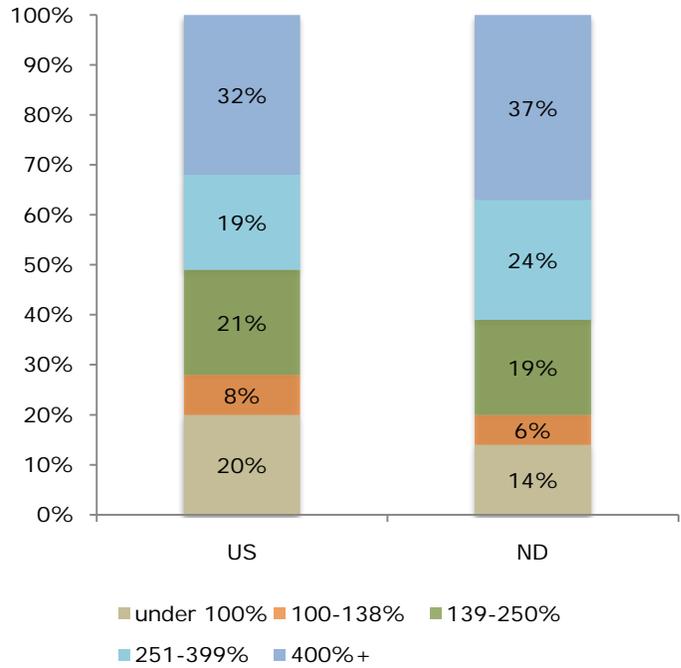
¹⁰ US Census Bureau, 2010 American Community Survey

¹¹ US Census Bureau, 2010 American Community Survey

¹² The Kaiser Family Foundation, statehealthfacts.org.

¹³ The Kaiser Family Foundation, statehealthfacts.org. Data source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements)

Table 2.1
US & North Dakota Population by Federal Poverty Level



While there is some county-specific variability in **language**, most North Dakotans speak English well (98.7% for North Dakotans vs. 91.3% of the population as a whole – See Table 2.2.)¹⁴ Although explicit language translation requirements have not been defined for the exchanges, many industry experts are referencing CMS standards, which require translation for regions where at least 10% of the population primarily speak another language. These figures suggest that the language support services needed for North Dakota could be less onerous than other states with more heterogeneous populations.

¹⁴ US Census Bureau, 2010 American Community Survey

Table 2.2 % North Dakota Population >5 yrs speaking English "very well"	
North Dakota	98.7%
California	80.2%
Texas	85.6%
New York	86.5%
United States	91.3%

As indicated in Table 2.3 -- and similar to the rest of the country -- the majority of North Dakotans have **Internet access** and that figure is on the rise¹⁵. While a majority of the North Dakota population could have access to an online exchange, these figures also suggest that other venues will be needed to ensure access for all eligible customers.

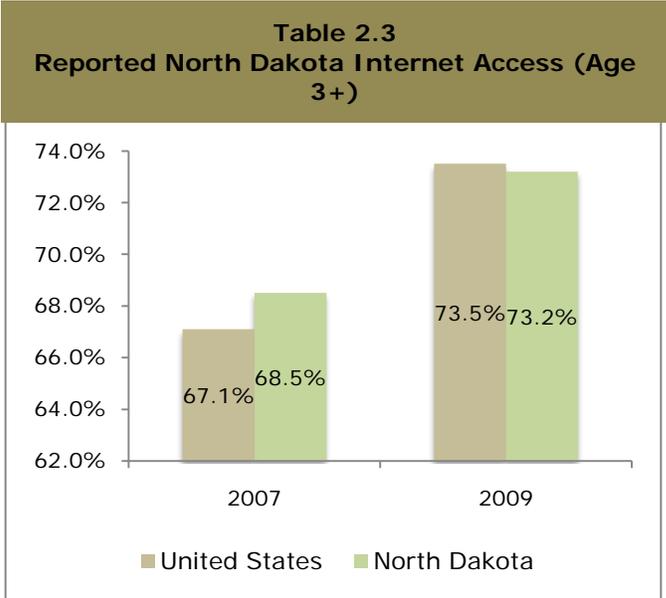


Figure 2.1 summarizes the current sources of **health insurance coverage** in North Dakota^{16,17} which shows over half of the North Dakota population is covered by employer-based insurance but employer-based insurance is declining with a weak economy, hastening

¹⁵ US Census Bureau, Current Population Survey, October 2009

¹⁶ The Kaiser Family Foundation, statehealthfacts.org.

¹⁷ Note: Percentages may not correspond precisely with enrollment figures presented here or in demographic modeling section. For actual enrollment figures, alternative sources were sometimes used to ensure most accurate figures.

an overall trend. North Dakota experienced a 3% decline in employer-based insurance from 2007 to 2009 among non-elderly adults¹⁸. Small firms (fewer than 50 employees) make up 53%¹⁹ of North Dakota firms and are less likely to offer health insurance than larger ones (39% compared to 96%)²⁰. Furthermore, some employees are not eligible or cannot afford employer-based coverage. Nationally, among firms that offer coverage, 79%²¹ of employees are eligible. The average per member per month premium in North Dakota is \$296.13 for small employers and is \$305.64 for large employers²². Employer contributions of 81% of a single premium in North Dakota are slightly higher the US average of 79%²³.

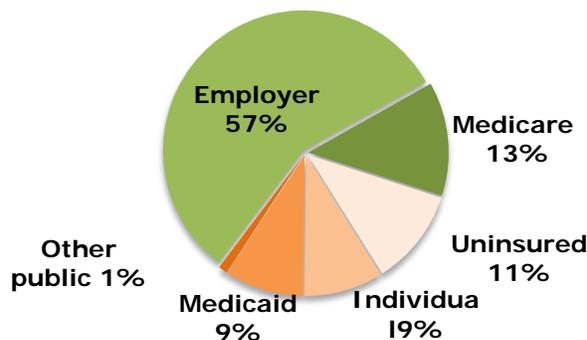


Fig 2.1: Current Sources of Health Insurance Coverage in North Dakota

Those not covered through employer-based insurance may encounter barriers to obtaining coverage elsewhere. For example, Medicaid, which covers 9% of the North Dakota population, covers four main groups of non-elderly, low-income people, children, their parents, pregnant women, and people with disabilities. However, while all children from low income families are eligible for Medicaid, many parents and adults without dependent children are ineligible for Medicaid.²⁴ The current Medicaid population in North Dakota is approximately 65,000²⁵. National figures estimate that the percent eligible but not enrolled is about 32%²⁶. These eligibility rules are expected to change in 2014 with the onset of the

¹⁸ The Kaiser Family Foundation, *statehealthfacts.org*.

¹⁹ North Dakota Job Service Employment & Wages, 2011. *Business Establishment Class Sizes*

²⁰ AHIP, 2011 Health Insurance, Overview and Economic Impact in the States and The Kaiser Family Foundation, *statehealthfacts.org*. Data source: Agency for Healthcare Research and Quality, Center for Cost and Financing Studies. 1010 Medical Expenditure Panel Survey - Insurance Component. Table IIA.1.

²¹ The Kaiser Family Foundation, "The Uninsured: A Primer," October 2011

²² North Dakota Department of Insurance

²³ Source: KFF State Health Facts available at available at:

<http://www.statehealthfacts.org/profileind.jsp?rgn=36&ind=270&cat=5>

²⁴ Medicaid: Who Is Eligible? North Dakota Department of Human Services.

<http://www.nd.gov/dhs/services/medicalserv/medicaid/eligible.html>

²⁵ The Kaiser Family Foundation, "The Uninsured: A Primer," October 2011; North Dakota Department of Insurance

²⁶ Medicaid Expansion--The Soft Underbelly of Health Care Reform? *The New England journal of Medicine*, November 25, 2010

Modified Adjusted Gross Income (MAGI) test as a simplified and expanded means to determine eligibility²⁷.

While North Dakota has the lowest Medicaid enrollment among states, partially because of the limited eligibility rules, shifting to MAGI-based eligibility will lead the state to have one of the highest percent increases in enrollment under the ACA as seen in Table 2.4 ²⁸:

1. Nevada	61.7%	6. Colorado	47.7%
2. Oregon	60.6%	7. Texas	45.5%
3. Utah	56.1%	8. North Dakota	44.0%
4. Montana	54.5%	9. Kansas	42.0%
5. Oklahoma	51.2%	10. Virginia	41.8%

Medicaid enrollees will interact with the exchange through the eligibility and referral process only. However, the impact of the exchange to the Medicaid program will be broader. The Medicaid Program will need to update its eligibility system so that it is able to technically integrate with the exchange.²⁹ The exchange will also be connecting with the same payer, provider, and vendor community that is simultaneously scaling to absorb a significant new population.

Approximately nine percent of the North Dakota population is covered through the individual market but there are also obstacles to non-group coverage. The average per member per month premium for the North Dakota individual market is \$219.12³⁰. Although this number is lower than average premiums in many other states, cost still represents a significant barrier to individuals accessing coverage. Pre-existing conditions may result in either a higher premium or the policy may exclude coverage for specific conditions. Nationally, 29% of individuals ages 60-64 who applied for non-group insurance were denied coverage based on their health status³¹. Individuals without coverage may also lack the information about where to purchase coverage and an understanding of how health insurance works.

²⁷ While the income calculation for Medicaid eligibility currently differs among the states, the ACA issues a standard calculation of income, known as the Modified Adjusted Gross Income (MAGI), to be implemented across the country.

²⁸ The Kaiser Family Foundation, *statehealthfacts.org*. Data source: *Medicaid Coverage and Spending in Health Reform: National and State-By-State Results for Adults at or Below 133% FPL, the Urban Institute, May 2010*. Available at: <http://www.kff.org/healthreform/8076.cfm>.

²⁹ *Legislative Management (Health Care Reform Review Committee)*. (62nd Legislative Assembly of North Dakota, 2011). House Bill NO.1475. Retrieved from <http://legis.nd.gov/assembly/62-2011/special-session/documents/11-0836-01000.pdf>

³⁰ North Dakota Department of Insurance

³¹ The Kaiser Family Foundation, "The Uninsured: A Primer," October 2011; North Dakota Department of Insurance

The uninsured

The uninsured population represents about 11%³² of the North Dakota population and has a different profile than the general population. Table 2.5 compares the uninsured population to the general population on a number of characteristics³³:

Table 2.5: Comparison of North Dakota Uninsured with General Population		
	Uninsured	General Population
Age	84% are nonelderly adults (ages 19-64)	63% are nonelderly adults (ages 19-64)
Gender	59% of nonelderly male; 41% female	50% of total population male; 50% female
Household	18% of adults without dependent children uninsured	11% of total population uninsured
Employment	69% of nonelderly from families with at least one full-time worker; 16% from families with part-time workers	77% of total population from families with at least one full-time workers; 9% from families with part-time workers
Income	32% of nonelderly below 100% federal poverty level; 89% below 400% federal poverty level	14% of total population below 100% federal poverty level; 63% below 400% federal poverty level
Education	51% age 25 and over have no education beyond high school	36% age 25 and over have no education beyond high school
Internet Access (National)	51% of uninsured less than age 65 report use of internet to access health information	69% of insured less than age 65 report use of internet to access health information
Health Status (National)	Uninsured adults are more than twice as likely to report being in fair or poor health as those with private insurance; almost half of uninsured nonelderly adults have a chronic condition	

³² Figures for the uninsured presented here are from the Kaiser Family Foundation. Other data points for the uninsured rate have been presented in various settings. HTMS was unable to find sources for alternative rates for the uninsured, so the KFF figure has been offered here.

³³ The Kaiser Family Foundation, *statehealthfacts.org*. Data source: Urban Institute and Kaiser Commission on Medicaid and the Uninsured estimates based on the Census Bureau's March 2009 and 2010 Current Population Survey (CPS: Annual Social and Economic Supplements); US Census Bureau; US Census Bureau, 2010 American Community Survey 1-Year Estimates; Small Area Health Insurance Estimates; The Kaiser Family Foundation, "The Digital Divide and Access to Health Information Online," April 2011; The Kaiser Family Foundation, "The Uninsured: A Primer," October 2011

Native American population

The Native American population in North Dakota represents a disproportionate share of the uninsured population in North Dakota. While only 5.4% of the overall population, the Native American population represents 18%³⁴ of the uninsured population. This data suggests that North Dakota is among several states that will need to pay particular attention to the needs of the Native American population when identifying interventions to reduce the number of uninsured in the state. Beyond common financial barriers, Native Americans may face additional unique impediments to coverage. Examples of these challenges are presented in the table below:³⁵

Table 2.6: Native American Barriers to Coverage	
Understanding	<ul style="list-style-type: none"> • Lack of awareness of how insurance works • Belief that Indian Health Services (IHS) will provide comprehensive healthcare • Cultural barriers and the belief that insurance could cause harm or illness
Trust	<ul style="list-style-type: none"> • Lack of trust in insurance companies • Lack of trust in government programs
Barriers to Access and Eligibility	<ul style="list-style-type: none"> • Insufficient number of non-IHS providers near Indian population • Medicaid paperwork that is onerous, difficult to obtain, or perceived as intrusive • Medicaid ineligibility due to land holding

³⁴ US Census Bureau, 2010 American Community Survey, single race reported only

³⁵ "Barriers to Obtaining Health Insurance Among Native Americans in New Mexico," January 2006. Commissioned by: New Mexico Human Services Department and Interviews with State Departments.

2.3 Insurance Marketplace:

While all health care is local, and each state has its own health sector, the environment in North Dakota is notably different than the rest of the country in several ways:

Highlights and Key Findings

Market Concentration: The North Dakota marketplace is significantly more concentrated than most other states, with only three states (Alabama, Kentucky, and Iowa) showing greater market share by a single insurer.³⁶

Benefit Design and Premiums: High level analysis of survey data reported from health plans suggests very rich benefit plans on the whole, and yet North Dakota has the lowest small group insurance premiums in the country.³⁷

Other Factors: North Dakota ranks close to the median of states for a range of other factors related to the insurance marketplace, including the number of mandates and the present of large and small employers that offer health insurance to their employees.

Marketplace concentration

North Dakota has a highly concentrated health insurance marketplace. When compared with the individual market in other states, only Alabama, and Iowa have similar concentrations of market share in the top carrier. There are varying studies that suggest some of the challenges that can sometimes be associated with a concentrated health insurance marketplace. For instance, if a single insurer has a dominant market share, they have a great deal of control in determining the reimbursement rates to providers. Carriers with large market share may also have greater control over the development of exchanges, if their role in the market is so great that the exchange would lack sufficient coverage or credibility without their participation. While these subsequent effects have not been evaluated in and may not apply to North Dakota, these risks as presented in other states may be worthy of consideration.

There are a number of sources for data as well as methods for summarizing the concentration in the marketplace. The findings here are based upon insurance coverage as reported by health plans to the North Dakota Insurance Department for the year 2010.

³⁶ KFF State Health Facts, www.statehealthfacts.org

³⁷ HTMS Health Plan Survey Data and "2011 Health Insurance: Overview and Economic Impact in the State", September 2011, AHIP

Figure 2.2: Visual Display of Health Insurance Market Concentration in North Dakota



The degree of market concentration varies among states. About half of the states (24) have a single carrier that represents 40-59% of the marketplace, which represents significant concentration. North Dakota is among five states where this concentration is greater than 80%³⁸.

Table 2.6: Market Concentration	
Market Share of Largest Insurer (Based on Enrollment)	# of States at this Level
>80%	5
>70%	8
>60%	5
>50%	13
>40%	11
>30%	1

Benefit Mandates

There are also a number of methods for calculating state benefit mandates. The differences are due to whether mandates refer specifically to benefit mandates or if they also include provider mandates. Mandates may also be sometimes categorized as a single mandate with multiple parts, or be broken into different individual pieces. It is important to use the same method for defining mandates when comparing across states to ensure an accurate comparison.

³⁸ KFF State Health Facts, www.statehealthfacts.org

Table 2.7: Number of State Mandates³⁹

Mandate Range	# of States	State Detail
13-20	2	ID, AL
21-30	9	HI, MI, UT, DC, IA, MS, OH, SC, SD
31-40	11	DE, AK, AZ, IN, WI, NE, WY, MT, OK, WV, ND
41-50	14	TN, KS, VT, NH, NV, AR, GA, KY, NJ, IL, MA, FL, OR
50+	15	LA, NC, NY, ME, CO, CA, NM, PA, VA, WA, CT, TX, MN, MD, RI

According to the counting methodology used by the Council for Affordable Health Insurance, as presented on the National Council for State Legislators’ website, North Dakota has 34 mandates, which makes it in the middle of the pack when compared with other states.⁴⁰

The number of mandates in a state could be one of many factors to determine how much the essential benefits definition could impact the cost of health insurance. For instance, should the essential benefits package include a significant number of benefit inclusions beyond those benefits required by current state law, this could lead to higher prices. Should the essential benefits package be released with fewer benefit requirements than determined at the state level, it is not likely to be one of the key drivers of premium increases.⁴¹

Health Insurance Plan Design and Premiums

To gather a snapshot of the plan designs in North Dakota, HTMS prepared a brief survey of the plans actively selling insurance in the state. This survey included a range of questions related to the carrier’s current business and planning for exchanges. As part of the survey, health plans were invited to provide detail into the benefit plan design for their business in North Dakota. Several health plans were able to offer this detail, but the survey findings do not include the complete spectrum of coverage in the state. Still, with considerable market share represented, they provide a view into benefit designs often offered in North Dakota.

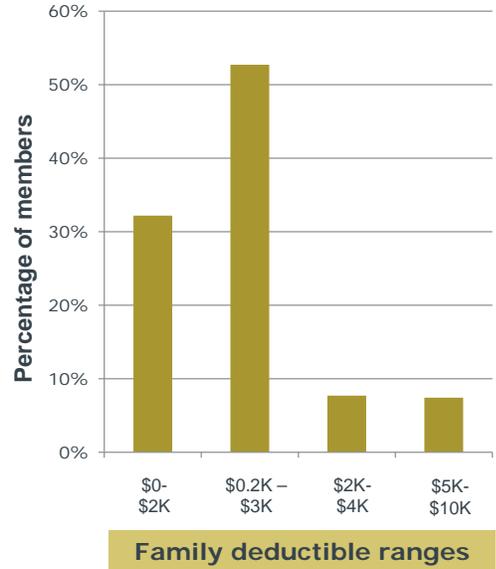
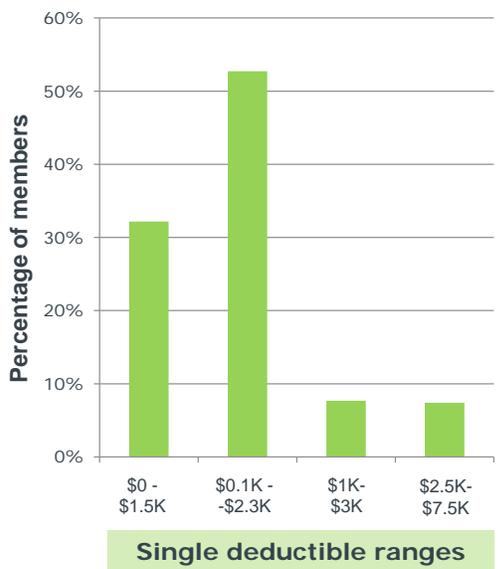
³⁹ Victoria Craig Bunce and JP Wieske, “Health Insurance Mandates in the States 2010,” Council for Affordable Health Insurance, 2010. NCSL Mandated Health Insurance Benefits and State Laws.

⁴⁰ There are different methodologies for counting mandates, depending upon inclusions and grouping. The methodology from this source allows for comparison between states. According to North Dakota’s own method of calculation, the state has 23 mandates. To compare states using this number, the remaining states would mandates would need to be re-calculated using the same methodology.

⁴¹ Beginning 2014, Medicaid plans and qualified health plans offered through the exchanges must begin to cover the defined essential benefits. Plans can no long impose lifetime dollar limits on these services. All plans must phase out annual dollar spending limits for these services by 2014, except for grandfathered individual health insurance policies. The Department of Health and Human Services is responsible for defining the essential health benefits package. Further details available at <http://cciio.cms.gov/resources/regulations/index.html#alw>.

North Dakotans tend to have rich benefit plan designs. Over 80% of North Dakotans are covered by health plans with lower deductibles, and only 7% of those represented here are covered by high-deductible / HSA eligible plans.

Figure 2.3: Deductible Ranges for Health Insurance Products



North Dakotans not only tend to have lower deductibles; they also have low rates of co-insurance. More than 60% of members represented in the survey responses have plans with coinsurance that cover 90-100% of in-network allowed charges after deductibles are met.

Despite these rich benefit plans, North Dakotans also tend to have low health insurance premiums. Among the 36 states reporting small group premiums as part of a 2011 study by the Association of Health Insurance Plans (AHIP), North Dakota had the lowest premiums for both individuals and families.

Table 2.8: The 5 lowest and the 5 highest average cost for small group family premiums⁴²

Low	
North Dakota	\$9,516
Arkansas	\$9,612
Utah	\$10,356
Kentucky	\$10,464
Washington	\$10,476
High	
Massachusetts	\$15,240
Nebraska	\$15,434
New Hampshire	\$16,512
New York	\$17,460
West Virginia	\$17,796

⁴² "2011 Health Insurance: Overview and Economic Impact in the States," September 2011, AHIP

Section 3: Modeling

3.1 Demographic Model

Quantitative analysis can be used to model potential participation in the exchange by various constituents. This type of analysis is most often done through spreadsheet modeling or through the use of micro simulation models.

Micro simulation models are often proposed as the most robust mechanism for making these predictions. Many large think tanks and consulting firms have invested millions of dollars into building complex micro simulation models that take into account numerous variables when modeling the potential impact of health reform in general, and more specifically of exchanges in any given region. These models, especially those that offer modeling trends and assumptions to the public, are valuable resources to the health community and the public in general. They offer a rich view into the different variables and scenarios that could impact the exchange environment. They also provide broad ranges estimates for how these could play out in any given State.

Consistent with HTMS's practical and efficient approach to projects, we performed initial modeling through traditional spreadsheet analysis. The assumptions that fed this modeling included referencing those made by a range of publically available models. Because each state has its own local health market, the assumptions were customized to reflect the unique North Dakota environment.

This approach provides a good indication of how the exchange could impact North Dakota within different scenarios, but without the costs and resource requirements associated with extensive micro simulation modeling. North Dakota may indeed choose to perform more detailed analysis, especially as more uncertainties are defined. Until then, the HTMS model provides a strong estimation of the direction and range of participation levels that could be expected for the exchange.

Highlights and Key Findings

Overview: The objective of this model is to provide a tool to enable North Dakota to estimate the number of participants in the exchange and how this population is distributed across market segments. Data and assumptions reference other models, but were customized to reflect the unique nature of the North Dakota population and marketplace.

Participation Estimates:

**Table 3.1: Estimated Exchange Participation
Based upon HTMS Demographic Model**

Scenario	2014	2017	2020
Low	33,603	58,079	74,034
Mid	44,785	71,794	96,702
High	55,894	78,373	101,554

Flexibility: The model created for North Dakota allows users to change many of the assumptions as to how groups and individuals may behave as the market for health care coverage changes over the next several years. The results of these changes will be dynamically adjusted automatically throughout the model.

Model advantages and limitations

This model employs fewer variables and less complexity than a micro simulation model. It does not attempt to measure all of the factors that could influence coverage decisions.

Some of the data used to describe current market characteristics comes from different sources, for differing time periods. No single data source was complete or detailed enough to provide what was needed. This led to some averaging, rounding or otherwise adjusting to produce base line population projections and distributions that are consistent and relevant for the North Dakota.

In reviewing other models, studies, and related literature, some degree of policy bias and widely divergent predicted outcomes were noted. One contributing factor is that many of the regulations and guidelines related to the implementation of the law have not yet been developed. This leads to some degree of speculation and uncertainty about what is likely to occur in the future. For example, many studies conclude employer groups will drop coverage, while one study reviewed concluded groups would *add* coverage. The model constructed for North Dakota allows the user to determine to what degree either or both of these possibilities may occur by changing the assumption values in the model.

**Model Workbook
Scenario Tab**

This tab contains most of the variables used in the model. This tab enables the user of the model to change the values of the assumptions used for one or more of the variables. The change will ripple through the formulas in the model and will alter the result found in the Distribution of Coverage tab. Making such changes will result in changes to the distribution of the population by coverage category and the projected enrollment in the exchange. Making multiple changes to individual variables will enable the user to test sensitivity of each variable.

Demographic Modeling Assumptions

Base Population & Growth

The initial step in the model identifies population characteristics for a base period, then projects population growth and shifts in demographics over time. This base projection is neutral as to the specific provisions of health care coverage reform regulations. The 2010 census reports 672,591 people live in North Dakota⁴³. This represents an increase of 4.9% from the 2000 Census. We also looked at data from projections done by North Dakota in 2002⁴⁴ and a Department of Labor projection report⁴⁵ issued in 2005. Both reports have significantly lower base population starting points and the projections for 2015 and 2020 did not reach the 2010 Census level. This gap is likely due to the fact that these earlier projections were made before the onset of population growth related to energy exploration and development in the Western part of the state. As such, the HTMS model uses slightly higher growth rates than the historical growth rates in Census data, a flat rate annual assumption of .6% growth per year. These steps lead to a 2020 North Dakota population projection of 714,000.

Employed Population

Since most consumers obtain health care coverage through their employer, the model projects the number of employed individuals through 2020. Job Service North Dakota in the North Dakota Employment Projections 2008-2018 edition⁴⁶ projects a ten-year employment growth rate of 9.17% and shows August 2011 employment to be 392,000⁴⁷. It also identifies 70,100 Public Sector employees. We therefore conclude that the Private Sector employment must be approximately 322,000.

- The model uses .09% per year employment growth rate.
- Small groups provide 53% of the private sector employment North Dakota Employment and Wages, 2011 edition⁴⁸)
- These factors are used to project a base number of employees by group size.

Projected Over 65 Population

The Census⁴⁹ indicates 14.5% of the population is over 65. The North Dakota Data Center Projections 2002⁵⁰ show the over 65 population to grow at 3.0% through 2015 and 3.2% through 2020. The Census data shows an historical growth rate of about .31% per year.

⁴³ US Census Bureau, <http://quickfacts.census.gov/qfd/states/38000.html>

⁴⁴ North Dakota State Data Center, North Dakota Population Projections: 2005 to 2020, Sept. 2002 & updated May 2003. <http://www.ndsu.nodak.edu/sdc/data/ndpopulationprojections.htm>

⁴⁵ Interim Projections of the Total Population for the United States and States: April 1, 2000 to July 1, 2030

⁴⁶ Job Service North Dakota, North Dakota Employment Projections, May 2010, <http://www.ndworkforceintelligence.com/gsipub/index.asp?docid=357>

⁴⁷ Job Service North Dakota, Jobs Report – August 2011 <http://www.ndworkforceintelligence.com/gsipub/index.asp?docid=518>

⁴⁸ Job Service North Dakota, North Dakota Employment & Wages, 2011 edition. <http://www.ndworkforceintelligence.com/gsipub/index.asp?docid=354>

⁴⁹ US Census Bureau, <http://quickfacts.census.gov/qfd/states/38000.html>

⁵⁰ North Dakota State Data Center, North Dakota Population Projections: 2005 to 2020, Sept. 2002 & updated May 2003. <http://www.ndsu.nodak.edu/sdc/data/ndpopulationprojections.htm>

- The model uses a rate of 2% growth in the over 65 population and applied the 2% rate of change to the 2010 Census numbers.

Projected Distribution of Population by FPL

The Kaiser Family Foundation⁵¹ provides population distributions for income level as a percent of population for 2009. The model applied these distributions to the 2010 census population to arrive at population numbers.

- The model projects the distribution of population by FPL to remain constant.

Employer Sponsored Coverage

America's Health Insurance Plans (AHIP) published the 2011 Health Insurance Overview⁵² which indicated that in North Dakota 96% of large groups and 38% of small groups offer health care coverage. The Kaiser Family Foundation-State Health Facts report these numbers as 96% and 40%⁵³. The model uses 39% for small groups. The market analysis reports from the NDID⁵⁴ shows average family size for small groups to be 1.92. Without more specific data, the model uses 2.2 for large groups. This is consistent with industry patterns and is closer to the ND average, as reported by the Census Bureau, of 2.24⁵⁵.

For simplicity and without specific data, the model assumes an even distribution of employees across employers by size category. This means if 38% of employers offer coverage than 38% of employed workers have coverage available.

The Employee Benefit Research Institute (EBRI) Data Book on Employee Benefits⁵⁶ provides national average data on the participation in health benefits when offered by an employer. The rates are: 63% for large groups; 42% for small groups; and 82% for public employees.

Using the 42% for small groups produces projections of current numbers well below the current coverage numbers reported by the NDID. Therefore the model adjusted this assumption to approximate actual enrollments.

Using the 82% for public employees produces numbers well above enrollment reported by the North Dakota Public Employees Retirement System (ND-PERS). The Annual Report indicates 19,328 active enrollees⁵⁷. This compares to approximately 60,000 reported employees. The model also factors early retirees and about 9,000 Federal employees.

⁵¹ Kaiser Family Foundation, Statehealthfacts.org,

⁵² America's Health Insurance Plans, 2011 Health Insurance: Overview and Economic Impact in the States, <http://www.ahipresearch.org/2011statedata/NorthDakota.pdf>

⁵³ Kaiser Family Foundation, Statehealthfacts.org

⁵⁴ North Dakota Department of Insurance, Market Share Analysis reports

⁵⁵ US Census Bureau, <http://quickfacts.census.gov/qfd/states/38000.html>

⁵⁶ EBRI Data book on Employee Benefits, Chapter 4.

<http://www.ebri.org/pdf/publications/books/databook/DB.Chapter%2004.pdf>

⁵⁷ North Dakota Public Employees Retirement System-Comprehensive Annual Financial Report, for the fiscal year ending June 30, 2010. <http://www.nd.gov/ndpers/forms-and-publications/publications/2010-annual-report.pdf>

Combining these factors, the model projects the number of covered lives through employer sponsored coverage.

Impact of Premium Rates

The actuarial firm, Milliman Inc., has published several papers on how ACA is likely to increase premium rates⁵⁸.

Table 3.2: Factors in ACA Likely To Drive Increases in Premium Rates	
<i>Expanded benefits</i>	Increases in the quantity and intensity of healthcare services covered by health insurance may be expected to occur, particularly in the individual health insurance market, to meet minimum essential benefits requirements.
<i>Adverse selection</i>	A higher propensity for less healthy individuals to increase their insurance coverage level beyond minimum requirements.
<i>Risk pool composition changes</i>	The population enrolling in the individual health insurance market in 2014 is estimated to have a higher level of morbidity
<i>Manufacturer & carrier fees pass-through</i>	ACA provider and carrier assessments will be included in the development of premium rates.
<i>Provider cost shifting</i>	The significant expansion of the Medicaid population may result in increased charges to commercial payers to account for low provider reimbursement under Medicaid.
SUMMARY	Milliman estimates that the increases could be 55% to 85% for individual business, 5% to 15% for small groups and up to 5% for large groups ⁵⁹ .

A Council for Affordable Health Insurance report comparing the benefit mandates in all States⁶⁰ shows that North Dakota has 34 separate mandates covering benefits, providers and covered persons. The national average is 42. Additionally, North Dakota has avoided some of the costlier mandates. While this has enabled North Dakota to moderate costs of health coverage, it may result in higher premium increases as the minimum coverage requirements are implemented. This may bias employer groups against continuing employee coverage or offering new coverage. It may also deter uninsured individuals from acquiring coverage.

A separate HTMS analysis of benefits offered in North Dakota shows the levels of cost sharing to be lower than typically found in other States. This will moderate some of the increase in premiums. According to the Congressional Budget Office's (CBO) Health

⁵⁸ Milliman Inc. <http://insight.milliman.com/healthcare.php>

⁵⁹ Milliman Inc. - Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange, August 31, 2011. Prepared for the Ohio Department of Insurance.

⁶⁰ Council for Affordable Health Insurance-Health Insurance Mandates in the States 2010. http://www.cahi.org/cahi_contents/resources/pdf/MandatesintheStates2010.pdf

Insurance Simulation Model⁶¹, for a 10% increase in premiums there is a 3.5% decrease in the perceived value of maintaining health coverage. The model uses this factor in calculating the movements into and out of health coverage plans. The model does not factor in annual inflationary increases.

Base Distribution of Population by Coverage Category

There are no estimates of 2010 Census data by the coverage categories. There are actual 2010 counts from other sources for some -- but not all -- of the categories. Kaiser Family Foundation (KFF) has estimates of the distribution for 2009⁶², but their 2009 population total is significantly lower than the Census number for 2010. Applying the KFF distribution to the 2010 Census data produces some results that are at odds with the reported actual counts. The model has used data from multiple sources to estimate a distribution that approximates the actual counts and ties to the actual population total.

For base projections into 2020 the Model takes the percent distribution by category and applies it to the total population estimate, with two exceptions. A different growth rate was used for the population receiving coverage through employers. The difference in the growth factor is small and does not adversely impact the model. The method to project the population covered by Medicare started with the projected over 65 population. The growth factor for this segment is significantly higher. Consequently this rate introduced a distortion into the model such that the base population by coverage category added up to a number greater than the total population. Therefore, the model includes an ageing out factor to account for the higher proportional growth of the over 65 segment and reductions in the other segments.

Medicaid – The current Medicaid population (and therefore the base projection) consists of people in several Federal Poverty Level (FPL) categories. The model calculates the difference between current enrollees and projected population by FPL's under and over 138%. All under 138% will become eligible. Data for the population distributions by FPL come from the KFF State Health Facts⁶³.

Research from the Kaiser Family Foundation also indicates that about 75% of children eligible and 68% of adults eligible actually enroll⁶⁴. The model uses an estimate of 70% and assumes that this figure will increase slightly over time. The model also assumes the newly eligible will enroll at a slightly lower rate than those historically eligible and factors in people over 138% FPL who will lose their Medicaid eligibility.

The newly eligible for Medicaid were previously either uninsured or covered through an employer or non-group coverage. Data from KFF State Health Facts indicate that for the population of non-Medicaid, non-elderly under 138% FPL, about 48% are uninsured, 28%

⁶¹ Congressional Budget Office, *Background Paper-CBO Health Insurance Simulation Model: A Technical Description*, October 2007.

⁶² The Kaiser Family Foundation, statehealthfacts.org

⁶³ The Kaiser Family Foundation, statehealthfacts.org

⁶⁴ The Kaiser Family Foundation, statehealthfacts.org

have non-group coverage and the remaining 25% from group coverage⁶⁵. The model removes these people from the other categories.

There will be a significant increase in the enrolled Medicaid population. The model uses a relatively high take up rate for the newly eligible. This assumption creates a higher estimate than has been made by the ND-DHS which used a lower take up rate. The difference in the two estimates can be resolved by changing either take up rate assumption.

Medicare

The US Census bureau shows that 98.1% of North Dakota's over 65 populations is enrolled in Medicare⁶⁶. It also indicates about 11% of Medicare enrollees are under 65⁶⁷. The model uses these data elements as constants since small variations in these amounts will not have an appreciable impact on the outcomes. The increase in Medicare corresponds to the projected growth in the over 65 population reflecting both the "baby boom" entering the cohort and increased life expectancy.

Non-Group Coverage

Some of the people dropped from group coverage will wind up purchasing non-group coverage. For individuals between 138% and 200% of FPL, the degree to which their premiums will be subsidized in the exchange will create take up rates approaching 100%. For individuals between 200% and 400% the partial subsidization will create enough incentive so that a large portion of people in this category will choose to use the exchange to acquire coverage. For the population over 400% FPL, the increased costs will cause some to drop any qualified coverage. For those keeping coverage there will be a split between those keeping existing coverage and those moving to the exchange. Overall this category will see significant growth and a sizable portion will be in the exchange

Groups Dropping Coverage

Most of the studies and models we have reviewed acknowledge that one of the consequences of ACA is that some employer groups currently offering coverage could stop offering the coverage. This transition is more likely to occur with small groups than large groups, and when the added cost of providing coverage will exceed the penalties for not providing coverage. Early retiree programs, not covered by mandates, are likely to be dropped, discontinued for future retirees, or converted to defined contribution plans. These factors may be less prevalent in North Dakota than in other states. North Dakota has higher employer contribution rates than national averages, even among small groups. This gives ND groups an option of maintaining or lowering contributions as an alternative to dropping coverage. The rate of dropping coverage will increase over time as health costs continue to increase, and the concept of defined contribution health coverage becomes more widespread.

⁶⁵ The Kaiser Family Foundation, statehealthfacts.org

⁶⁶ U.S. Census Bureau, 2009 American Community Survey

⁶⁷ U.S. Census Bureau, 2009 American Community Survey

The model assumes all displaced persons will become uninsured, and makes assumptions about if and how these displaced individuals obtain coverage.

Groups Adding Coverage

Of the studies reviewed, only the Rand study concluded the number of employers offering health care coverage would expand. For large groups it assumes the growth will be from about 93% of firms providing coverage to about 99% of firms providing coverage. For small groups the percentage of firms offering coverage will grow from about 60% to about 80%⁶⁸. There is a tax incentive for some small groups, with low income employees, to offer coverage. The incentive is for a limited time, decreases in amount for firms above 25 employees with average salaries over \$25k, and is further restricted by the level of employer contributions made. This is not likely to have a significant impact on employer decisions. The model offers input cells for users to assumptions about the number of employers adding coverage.

State Employees (PERS) Transfer to Exchange

Some state and local governments in other states have indicated interest in shifting their employees to purchase insurance through the exchange. The Model has an input cell for making an assumption about this transfer. Assumptions about the transfer of state employees to the exchange it is not based on any facts or decisions and has been provided as a place-holder and example of how the model can work.

Uninsured

From the Kaiser Family Foundation, State Health Facts, about 11% of North Dakota population is uninsured:⁶⁹ about 74,000 lives. The model assumes that in the absence of any ACA mandated changes, this percentage will remain constant for determining the base starting point.⁷⁰

⁶⁸ The Kaiser Family Foundation, statehealthfacts.org

⁶⁹ The Kaiser Family Foundation, statehealthfacts.org

⁷⁰ As previously noted, different uninsurance rates have been presented for North Dakota. HTMS references here the one we were able to obtain sourcing for.

Table 3.3: Factors Influencing Use of Exchange by the Uninsured	
Changes in employer based coverage	Employers currently offering coverage decide to drop coverage, or switch to defined contribution plans, thus leaving currently covered individuals without coverage.
Medicaid eligibility	With the expansion of Medicaid eligibility some currently uninsured will become covered by Medicaid
Mandate penalty	The penalty imposed by the mandate to purchase coverage will provide incentives for some individuals to obtain coverage. The amount of the penalty is low compared to the typical price of coverage. If the cost of coverage is high, the penalty will not be enough of an incentive to drive people to purchase insurance, especially for those with limited or no subsidy. Young and healthier individuals may be more likely to forego coverage and make this economic trade-off.
Premium subsidies	Premium subsidies for those with incomes below 200% FPL will offset any cost issues. Since they will pay little if anything, obtaining coverage is no longer a question of economics. Those with incomes between 200 and 400% will have some subsidies and therefore will likely choose coverage at a greater rate than those over 400% FPL
Premium price increases	Some currently insured could choose to forego coverage due to premium increases resulting from insurance market regulations also in effect in 2014.

Overall with the expansion of Medicaid and the subsidization of those with incomes below 400% FPL, the number of uninsured will be reduced.

3.2 Start-Up and Operating Model

Highlights and Key Findings

While there are some requirements for exchanges outlined in the ACA and subsequent proposed guidance from HHS, there is still considerable leeway at the state level as to the scope and scale of the exchange. Thus, there are limitations to the specificity of startup and operating costs that can be defined at this time.

In the absence of key business decisions in North Dakota, HTMS developed its startup and operational modeling by benchmarking data against other states, identifying a range of base and robust model costs.

Reference startup costs range from \$9M to \$89M.
Reference operating costs range from \$4M- \$47M.

Initial and operational cost model development

In order to appropriately plan for the financial impact of starting and operating an HBE for North Dakota, in conjunction with the North Dakota Insurance Department, HTMS determined that due to time constraints of the project timeline, full simulation models would not be possible. Ideally, cost estimates for exchange start-up and operations would be developed by gathering robust business requirements and in-depth cost estimations for both internal development and from available vendors.

Per the parameters of this project, only estimates are readily available for comparison purposes. To accomplish this, HTMS employed the following approach:

Cost estimates for HBE's are, by definition, imprecise at this point in time. There are a range of business decisions that could significantly impact HBE operations. By providing cost estimates before these decisions are made, many states provide high estimates to ensure that resources to ensure there will be adequate funding if unanticipated costs arise.

As an example of the choices that each state must make which could significantly impact both startup and ongoing costs a few areas of cost have been included. In table 3.4, there is a comparison of both risk management and premium aggregation. The ACA allows for a wide variety of decisions to be made by the state as to how "rich" or how "light" the state will choose to implement these items. These rich and light choices will directly affect the costs of how these areas will be implemented and administered.

Table 3.4: Sample Comparison of Exchange Business Decisions Impacting Cost

<i>Category</i>	<i>Extreme Light</i>	<i>Extreme Rich</i>
Risk management	Outsource all risk management requirements of the exchange to an vendor that provides these services for a fee	<ul style="list-style-type: none"> • Build a claims database to store and report on claims experience for all insurers in the state • Apply severity factors and other ratings to qualify differences between plans • Develop a methodology for comparing risk between plans • Complete actuarial and other analysis to determine a risk factor • Compare methodology against other states to refine model • Maintain ongoing risk management capability • Hire and train some combination of data analysts, health care economists and actuaries, or contract for parts of those skill sets.
Premium aggregation	<ul style="list-style-type: none"> • Perform only minimum premium aggregation requirements as defined by HHS. Primarily serve as a gateway to enrollment at public plans or with insurers. • Determine tax credits and other subsidies for individuals and small group; no billing or collections required. 	<ul style="list-style-type: none"> • Establish policies and operational procedures for managing high volume of financial transactions • Define approach and establish staffing to manage premium billing and collections • Define paths for flow of dollars between employers, health insurers, other parties, and the HBE • Establish financial audit procedures • Define process for financial reporting and communications between stakeholders • Train HBE customer service and Navigators to address financial questions related to interacting with the HBE • Develop solutions to address additional risks related to theft, embezzlement, failure to meet fiduciary responsibilities and related risks

Note: There are a variety of decisions that have a broad range of solutions. In some cases, there may be a vendor solution in the marketplace.

High-level cost estimation benchmarking methodology

To bypass these limitations for initial cost ranges, HTMS pursued a benchmarking strategy, as described in Table 3.5 below. Because most planning grants were written with costs associated with each specific core area as defined by the ACA, HTMS calculated a baseline percentage of total budget assigned to each core area. Once these percentages were defined, they could be applied to each comparative State’s total budget.

Table 3.5: Approach to Benchmark Determination

<i>Steps</i>	<i>Description</i>	<i>Determination</i>
Cost Structure	Determine necessary cost budget categories	Costs are most often categorized into the core areas listed within the planning grants. Development of overall budgets based on each of these core areas.
Cost Assumptions	Determine variables within possible budget scenarios	Define the richness/leanness of core area which is being used as an input into the cost model. Use these factors to determine high and low cost estimate categories.
Determine Core Area Approximate Costs	Determine how costs are being applied by similar entities across core areas	Pull available cost estimates from other planning grants and determine average, low and high percentage of budget rates across total budget.
Expand Sample Data Set	Obtain broader samples	Apply core area formulas to a wider set of available budgets to determine a more accurate overall average, low and high budget sample.
Produce Final Result	Determine which results should be included in final deliverable	Deliver applicable budgets with definitions and average, low and high costs for both initial and operational costs.

Core areas defined in planning grants: Basis for initial and operational models

As listed in the ACA planning grant requirements, Health Benefit Exchanges are broken down into “Core Areas,” which are intended to classify individual aspects of the Health Benefit Exchange for structural and financial reasons. Although specifically defined within the planning grants, these definitions are modified to reflect more accurately how different States are categorizing their costs. These definitions are designed to serve as a guide for cost allocations costs⁷¹.

⁷¹ *Obtaining Exchange Funding and Achieving Consumer-Friendly Outcomes.* www.familiesusa.org/resources/publications

Core Area	Definition
Financial Management	Establishment of a financial structure that adheres to generally accepted accounting principles. Research, development and implementation of a plan to ensure self-sufficiency and sustainability of the exchange.
Oversight and Program Integrity	Development and institution of a long-term plan that will prevent waste, fraud and abuse. Enact oversight for the auditing of funds used to implement and operate the exchange.
Health Insurance Market Reforms	Prevention of adverse selection, risk leveling, and evaluation of state mandated benefits that exceed essential health benefits. Enforcement of Federal regulations of Health Market Reforms.
Providing Assistance to Individuals & Small Businesses, Coverage Appeals & Complaints	Ensure that services are available that will meet the needs of individuals and small businesses by providing information about consumer protections, eligibility determination assistance, complaints and appeals.
Business Operations of the Exchange	<ul style="list-style-type: none"> • Certification, recertification, and decertification of QHPs • Consumer call center • Exchange website • Premium tax credit and cost-sharing reduction online calculator and administration • Quality rating system • Navigator program • Eligibility determinations: exchange participation, advance payment of premium tax credits, cost-sharing reductions, and Medicaid • Seamless eligibility/ enrollment processes with Medicaid & other state health subsidy programs • Enrollment process • Applications and notices • Individual responsibility determinations • Adjudication of appeals of eligibility determinations • Notification and appeals of employer liability • Information reporting to the IRS and enrollees • Outreach and education • Risk adjustment and transitional reinsurance • SHOP exchange-specific functions

Initial Exchange Cost - Reference Estimates (in thousands)

Using the previously described methodologies, HTMS was able to determine an “average percent of budget” for those states that have broken down their initial cost estimates based on core areas. Once each of these percentages was known, HTMS applied these percentages to other states for comparative value. Figures referenced here were obtained from Establishment Grant applications and other publically available materials. Where a specific figure was not available, HTMS calculated the missing number through an average percent of budget as determined from other state calculations.

Table 3.6: Start Up Cost Reference Estimates							
Core Area	Avg % of Budget	By State & Reference Total					
		Arizona 22M ⁷²	West Virginia 9M ⁷³	Illinois (base) 57M ⁷⁴	Illinois (robust) 89M ⁷⁵	Rhode Island 74.5M ⁷⁶	New Mexico 34M ⁷⁷
Background Research	0.90%	202	87	514	802	671	309
Stakeholder Involvement	1.41%	316	136	804	1,255	1,051	484
Legislative and Regulatory Action	0.26%	59	25	150	235	196	90
Governance	0.46%	104	45	265	413	346	159
Program Integration	2.75%	615	266	1,565	2,444	2,046	942
Exchange IT Systems	75.65%	16,930	7,314	43,121	67,330	56,360	25,948
Financial Management	1.97%	442	191	1,125	1,757	1,471	677
Oversight and Program Integrity	0.74%	165	71	421	658	550	253
Health Insurance Market Reforms	1.75%	392	169	997	1,557	1,303	600
Assistance to Ind'ls and Sm Bus Coverage Appeals and Complaints	1.27%	284	123	724	1,131	947	436
Business Operations of the Exchange	12.83%	2,871	1,240	7,313	11,418	9,558	4,401

Note: Estimates in this presentation do not include all State references and/or formulas. The actual model includes a broader set of states.

⁷² "Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges Level One Establishment Grant Application". State of Arizona's Governor's Office. Oct 2011. <http://www.azgovernor.gov/hix/>

⁷³ "West Virginia Health Benefit Exchange Level 1 Establishment Grant Budget Narrative". West Virginia Offices of the Insurance Commissioner. June 2012. <http://healthbenefitexchangewv.com/background-planning-and-development>

⁷⁴ Health Management Associates, et al. "Illinois Exchange Strategic and Operational Needs Assessment Report". Illinois Department of Insurance. Oct 2011. <http://www.insurance.illinois.gov/hirc/hie.asp>

⁷⁵ "Health Management Associates, et al. "Illinois Exchange Strategic and Operational Needs Assessment Report". Illinois Department of Insurance. Oct 2011. <http://www.insurance.illinois.gov/hirc/hie.asp>

⁷⁶ "Rhode Island Exchange Establishment Grant Two". Office of the Health Insurance Commissioner. Sept 2011. http://www.ohic.ri.gov/2010%20RI_Grants.php

⁷⁷ "State of New Mexico Level I Establishment Grant". New Mexico Department of Human Services. Nov 2011. <http://www.hsd.state.nm.us/pdf/hcr/NM%20Health%20Insurance%20Exchange%20Establishment%20Grant.pdf>

Operational Exchange Cost - Reference Estimates (in thousands)

HTMS also applied the same comparative methodology to operational costs of the exchange.

Figure 3.7: Operating Cost Reference Estimates

Core Area	Avg % of Budget	Ohio (base) 19M ⁷⁸	Ohio (robust) 33M ⁷⁹	Illinois (base) 32M ⁸⁰	Illinois (robust) 47M ⁸¹	Delaware 8M ⁸²	North Carolina 23.5M ⁸³	Wyoming 4M ⁸⁴
Background Research	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A
Stakeholder Involvement	1.73%	330	572	555	798	134	408	73
Legislative and Regulatory Action	2.19%	417	724	702	1,009	169	516	92
Governance	3.28%	622	1,081	1,048	1,507	252	770	138
Program Integration	2.81%	533	926	898	1,291	216	659	118
Exchange IT Systems	50.73%	9,637	16,740	16,232	23,334	3,906	11,921	2,131
Financial Management	5.75%	1,093	1,898	1,840	2,645	443	1,351	242
Oversight and Program Integrity	3.74%	710	1,234	1,196	1,720	288	879	157
Health Insurance Market Reforms	3.09%	587	1,020	989	1,421	238	726	130
Assistance to Ind'ls & Sm Bus Coverage Appeals & Complaints	4.65%	884	1,535	1,489	2,140	358	1,093	195
Business Operations of the Exchange	22.24%	4,225	7,338	555	10,228	1,712	5,225	934

⁷⁸ Milliman, Inc. "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange." Ohio Department of Insurance. Aug 2011. www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf

⁷⁹ Milliman, Inc. "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange." Ohio Department of Insurance. Aug 2011. www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf

⁸⁰ Health Management Associates, et al. "Illinois Exchange Strategic and Operational Needs Assessment Report". Illinois Department of Insurance. Oct 2011. <http://www.insurance.illinois.gov/hirc/hie.asp>

⁸¹ Health Management Associates, et al. "Illinois Exchange Strategic and Operational Needs Assessment Report". Illinois Department of Insurance. Oct 2011. <http://www.insurance.illinois.gov/hirc/hie.asp>

⁸² Public Consulting Group. "Health Benefit Exchange Project Budget Estimate Operations." Wyoming House Labor, Health and Social Services Committee. Oct 2011.

⁸³ Milliman, Inc. "North Carolina Health Benefit Exchange Study". The North Carolina Department of Insurance. March 2011. <http://www.nciom.org/wp-content/uploads/2010/12/Health-Benefits-Exchange-Study-DRAFT-4-2011-03-31-FULL-REPORT.pdf>

⁸⁴ Public Consulting Group. "Health Benefit Exchange Project - Budget Estimate for Exchange Operations". Oct 2011. <http://legisweb.state.wy.us/InterimCommittee/2011/SHERPT1010.pdf>

Note: Estimates in this presentation do not include all State references and/or formulas. The actual model includes a broader set of states.

Cost estimates vary

There are still many items of the exchange that have not been fully defined by the federal government. As these regulations are released, some changes will be inevitable. Due to this uncertainty, many states are providing conservative or high estimates for the cost of building their exchange. States could make different decisions regarding the scale and scope of their exchanges, which could significantly impact costs assumptions. Additionally, states may vary in their risk threshold, and may build in larger contingency requirements around the unknowns.

Standard project processes can provide the opportunity for more accurate estimates

Even though there is great uncertainty as to what the total costs will be for each state, standard project processes can provide practiced, repeatable methodologies for deriving more accurate cost estimates. These include development of business requirements, gathering vendor feedback, potentially through Request for Information (RFI), and decision-making regarding approaches to fulfill a range of exchange functions.

4. Stakeholder Perspectives

As part of the Health Benefit exchange planning project, HTMS worked with the North Dakota Insurance Department to create and execute a multi-faceted research plan that allowed for input from various constituents in North Dakota who would likely have opinions on exchanges. While this research was by no means exhaustive, it provided important insights and indicated areas where additional research may be required in the future. The constituents included representatives of North Dakota's state department, health plans, small employers/businesses, consumers and consumer groups.

There are a range of stakeholder engagement activities required for submitting applications for Establishment Grants to HHS for HBE funding. NDID had engaged a (different) consulting firm to engage in initial stakeholder meetings. Additional meetings may be pursued by relevant state departments as part of this ongoing stakeholder engagement process. The stakeholder outreach performed by HTMS as part of this research was conducted in a condensed period of time with quick-hit techniques to gather high-level data. HTMS proposes a more thorough stakeholder engagement plan at the end of this section so that this important input to exchange development can be thoroughly explored.

4.1 North Dakota State Officials:

In September 2011, the HTMS project team conducted in-person interviews with a wide range of state officials to learn their perspectives on the exchange and its implementation. The HTMS team also reviewed notes from a series of stakeholder meetings that the NDID held in August and September 2011, in several cities across the state.

Highlights and Key Findings From Stakeholder Interviews

Governance: Officials shared that they viewed the main purpose for developing an exchange is to comply with Federal law, with the potential benefit of helping those who are currently uninsured or underinsured. Stakeholders and officials also shared a variety of perspectives about whether the exchange should be developed at the federal or state level. Many wanted to keep it at the state level because decisions would be made by those who know the unique needs in North Dakota, while others preferred starting at the federal level with the option of moving to a state exchange at a later time. Many officials shared concerns about costs and timelines, and felt that those considerations should be treated as significant factors in decision-making about the exchange.

Risk Selection: Stakeholders and officials shared concerns about the risk pool inside and outside of the exchange. However, many risk mitigation strategies can be implemented to deal with these issues.

Role of Agents/Brokers: Many stakeholders and officials had opinions and questions about the role of brokers once the exchange is implemented. The role of

brokers needs to be defined, but stakeholders and officials generally agreed that brokers will continue to play an important role in the distribution of health insurance in North Dakota.

Choice of Products: Stakeholders indicated that they would prefer to have a broad choice of health products offered via the exchange. However, academic research, findings from other industries, and experience with exchanges in other states has shown that there are limits to how many choices benefit consumers.

4.2 Health Plans:

In late September and early October 2011, HTMS conducted an online survey of health plans in North Dakota. The NDID invited health plans with active business in the state to participate in the survey. Six health plans answered the survey, representing the majority of health plan members in the state. Survey topics included: numbers of members served by line of business, current product design, interaction with agents, internet access, intentions for selling through an exchange and expected growth or decline of members, reporting requirements, consumer benefits, individual and SHOP exchanges, needs for operating on an exchange, and assumptions about risk.

Highlights and Key Findings From Online Health Plan Survey

Product Design: A subset of participating plans provided a greater level of detail on the benefit design of health insurance products sold in the state. In general, the products reviewed have low deductibles and low levels of cost-sharing when compared with other states.

View of Exchange: Plans are generally positive about the prospect of an exchange (with none indicating unwillingness to join). Uncertainty and lack of knowledge are prime drivers of hesitation. They are aware of reporting requirements and willing to help define them.

Risk Pools: Plans do not support merging individual and small group pools at the outset, fearing premium increases for small groups.

Role of Agents/Brokers: Plans indicated that brokers can be a critical sales channel for individual and small group markets. Health plan services for brokers/producers will also be impacted by changes in distribution strategies.

Market Growth: Plans are uncertain about exchange-driven growth in both individual and small group markets with the latter being the source of the greatest uncertainty, which is likely driven by the large number of undecided factors related to exchanges both at the state and federal level.

Exchange Services: Plans have high expectations for exchanges to provide services to help consumers, provide accountability, and manage risk.

- **Agents/Brokers:** Plans reported that producers are their most common sales channel for the individual and small group markets, but plans have different structures and processes in place for working with agents. Some plans reported working with as many as 250-500 brokers, while others work with just a handful (or fewer). Some plans also shared that they have internal staff roles that exist to support brokers. Lastly, plans shared detailed information on how they interact with and compensate brokers. In sum, any changes to the agent structure needs to be assessed by impact to the industry overall. There are many marketing and sales functions in support of the current distribution strategies. Transforming these would mean more than changing roles for brokers alone.
- **Online Services:** Plans shared that they typically have online services available to their members, but there is no standard for what is offered. The online channel tends to be part of plans' approach to communicating with members, but it is not a primary strategy. Plans were not tracking the percent of membership with access to internet access.
- **Selling on the Exchange:** Plans generally reported that they are open to joining the exchange; where hesitation exists, it is due to uncertainty or lack of knowledge, rather than not having a business interest in the exchange itself. No health plan in the survey reported that they do not intend to join the exchange.
 - *Growth in the Individual Market:* For the individual market, plans report that they are mostly unsure of growth due to the exchange; however, they do anticipate growth if the individual mandate remains law in 2014. No plan reported that they expect to lose individual members when the exchange is enacted. Additional impact to the individual marketplace may result from mandated benefits. If the mandated benefit package is richer than current products, costs for individual plans will rise, potentially impacting growth.
 - *Growth in the Small Group Market:* All responding plans were unsure whether they would have growth in the small group market as a result of the exchange. Plans seem more unsure about changes to occur in the small group market than they are about the individual market. Several variables that plans are struggling with to determine the viability of the small group market are ones that will be determined at the state level, including how employees can be referred to the exchange, how the exchange will take on premium aggregation functions, and rules around benefit definition. Additionally, administrative efficiency was identified as a factor that would drive small employers to do business with the exchange.
- **Reporting Requirements:** When reminded of the reporting requirements of exchanges as defined in the ACA, all plans said they would try to meet the requirements as best they could. Additionally, plans demonstrated that they have a working knowledge of exchanges, and, at times, demonstrated an interest in participating in defining rules related to exchanges.

- **Impact of the Exchange on Consumers:** In general, health plans expect that consumers will benefit from the exchange. Overall, plans think consumers will benefit from more choices, greater product transparency, and easy access to subsidies. Plans also shared a few concerns related to how exchanges could impact consumers, including that consumers will only make choices based on price and uncertainty around who would be harmed and helped as a result of the exchange.
- **Risks Pools for Individuals and Small Groups:** Health plans support keeping the individual and small group risk pools separate, particularly in the beginning. Health plans shared that they believe mixing the higher risk individual pool with the lower risk small group pool will increase overall risk and result in much higher cost premiums for small group members.
- **Services Provided by the Exchange:** Plans expressed high expectations for the services that should be provided. Plans reported that the following items should be offered by the exchange to serve the needs of the plans themselves, as well as the needs of employers and consumers:
 - Items to help consumers
 - o Product comparison and selection that is easy to navigate and with a cost comparison function
 - o Determine eligibility for coverage and for subsidies
 - o Easy enrollment in an insurance plan
 - o Display provider networks by insurance carrier
 - o Access to Navigators and access to brokers, along with a clear definition of their function and certifications
 - o Online accounts for users, possibly connecting users from the same household
 - Accountability items
 - o Exchange should be accountable to the consumers and small businesses who use it
 - o Advisory structure should be in place to ensure accountability
 - o Provide analytics / reports
 - Items related to risk
 - o Exchange should be sure to include effective management of risk adjustment, reinsurance, and risk corridors
 - o Protect Health Plans from adverse selection
 - o Apply standard quality measures to data from QHP's
 - o Risk issues should be overseen by those who are an expert in this topic

4.3 Small Employers:

In October 2011, HTMS held two group interviews for small businesses via web conference. The Chamber of Commerce provided list of small businesses to invite, and NDID also invited an additional list of small businesses. For the two sessions, a total of 3 businesses attended, representing employment in Bismarck, Fargo, and Minot. The companies ranged in size from 16-175 employees. Participants included company CEOs/owners and an HR/benefits advisor. While the information gathered was informative and indicated potential key findings, the small number of participants limits the generalizability of the data gathered.

Highlights and Key Findings From Small Employer Web Conference Calls

Benefit Levels: The small business participants shared that benefit levels for their employees is very important to them. The businesses are offering a high level of coverage to their employees (typically 80/20 with about \$1,000 deductible) and are covering most if not all of the premium expenses for employees. The businesses said they do this to protect people they care about and to have “peace of mind” for themselves. In sum, insurance benefit levels are very important to the small businesses interviewed, so more research may need to be done to understand what coverage levels are acceptable to them.

Knowledge of Health Care Changes: Participating small businesses also shared confusion about health care changes, as well as a desire to learn more. They report not being knowledgeable about exchanges and the impact their business; they are getting lots of (potentially incorrect) information from other small business owners. Participants learned a great deal about exchanges during the sessions and indicated that they want to learn more

Engaging Small Businesses: The low response rate to the invitation to join the group interviews emphasizes the difficulty of engaging small business owners. An outreach plan to engage this busy group will require additional attention and focus. To reach small businesses, the NDID likely needs to reach them where they already are (Chamber events, conferences, etc.), rather than setting up separate meetings. Online options may continue to work as well, but likely additional advertising and communication is needed so that the sessions have credibility and visibility among small businesses.

4.4 Consumer Survey:

In mid-October 2011, HTMS conducted a short online survey for individuals and membership organizations to provide input on their health insurance needs and thoughts on exchanges. Survey topics included factors in purchasing health insurance, current health insurance options, purchasing health insurance online, and impacts of an exchange. This survey complements input from NDID’s stakeholder meetings, held in August and September 2011.

Highlights and Key Findings from Consumer Survey

Response rate & how findings can be generalized: All respondents were self-selected, often with an opinion bias regarding exchanges. As such, these findings are not intended to be a representative sample of consumer view points in the state. Rather, they provide anecdotal information that can offer unique and sometimes important perspectives.

Awareness and Knowledge: Organizations are moderately aware of exchanges and divided in opinion of its impact on both cost and ease of obtaining coverage

Desired Changes: Improvements to the cost, service and clarity of health insurance are most important as they are generally not seen as currently meeting peoples’ needs.

Exchange Services: Like other constituents, representatives of consumer organizations generated a long list of desirable functions and services for the exchange including governance transparency, benefit design, usability, and inclusiveness

Online purchasing: Education and support is needed for the population less confident and experienced in Internet self-service

Invitations to participate were distributed to organizations identified by NDID (see Table 4.2 at the end of this section) and via an NDID press release. About 40 responses were submitted: 15 responses represented 14 membership organizations in the state, and 24 responses were from individuals from locations across the state. Respondents to the survey self-selected to participate; the survey did not include random or representational sampling of North Dakotans. For the individual respondents, public invitation to participate was sent out by the NDID via press release – no attempt was made to have a representative sample from the state to complete the survey. Therefore, those with a strong interest in the exchange were more likely to respond as were those with strong opinions about changes to health care laws. Because the individuals’ responses represent so many fewer people than the organizations’ responses do and because of considerations about the sample (who took the survey), most analysis is focused on the responses from the organizations. When the individuals offered additional important information that is included as well.

Findings from the survey are given below.

- **What’s Most Important for Purchasing Insurance:** When ranking “What factors are most important to your organization’s members in buying insurance for individuals and families?” organizations ranked highest the cost of monthly premium, coinsurance and copay and deductible levels, customer service, and clear and understandable

explanations of what is covered or excluded. Individuals had similar responses for what was important, with the exception that customer service did not rank as high.

- ***Do Current Health Care Options Meet People's Needs?:*** No organization that participated in the survey believes that current health insurance options meet people's needs. About half said current options do not meet people's needs, while the other half said that people's needs are partially met. Organizations shared a variety of reasons why they think current health insurance options do not meet people's needs, often relating to the work of their particular organization.
- ***Desired Changes in Health Care Options:*** In general, organizations and consumers agree that changes to health insurance options should include lower prices, more coverage, and more choices.
- ***Making Health Care Purchase Decisions Online:*** Both membership organizations and individual consumers indicate that some consumers are confident with purchasing insurance online, while others are not. Because of these different needs by different purchasers, the education and outreach program for the exchange would need to address these groups separately to provide the right information and training to each type of consumer.
- ***Awareness of the Exchange:*** All organizations and 65% of consumers who answered our survey stated that they are aware of the exchange and its implementation by 2014. Even though this very high percentage of survey respondents reported being aware of the exchange, this likely reflects that survey respondents chose to participate – it was not a representative sample of North Dakotans. As we learned during our research with small business owners, basic education on exchanges is needed in the marketplace.
- ***Impact of the Exchange on Purchasing Insurance:*** Organizations were almost evenly split in thinking exchanges will simplify, complicate, or unsure about how exchanges could impact the process of buying insurance. As with other parts of the market, membership organizations are unsure how exchanges will impact the purchasing of insurance. Again, outreach and education is important to share how the exchange will impact different constituents.
- ***Factors the State should Consider if it Sets Up its Own Exchange:*** Organizations detailed numerous factors that they believe the state should consider as it possibly sets up its own exchange, including:

Governance	<ul style="list-style-type: none"> Be consumer-driven Be accountable and transparent Have strong consumer representation on the governing board
Coverage	<ul style="list-style-type: none"> Cover prescription drugs Include home and community-based services Provide clarity on coverage Have basic requirements for what is covered
Inclusion	<ul style="list-style-type: none"> Have extensive education and outreach to consumers Provide additional assistance to those who need it Have an office that consumers can consult with additional questions Offer extra help selecting a plan, especially for those with special needs Be fair to everyone
Usability	<ul style="list-style-type: none"> Clearly disclose costs Be very user-friendly Have adequate systems for health information, data, and payments Clearly communicate information on benefits
Other	<ul style="list-style-type: none"> Be an active purchaser of insurance Make clear who is paying for the uninsured Only enter patient information with express consent Don't enact anything until the Supreme Court has ruled on ACA lawsuits

Consumers who took the survey also offered ideas on factors to consider. Most are included in this list. Others were tied to a specific consumer's needs, such as "single policies for married people," or "cover my pre-existing condition."

- **Impact of the Exchange on the Price of Health Insurance:** Perceptions among organizations and consumers about the exchange's impact on the price of health insurance vary, but consumers who opted to take the survey are more pessimistic about potential impact to price than the organizations are. For example, 8% of organizations think health insurance costs will rise due to the exchange, while 39% of consumers think the exchange will cause costs to rise. Overall, many survey respondents mirror the conclusions of experts when they indicated that they do not know what will happen to the price of health insurance when exchanges begin.

Initial information gathered from consumers and consumer organizations offers a starting point for working with stakeholders and creating a comprehensive outreach and education plan. Continuing work with stakeholders – including consumers from various segments – will be important in informing the development of the exchange. More education is needed as

part of the engagement process to ensure that consumer feedback is reflective of the true rules and regulations related to the exchange.

**Table 4.1 Online Consumer Survey:
North Dakota Membership Organization Invited to Respond**

<i>Organization</i>	<i>Approximate Number Served</i>
AARP-ND	83,000
American Cancer Society Cancer Action Network	2,600
American Heart Association	Not reported
The Arc of Bismarck	400-500
Children’s Defense Fund	Not reported
Community HealthCare Association of the Dakotas	500
Division of Children’s Special Health Services, North Dakota Department of Health	2,000
Family Voices of North Dakota	4,000
Heartview Foundation	Not reported
North Dakota Center for Persons with Disabilities	Thousands
North Dakota Professional Insurance Agents	Over 1,000
North Dakota Nurse Practitioner Organization	250
North Dakota Optometric Association (providers & patients)	138
Valley Community Health Centers	6,800

Section 5: Strategic and Operational Decisions

Overview

Governance: State, Federal and Partnership models explored in other states represent a range of advantages and disadvantages with the respect to structure, authority and function. Section 5.1 enumerates and compares the models and options with particular attention to Federal-State partnerships

Revenue Sources: In addition to Federal funding for feasibility studies and exchange startup costs, options for funding long term operations are presented along with guiding principles for sustainability.

Premium Aggregation: Based on proposed regulations to-date from HHS, small employer (SHOP) and individual premium aggregation approaches are discussed referencing the functions selected by other states.

Individual and Small Group Markets: ACA guidance on managing risk pools allows States the option of combining individual and small groups into a single pool⁸⁵. Emerging research is presented with advantages and disadvantages of different approaches.

5.1 Governance

While federal legislation provides guidance on the development of state-level exchanges (Subtitle D, Part 3 of the ACA), there are still a host of key governance issues to be determined at the state level.

There are a range of requirements determined at the federal level over which the state has no control. This includes the requirement to develop an exchange at all. The federal government also determines whether sufficient progress has been made and determines whether a state is ready to begin selling insurance. Further, the federal government determines the timelines for the exchange. This includes the schedule to apply for federal funds (should states decide to do so), the requirement for when exchanges need to be tested for readiness (1/1/2013), when they need to be operational for consumers (10/1/13), the effective date for the first insurance on the exchange (1/1/14), when exchanges need to be self-sustaining (1/1/2015), and a range of other requirements⁸⁶.

The federal government also provides boundaries and benchmarks around a range of decisions for which the state can make more specific determinations. Some examples of decisions with state-level flexibility within federal guidelines include: *governance*; consumer support functions, including the role of the navigator; the eligibility processes; and health plan and network requirements.

⁸⁵ H.R.3590: The Patient Protection and Affordable Care Act. 111th Cong., 2nd Sess. (2010).

⁸⁶ H.R.3590: The Patient Protection and Affordable Care Act. 111th Cong., 2nd Sess. (2010).

Within these boundaries, there is still a great deal of control for exchanges that are developed at the state-level. Some examples of state-level determinations include:

- **Governance:** *Leadership, ownership, accountability, funding, management, etc.*
- **Strategy and goals:** *Primary purpose, secondary goals, strategic orientation, guides decisions*
- **Model:** *Components, functionality, roles, and other decisions that define the exchange*
- **How to Make it Happen:** *Method for implementing the defined model*

The decision whether to operate a state or federal exchange is one of many decisions states need to make. A summary of these decisions is provided in Table 5.1.

Table 5.1: Governance Issues and Decisions	
<i>Governance decision</i>	<i>Sample variables for consideration</i>
Jurisdiction	State, Federal, or partner
Geography	Single state, multi-state, which state(s)
Structure	Government agency, quasi-governmental agency, independent organization
Regulatory oversight	Insurance Department, Human Services, Office of Management and Budget, etc.
Board oversight	The size, background, role and degree of authority granted to a governing board
Public inclusion and oversight	Role of stakeholders, communications, and transparency
Market	Degree of separation for Individual and SHOP exchanges

Jurisdiction – Federal, State, or Partnership Model

The most critical decision for a state to make is whether to pursue an exchange at the state or federal level, or take advantage of a new partnership option. There are some fixed roles for state and federal governments that will remain true regardless of which model is selected. These include:

State Responsibilities
Ensure insurance department, Medicaid, and CHIP cooperation to coordinate business processes, systems, data/information, and enforcement

HHS Responsibilities

Perform all other exchange functions other than described above, ensure that exchanges meet all requirements, and maintain and coordinate with States for end-to-end system functionality to ensure a seamless consumer experience

Regardless of whether an exchange is state or federally run, HHS activities to support exchanges include:

- Grants;
- Access to the Data Services Hub --a system to connect to the Internal Revenue Service (IRS), Social Security Administration (SSA), and Department of Homeland Security (DHS);
- Financial management support related to payment processing of financial assistance,
- a federal risk adjustment model, or allow HHS to run risk adjustment on the state's behalf (if the state chooses); and
- Development and management of the risk corridors program.

A federal run exchange.

Some states could choose to move forward with a **federally-run exchange**. Selecting a federal exchange does not reflect a single perspective or idea; a state could reach this decision for a range of different reasons, including:

- *Waiting for repeal:* The state is hesitant to invest considerable money and resources into an element of federal law that has the potential to be either partially or entirely overturned by the Supreme Court or overturned by a future administration.
- *Resistance:* State leaders feel strongly that they do not want to be perceived as complying with any elements of the ACA.
- *Operational:* The state is hesitant to make state-level investment in a concept that has little experience in the market. The state would prefer to the exchange developed and proof-tested before it takes on accountability.
- *Practical:* The state has considerable operational and technical challenges to face to become ready to interact with any exchange (state or federal). As such the state is hesitant to take on the responsibility for developing the exchange in addition to these other requirements.

The core functions of an exchange that HHS will manage in a federally-run exchange include:

Consumer Assistance which includes consumer support; education and outreach; Navigator management; call center operations; website management; and written correspondence with consumers to support eligibility and enrollment.

Plan Management functions which include defining an approach to plan selection (e.g., active purchaser or any willing plan); collecting and analyzing plan rate and benefit

package information; monitoring and overseeing plan participation; ongoing plan account management; and plan outreach and training.

Eligibility tasks including accepting applications, conducting verifications of applicant information; determining eligibility for enrollment in a Qualified Health Plan and for insurance affordability programs; connecting Medicaid and CHIP-eligible applicants to Medicaid and CHIP; and conducting redeterminations and appeals

Enrolling consumers into qualified health plans; managing transactions with Qualified Health Plans; and transmitting information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions

Financial Management of user fees, financial integrity, support of risk adjustment, reinsurance, and risk corridor programs.

In building and managing the federally mandated exchange for a state, HHS will use the following guiding principles in working closely with the state:

- Consult and work with key state and local stakeholders to perform outreach and education to consumers and small businesses about health plan options;
- Make decisions where there is flexibility to make them (for example, network adequacy and marketing);
- Utilize state standards to synchronize rules in and outside the exchange;
- Determine eligibility for qualified health plans, tax credits, cost sharing, Medicaid and CHIP;
- Provide eligibility information to applicable State agencies for health coverage enrollment;
- Potentially charge user fees to insurance companies selling plans on the exchange; and
- Solicit input when running the exchange.⁸⁷

⁸⁷ *Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. State Exchange Grantee Meeting, September 19-20, 2011.*

Table 5.2: Advantages and Disadvantages of a Federally-Run Exchange

Advantages	Disadvantages
<ul style="list-style-type: none"> • Allows states to focus on Medicaid eligibility upgrade, market reforms, and other requirements taking place at the same that exchanges need to be developed. • Ensures that the state does not invest considerable funds and time into a concept that has the risk of being overturned or repealed. • Ensures that the concept is operational and effective before the state considers absorbing responsibility at a later time. • Aggregates the cost of development over a broader base, which could be an advantage for a state with a small population. 	<ul style="list-style-type: none"> • There may be some loss of state-level control (although HHS seems to indicate that there will state be customized, state-level exchanges, even if federally operated). • Some states have greater faith in their own residents' ability to make decisions and develop institutions that will be appropriate for the state's own population. • Most institutional stakeholders (payers, providers, hospitals, etc.) would prefer for the exchange to be operated at the state level to ensure they have appropriate input into its operations. • There is no known funding available to assist states in paying for the transition to a state-level exchange at a future time.

A state-run exchange

Similar to the federally-run exchange, proponents of an exchange developed at the **state level** may choose this perspective for a variety of reasons. They may enthusiastically embrace exchanges as an opportunity to refine the insurance marketplace, they may have a strong desire for state control over its own institutions, or feel that they are better able to meet constituent needs at the state level. As such, a broad spectrum of constituents from different backgrounds may come together toward meeting a common goal. State-level exchanges have been decided upon in a range of states – mostly those with Democratic governors, and several with Republican. Many states have not yet determined their ultimate direction for exchanges, but may be working behind the scenes so that they are ready to operate an exchange at the state level should the external factors not undo the requirement to develop an exchange.

Table 5.3: Advantages and Disadvantages of a State-Run Exchange

Advantages	Disadvantages
<ul style="list-style-type: none"> • Maximizes the degree of control and customization to meet a state's needs. • Minimizes the role of the federal government in state-level institutions. • Maximizes the opportunity to use federal funds to develop an exchange 	<ul style="list-style-type: none"> • Requires significant development in a short timeframe with resources that are already short. • Could have a high learning curve to create a new institution in the state. • For states with a relatively small population, could have a high per-person development cost.

Federal-State Partnership Guidance

Beginning in September 2011, HHS created a new possibility for a federal-state partnership that is intended to ease the development of exchanges for states.⁸⁸ States may take advantage of federal modules where they provide value, reduce costs, or assist with time pressure. Some states could also begin with a partnership exchange with the intent to undertake all components of an exchange at some point in the future. The three options for partnership include the following modules:

1. **Plan management.** The state will be responsible for tailoring health plan choices, collecting and analyzing plan information, such as rates and benefit packages, and for monitoring and overseeing health plans and products including data collection and analysis for quality. HHS will be responsible for coordinating with the state on health plans and data to enter into federally facilitated exchange eligibility and enrollment functions as well as plan oversight including consumer complaints and issues with enrollment reconciliation.

2. **Consumer access and assistance.** The state will be responsible for management of the Navigator program, including providing direct assistance to help people sign up for insurance and outreach and education to consumers and small employers. HHS will be managing call center operations, the consumer website, and written correspondence with consumers.

3. **Plan management and consumer support.** The state manages all plan management and consumer access & assistance functions

Table 5.4: Advantages and Disadvantages of a Partnership Exchange

Advantages	Disadvantages
<ul style="list-style-type: none"> • States will be able to get federal help in setting up their health insurance exchanges without having the federal government run the whole exchange • Allows states to tailor their exchange to local needs and market conditions while offering a way to transition to fully operating their own exchanges in the future • Takes advantage of the State’s expertise and knowledge of their insurance markets to support local consumer needs 	<ul style="list-style-type: none"> • Design and specifications on partnership are still evolving as public comments are still being sought. Final rules could include business decisions that are not aligned with North Dakota’s preferences. • Increased coordination requirements between federal and state agencies • Federal funding for exchange is only through 2014. There is no indication of federal funding available to help states transition from the federal exchange to a state run exchange.

⁸⁸ “Exchanges: A Proposed New Federal-State Partnership,” HHS, CCIIO, State Exchange Grantee Meeting, September 19-20, 2011.

Geography

States must also consider whether to move forward with a single state or **multi-state exchange**. To date, there is only one multi-state effort known. A consortium is being led by the University of Massachusetts Medical School to create and build a flexible exchange information technology framework in Massachusetts and to share the platform with other New England states including Connecticut, Minnesota, Massachusetts, Rhode Island, and Vermont. This consortium has received \$35.6M in Exchange Innovator funds.

Table 5.5: Creation of/Participation in Multi-State Exchange Partnership
The exchange may also be separate from the state government.

Advantages	Disadvantages
<ul style="list-style-type: none"> • Economies of scale can be obtained for administrative functions • Greater number of competing health plans, which could lead to lower premiums • Managing large metropolitan areas that cross state boundaries • Opportunities for pooling across state lines • Increased critical mass in small population states 	<ul style="list-style-type: none"> • Greater complexity in identifying, managing and integrating multiple state laws, requirements, and agencies into operations, which will be an additional challenge due to the short implementation timeframe • May require the adoption of identical statutes in participating states, which could require Congressional approval • Risk segmentation may be difficult to avoid if rules governing plans in the multi-state exchange differ from those governing plans operating outside the exchange in even one state • Creates a complex environment for policy decision making

Structure

A state’s unique set of statutes, regulations, and strategic objectives will guide the selection of the governance structure of an exchange at the state level. There are three governance structures referenced in existing exchanges (those explored here include Massachusetts, Utah, and New York’s HealthPass) or under consideration by states developing their own exchange. Each of these governance structures has advantages and disadvantages. States may also define additional approaches that do not fit into one of these models.

Tables 5.6, 5.7, and 5.8 compare advantages and disadvantages of the three potential exchange models.

Table 5.6: Creation of a State Exchange Agency

The Exchange will reside either in an existing state agency, such as the Medicaid agency or the state's insurance department or a new state agency is created. The state will have oversight and regulatory control of the Exchange.

Advantages	Disadvantages / Challenges
<ul style="list-style-type: none"> • Clear focus on exchange development; no competing roles and responsibilities • Direct communication with Governor rather than through other state agency leadership • Allows for direct monitoring and control at the executive level 	<ul style="list-style-type: none"> • Exchange leadership could be subject to changes in governorship and could impede progress • Would need to start from scratch to build new relationships with agencies • Being a start-up adds additional activities, such as hiring for a broad set of positions, space, development of agency processes and procedures, etc. • State laws and procedures that can be barriers to exchange development may still apply • There could be political challenges with establishing another government agency

Table 5.7: Creation of a Quasi-Governmental Agency

Per HHS, a quasi-governmental entity is created or established by the State (through legislation or other law) and the governing body is established, appointed, and overseen by the State. The entity is subject to specific limitations on its authority to act as established by the State.⁸⁹ The entity may be partially or majorly funded by the state and may receive some revenue from charging customers for its services.

Advantages	Disadvantages / Challenges
<ul style="list-style-type: none"> • Focused efforts on developing the exchange rather than competing priorities • Potential freedom from existing procedural constraints of being a government agency (such as for personnel hiring, procurement, etc.) and flexibility to design processes • Greater insulation from political influence and special interest groups • May be able to more easily secure the authority to procure health plans and information technology and negotiate with third parties 	<ul style="list-style-type: none"> • Limited resources may require outsourcing of many functions • Building/start up from scratch is always difficult including hiring, space, development of agency processes and procedures, etc. • The need to ensure transparency and public accountability, such as the requirement to adhere to open meeting and open record laws, can make running the exchange process-heavy.

⁸⁹U.S. Department of Health and Human Services, *Exchange Establishment Cooperative Agreement Funding FAQ* (Washington: The Center for Consumer Information and Insurance Oversight, 2011).

Table 5.8: Creation of an Independent/Non-Profit

The Exchange may also be separate from the state government.

Advantages	Disadvantages
<ul style="list-style-type: none"> • Focused efforts on developing the exchange • Potential freedom from existing procedural constraints (personnel hiring, procurement) • Greater independence from political process; less affected by political leadership changes • Enhanced flexibility in designing operations and managing issues 	<ul style="list-style-type: none"> • Political isolation may cause difficulty in communication and coordination with other state agencies • State hesitancy to assign operations and resources to an entity for which it has limited control • Certain functions, by state constitution, can only be performed by the state, such as regulating economic activity and levying taxes • May be required to meet statutory requirements applicable to government agencies, particularly those for transparency and public accountability • Conflicts of interest could arise if providers, insurers, brokers, etc. are on the board; may invite scrutiny under antitrust laws • May not have easy access to state databases that allow for enrollment into state program

Board Oversight

Forming a Board for the exchange should include members who have the relevant expertise to address the myriad of issues that the exchange will face. The Board can greatly influence the strategic direction of the exchange as well as the credibility and perception. There has been considerable focus on potential conflicts of interest of the exchange Board in other states. Many believe that the Board should consist of a broad set of stakeholders; however, opinions vary as to whether those with a direct interest in the exchange should have board seats.

Some exchanges avoid this risk by ensuring that board members do not directly represent any key constituent group; instead, these critical perspectives are represented through stakeholder-specific advisory panels, such as for Payers, Providers, Producers, Employers, etc. In this way, no single representative of a constituent group is presumed to represent the interest of all members of that group. (For instance, small and large payers may have different priorities for the exchange – in those cases, all payers have a voice at the Payer Advisory Board rather than having one payer presumed to represent the interest of its competitors). This approach also prevents Board members to advocate and vote for particular policies that would uniquely benefit their own interests.

Other states see the expertise that these constituent groups bring to the table as critical for the effective management of the exchange. As such, they are intentionally represented on the board. In these instances, a great deal of trust is placed on any stakeholder Board

member to represent the interests of the broader stakeholder group rather than of their own unique position.

**Table 5.9:
Sample Approaches To Mitigate Exchange Board Member Conflict of Interest**

California Board members of the independent state agency running the exchange cannot be affiliated with any entity involved in the exchange (carriers, brokers, providers, etc.) or benefit financially from the exchange while serving on the board.

Colorado prohibits Board members of the non-profit running the exchange from making decisions that benefit them financially.

Connecticut does not allow any representative of the insurance industry or providers as board members of the quasi-public agency running the exchange.

Maryland Board members of the independent state agency running the exchange cannot be affiliated with any entity involved in the exchange (carriers, brokers, providers, etc) or benefit financially from the exchange while serving on the board.

Nevada Board members of the independent state agency running the exchange cannot be affiliated with insurance carriers or be a legislator.

Oregon's Exchange Board, an independent public corporation of the state requires, a balance between consumer representation and health insurance experts.

West Virginia Board members of the new entity within the Office of the Insurance Commissioner that is running the exchange are not allowed to receive compensation and must represent various stakeholders as defined in the law.

5.2 Revenue Sources

Feasibility and Start Up Funds

The Federal Government has provided funding to cover the costs for feasibility studies and startup of health benefit exchanges (HBE)⁹⁰. These include:

- **Exchange planning grants.** Section 1311 of the Affordable Care Act (ACA) provided funds of up to \$1M to states to perform initial research and planning related to the potential establishment of an exchange in the state. These one-year planning grants were awarded to 49 states, the District of Columbia, and four territories in September/October 2010 and March 2011.
- **Innovator grants.** Over \$241M have been awarded to seven states to support the development of HBE IT systems that are reusable and transferable.
- **Establishment grants.** Two categories of funds are available. States can apply for either level one or level two grants depending on their progress.

⁹⁰ *Affordable Insurance Exchanges. The Center for Consumer Information and Insurance Oversight.*
<http://cciio.cms.gov/programs/exchanges/index.html>

- **Level One grants** provide funds for up to one year to states who have made progress under their exchange planning grant. States are allowed to apply for a second year of funding so they can meet the criteria to apply for level two establishment grants.
- **Level Two grants** provide funding through December 31, 2014⁹¹ to those who meet the eligibility criteria including:
 - The legal authority to establish and operate an exchange according to Federal requirements;
 - A governance structure in place for the exchange;
 - A budget and initial plan for financial sustainability by 2015;
 - A plan to prevent fraud, waste, and abuse; and
 - A plan that details the creation, continued operations, and/or expansion of consumer assistance, including a call center.

Long Term Operating Funds

For long term operations, Section 1311 of ACA requires states to ensure that their exchange is financially self-sustaining by 2015. ACA provides guidelines for exchanges for achieving this goal, including:

- State exchanges are allowed to charge assessments or users fees to participating health and dental carriers;
- States have the discretion to use other methods to generate funding to support operations;
- State exchanges are prohibited from using administrative or operational funds for giveaways, retreats or excessive compensation; and
- Some funds for the exchanges must come from the states, such as for the navigator program.

While this is a range of funding options for exchanges, the two options being considered by most states are the health carrier exchange participation fee and the general health carrier fee. At least 10 states - CA, CT, IL, IA, MD, MT, NJ, NM, OH, and OR - mentioned these two revenue producing options in their legislation or planning documents as potential approaches for generating revenue for financial sustainability.

The Health Carrier Exchange Participation Fee

The health carrier exchange participation fee is applied to Qualified Health Plans (QHPs) in the exchange and is either charged as a per member fee or as a percentage of premium of exchange members. Since some exchange participants are projected to bounce back and forth between individual, small group and Medicaid coverage in a year, it is most likely that these fees will be charged on a monthly basis rather yearly. These funds may not be enough to cover costs of the startup and early years of exchange operations because it is dependent

⁹¹ The last date to apply for Level Two establishment grants is June 29, 2012.

on enrollment volume. Ultimately, these fees may be passed onto the consumer causing an increase in premiums.

The General Health Carrier Fee

The general health carrier fee is a charge to health plans for its privately insured members within the state. It can be applied on a per member basis or percentage of premium of the health plan's privately insured members. In this model, the cost of exchange operations is spread over a wider population. These fees will likely also be passed onto the consumer and thus could raise premiums of the privately insured.

Other Revenue Generation Options⁹²

Secondary research uncovered additional options for generating revenue to assist with exchange financial sustainability:

- The **Employer fee** which is paid by the employer accessing the health plan products in the exchange. It is possible that this approach may deter employers from the exchange if the total cost for the exchange plan premium plus the employer fee is of higher cost than those products outside the exchange.
- **Member fees** are paid by members in individual or small group QHPs in the exchange. Revenue from this approach increases with Exchange enrollment. However, employers and employees may be deterred from participating in the exchange if the total cost for the exchange plan premium plus the member fee is of higher cost than those products outside the exchange.
- **Broker fees** are paid by brokers selling QHPs in the exchange. This could serve as an additional revenue stream but also likely to increase the cost of the QHP.
- **General revenue** from state coffers may provide a reliable amount of funding for startup and operations for the early years of the exchange. However, relying on general revenues exposes the exchange to the changing priorities of the state and of the political environment. There is a risk that general revenues may also fall short if enrollment targets cannot be met.
- **Divert revenue** from programs phase out due to health reforms. For example, this option presents a savings opportunity for the state while supporting exchange sustainability at the same time. However, programs for phasing out are likely to be unknown for a while and funding may not be available for startup or even year 1 or year 2 as the transition from the phase program need to occur first.
- A **targeted income tax** may be imposed on high income earners who are better able to bear the tax. However, this option is likely to face strong political opposition.

⁹² List compiled through HTMS research reviewing models being considered by other states.

- **Public and private sources** such as grants, endowments, and contributions are possible revenue sources. It is likely that these sources serve as supplemental rather than primary sources of revenue and not a reliable source long term. Disadvantages of this approach include resources required to apply and maintain grant requirements, exposure of the exchange to political and special interests and thus potentially jeopardizing exchange credibility.
- The exchange may seek **fees from other programs** for which it is performing eligibility determination, referral, and enrollment. Complex intra/inter-organizational policies, procedures and service level agreements between the exchange and associated programs will need to be developed. In addition, tracking and financial reconciliation will likely be complex.
- **Excise taxes** especially those targeted at unhealthy lifestyles such as soda, tobacco, candy and alcohol have been used in the past to fund various programs. These taxes are targeted to product users linked to health care utilization. However, these taxes have also been reversed and thus may not be a reliable stream of revenue.
- **Provider fees for clinical services and services** such as elective procedures and pharmaceuticals could serve as a revenue stream. The fees are targeted at health care utilization; those with health issues will have to pay more than those who are healthy. However, it may be quite difficult to collect these fees and may not be politically feasible.
- The state could funnel the **ACA penalties** for forgoing health insurance coverage to the exchange. This approach is most likely to be a supplemental income strategy for the exchange. The revenue declines as exchange enrollment increases. Finally, this option is subject to the outcomes of the individual mandate.

To date, there are two exchanges and one employer-like exchange that are collecting revenues to support operations. The Massachusetts Connector charges a fee that is built into the overall premium rate for both subsidized and nonsubsidized products it administers. Utah charges and collects \$6 per member per month which is paid to its vendor, Health Equity, which operates the exchange software. Finally, New York's HealthPass, a SHOP-like exchange which has been operational the last 11 years, collects an employer fee, a health plan assessment fee, and additional administrative revenues.

Guidelines for Sustainability

Milliman identified seven guiding principles⁹³ to help exchanges determine the best financial sustainability model that meets their needs. Table 5.10 lists them along with implications for North Dakota.

⁹³ Palmer, D., Herbold J. and Houchens, P. "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange," A Milliman Client report for the Ohio Department of Insurance, August 2011.

Table 5.10: Guiding Principles for Exchange Financial Sustainability and Implications for North Dakota

Guideline	Implication
Develop a defined process and decision criteria and engage stakeholders in choosing the financing approach	<i>Stakeholder engagement needs to be structured to address a range of particular issues to be decided and targeted to particular stakeholder groups</i>
The financing approach should be easy to explain	<i>An effective stakeholder-specific engagement policy needs to be deployed</i>
The financing option should not discourage participation in the exchange	<i>North Dakota needs to assess the relative impact of its revenue structure among a range of carriers and stakeholders</i>
Aim for an approach that is not difficult or too complex to implement	<i>Given timelines, it may be valuable to consider existing revenue mechanisms and currently available data.</i>
It should not contribute to adverse selection	<i>Scenario analysis should be performed on target revenue schemes to consider possible outcomes and, as needed, make adjustments to prevent risk-selection issues</i>
Develop a combination of reliable streams of financing with those of unstable/more unpredictable revenue streams	<i>North Dakota will need to develop a strategy to determine its level of comfort with unpredictable or one-time funding opportunities.</i>
Establish a financial surplus of 20-25% of the annual operating budget in 2014	<i>It may be valuable to establish initial revenue targets higher than operating level requirements</i>

5.3 Premium Aggregation

On July 15, 2011, the U.S. Department of Health and Human Services (HHS) issued proposed rules on exchange implementation: **Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)**. The proposed rules include specific guidelines on premium aggregation responsibilities for both the individual and small employer group (SHOP) markets⁹⁴:

⁹⁴ The federal government extended the comment deadline on these rules until October 31 at which time HHS will work to review all the comments and promulgate final rules on premium aggregation. At the time of the writing, HHS had not yet released final rules.

Individual Premium Aggregation

(Preamble, Sec. II.A.3. f; Regulatory Text: §155.240). HHS offers the exchange three options for premium aggregation in the individual market.

1. **Hands Off** – The exchange takes no part in payment of premiums
2. **Pass Through** – The exchange creates an electronic “pass through” without retaining any of the payments
3. **Facilitator** – The exchange or contracted third party collects premiums from enrollees and pays an aggregated sum to the QHP issuer

Regardless of which option is chosen by the exchange, it must allow enrollees to pay premiums directly to the QHP carrier.

SHOP Premium Aggregation⁹⁵

The key objective of HHS in developing the premium aggregation process for SHOPS is to simplify administrative procedures for small group employers in order to encourage exchange participation. HHS projects that most SHOP exchanges will aggregate employer and employee contributions for the selected QHP as a service to employers and aim to have small group employers pay only one bill rather than managing multiple bills from different QHP carriers each month. HHS is prescriptive in the three step premium aggregation process for SHOPS.

Step 1: The exchange will provide each qualified employer with a consolidated bill on a monthly basis that shows the total amount due to the QHP carrier(s) from the qualified employer. (The exchange will reconcile any premium tax credits and employer contributions to arrive at the final premium bill.)

Step 2: The exchange will collect payment from each employer the total amount due

Step 3: The exchange will make payments to the QHP carrier in the SHOP for all qualified enrollees

Regardless of whether the premium aggregation process is for individual market or SHOP participants, the HHS proposed rules are silent on aggregating contributions from other sources such as employees, second employers, spouses, and other potential contributors to the QHP premium.

Premium aggregation functions represent a complex undertaking requiring processes, policies, and procedures across stakeholders as well as integration across core areas and technology of the HBE. In particular, premium billing will be a trigger for discrepancies in

⁹⁵ ACA Preamble, Sec. II.A.5.b; Regulatory Text: §155.705.

the exchange enrollment system. The exchange will be the system of record that identifies what coverage and subsidies a consumer is eligible for as well as the data that needs to be communicated to all parties for accurate reconciliation and premium billing..

Documentation requirements must be developed to synchronize enrollment and eligibility in the QHP with the QHP issuer and the exchange enrollment system. Should the exchange outsource premium billing services, it must determine the scope of authority of its outsource vendor to correct enrollment discrepancies and reconcile the bill and its collection. Finally, depending on exchange administrative model, the interface for premium billing provides the opportunity to charge and collect fees for exchange participation for revenue generation.

North Dakota may still need to perform further due diligence to determine the level of effort the HBE will undertake with regards to premium aggregation.

Some approaches to keeping costs low could include:

1. Minimizing the premium aggregation and operational functionality taken on by the HBE;
2. Seeking vendor solutions where the development costs can be distributed across a much larger base; and
3. Maximizing opportunities for automation while federal dollars are available to build the HBE, driving toward minimal ongoing operational costs.

As North Dakota defines its strategy for premium aggregation, it will be important to assess the impact to the carrier marketplace. The decision of which premium aggregation and other services are managed by the HBE could be perceived to advantage or disadvantages different kinds and sizes of carriers in the marketplace. These implications need to be understood as part of the decision-making process.

5.4 Individual and Small Group Markets

Section 1312 of ACA provides exchanges the following guidance on managing risk pools:

- Individual health insurance enrollment *inside and outside of the state's exchange must be members of a single risk pool;*
- Small group health insurance enrollment *inside and outside of the state's exchange must be members of a single risk pool; and*
- *Exchanges have the flexibility to merge the small group and individual health insurance markets within the state. No date is provided for the merge of the two markets.*

In merging the individual and small group risk pools, health experience and risk for utilization of health care services of members of both markets are combined together to create one risk pool which then becomes the basis of the individual and small group

premiums. However, per Milliman⁹⁶, combining the risk pools together does not automatically mean that premiums in both markets will be the same. As long as state law and regulation allow, health plan carriers could use the merged risk pool experience as the starting point for their premium development. Actuarial adjustments can be made for the benefit plans sold to each market and add market-specific administrative expenses, broker commissions, and other retention charges to arrive at total premium amounts for each segment.

The actuarial adjustment approach described by Milliman may be attractive to health carriers since the prevailing experience and opinion is that individual and small group markets have very different risk profiles that impact premium costs. The three segments comprising the individual market are a) the actively working/no employer health coverage; b) the disabled/not working; and c) the not disabled/not working. The small group market accessing the exchange is composed of those actively working but no employer health coverage. The individual segments of the disabled/not working and the not disabled/not working have worse health status than the actively working/no resulting in higher premiums in the individual market overall. In a Milliman analysis of the Ohio population for its exchange, individual market premiums for a given age were estimated to be 8% - 12% higher than the group market.⁹⁷

State exchanges will still have the administrative flexibility for managing the market segments. The decisions on separation or integration of risk pools and member access for the small group markets offer choices that affect operations. The options range from member access and risk pools that are both separate to where member access and risk pools are both integrated. The choice of options will depend on the exchange administrative structure and the flexibility that allows them to manage the market segments efficiently. For example, an exchange could create one point of entry for both individual and small group segments and perform joint operations and administration.

⁹⁶ Palmer, D., Herbold J. and Houchens, P. "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange," A Milliman Client report for the Ohio Department of Insurance, August 2011.

⁹⁷ Palmer, D., Herbold J. and Houchens, P.

Table 5.11: Merging Individual and Small Group Market Segments	
Advantages	Disadvantages
<p>Administrative The population most likely to use and benefit from purchasing coverage in the exchange move between employer and non-group/individual coverage more frequently thus having one exchange will make it easier to manage these transitions. Fixed administrative costs can be spread across a larger pool of members and managing one exchange is less costly than two.</p>	<p>Administrative Balancing differing priorities of Individual and SHOP exchange may pose difficulties for one entity. It is likely that health carriers will have less flexibility to meet the unique needs of the individual and small group markets. For example, the individual and small group employers and members have different messaging and customer service needs.</p>
<p>Cost and quality The exchange will be better able to overcome adverse selection and offset large claims or a small number of high utilizers. Also, the exchange will have greater ability to impact cost and quality resulting in lower and more stable premiums.</p>	<p>Unfavorable premium impact to Small Groups The higher risk profile of the individual market will increase the risk profile of the small group market and its premium costs. In Ohio, the health benefit plan costs (premium plus member cost- sharing) are estimated to decrease 3% to 7% for individuals and increase 4% to 8% for small groups if the markets were to merge.⁹⁸</p>
<p>Even playing field Having one risk pool prevents health plan carriers in participating only in the small group market which is healthier than the individual market.</p>	<p>Lower enrollment Increase in premiums may motivate small groups to self-insure or drop coverage altogether rather than participate in the exchange.</p>
	<p>Barrier to entry Some carriers may not be willing or have the capabilities to serve both markets and thus may choose not to participate in the exchange. This could lead to fewer health plan carriers participating in the exchange.</p>

In the short term, it is projected that premium rates, plans, and health insurance carrier earnings will be highly unstable as consumers, employers, health insurance carriers, providers and other stakeholders react and adjust to the exchange impacts on the market. The general consensus amongst health carriers and some states that have performed

⁹⁸ Palmer, D., Herbold J. and Houchens, P.

deeper analysis on this issue is to study the existing health insurance market to assess the impacts of merging pools, especially those factors that may result in severe market disruption and rate shocks. The prevailing advice is to wait for the market to “shake out” before making the decision to merge the risk pools.

6. Outreach Plan

Outreach and Education are critical functions for a successful exchange. Because exchanges will be new to the marketplace, consumers and small business, as well as other constituents, will require education about how they fit in the marketplace. Exchanges represent a new means of doing business that includes a web-based interface, offers a distinct set of products that may be different from those on the general market, and provide consumers with a different set of information when making choices. Educational theory and consumer marketing strategy can be useful tools in addressing how to inform consumers about new options available to them in ways that may drive them to change how they shop for insurance.

Marketing research suggests that new products are often purchased initially by a subset of consumers, and then spread to a broader base over time. This pattern leads companies to realize that introducing new concepts requires some up-front investment, and also that it is important to please initial users of a product, in this case, the exchange.⁹⁹

Because of individual mandate that requires individuals to carry insurance coverage coupled with federal subsidies to assist individuals and small businesses with purchasing coverage, many consumers will be gaining access to commercial health coverage for the first time. This population may represent a significant portion of consumers purchasing through the exchange. These individuals may not be familiar with core components of insurance such as networks (especially if they are limited), deductibles, co-pays, out-of-pocket maximums, and other elements of how insurance works.

Because of these factors, the education and outreach plan for the exchange are critical to the organization's success. Even if all elements of technology, infrastructure, products, and service are in place, without sufficient education and outreach, especially in the early years, exchanges are unlikely to be successful. This section offers a core structure for how the exchange may want to consider establishing such a program.

Overview and Key Findings

Guiding principles: Exchange transparency and ongoing engagement of multiple constituencies – especially vulnerable ones – are foundational to the creation of an engagement plan.

Phasing: Effective outreach uses three successive campaigns building upon one another: awareness, education, and action.

⁹⁹ Lars Perner, *Consumer Behavior: The Psychology of Marketing*, available at <http://www.consumerpsychologist.com/>.

Channels: Outreach will rely heavily on Web-based messaging and tools it must also include traditional media outlets and in-person activities in order to achieve the broadest reach possible.

Outreach and Education are included as one of the “minimum functions of an exchange in HHS’s requirements for exchange establishment grants. HHS also provides a recommended timeline for outreach and education activities¹⁰⁰. Unlike activities and timelines for other parts of establishing an exchange, HHS has **not** made any items for outreach and education required, but it has offered some recommended activities by year, as identified in Figure 6.1¹⁰¹.

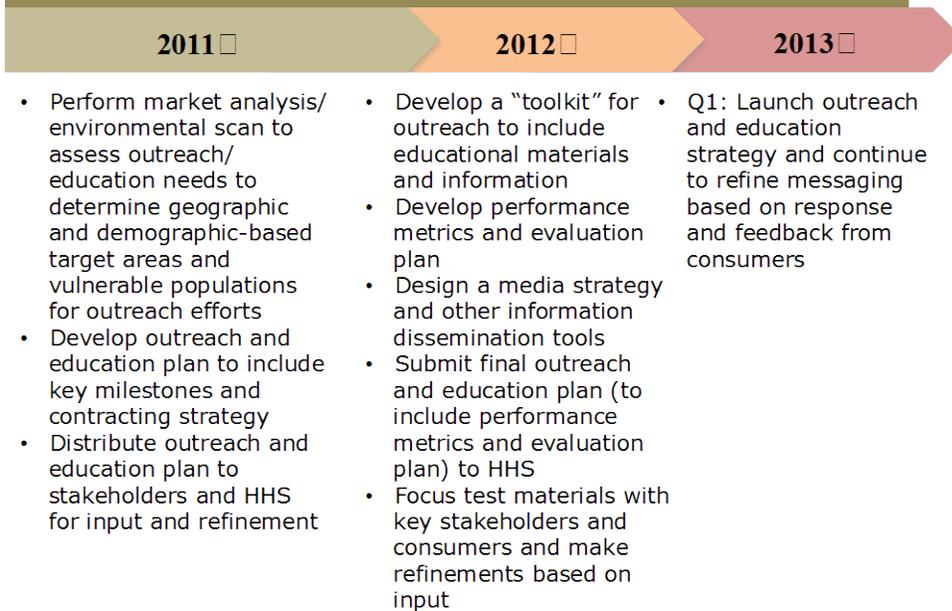
Each State will need to have in place a robust education and outreach program to inform health care consumers about the exchange and the new coverage options available to them. The exchanges must also educate consumers about the benefits of purchasing health insurance coverage through the exchange, including access to health plans that meet State and Federal certification standards and access to assistance with paying their premiums and cost-sharing. Each exchange may determine a unique strategy for conducting outreach and education activities and timelines may vary depending on the investment exchanges choose to make in these activities as well as the size and diversity of the populations each exchange serves.

Source: Office of Consumer Information and Insurance Oversight, 2011

¹⁰⁰ Affordable Insurance Exchanges. The Center for Consumer Information and Insurance Oversight. <http://cciio.cms.gov/programs/exchanges/index.html>

¹⁰¹ “Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges.” Office of Consumer Information and Insurance Oversight. Jan 2011. http://cciio.cms.gov/resources/fundingopportunities/foa_exchange_establishment.pdf

Figure 6.1: HHS Recommended Timeline for Outreach & Education



Stages of the Outreach and Education Plan

An effective outreach plan should have distinct stages, as the key messages change over time. For exchanges, the work can be divided into phases of outreach planning, then creating general awareness of the exchange, then educating about the exchange, and, lastly, communicating specific enrollment information and action steps. Stakeholder engagement across all these phases of engagement brings a venue for ongoing improvements to the outreach program.

Outreach planning is the necessary first step to establish a communications strategy, define messaging and goals, articulate activities by customer segment, and establish success metrics.

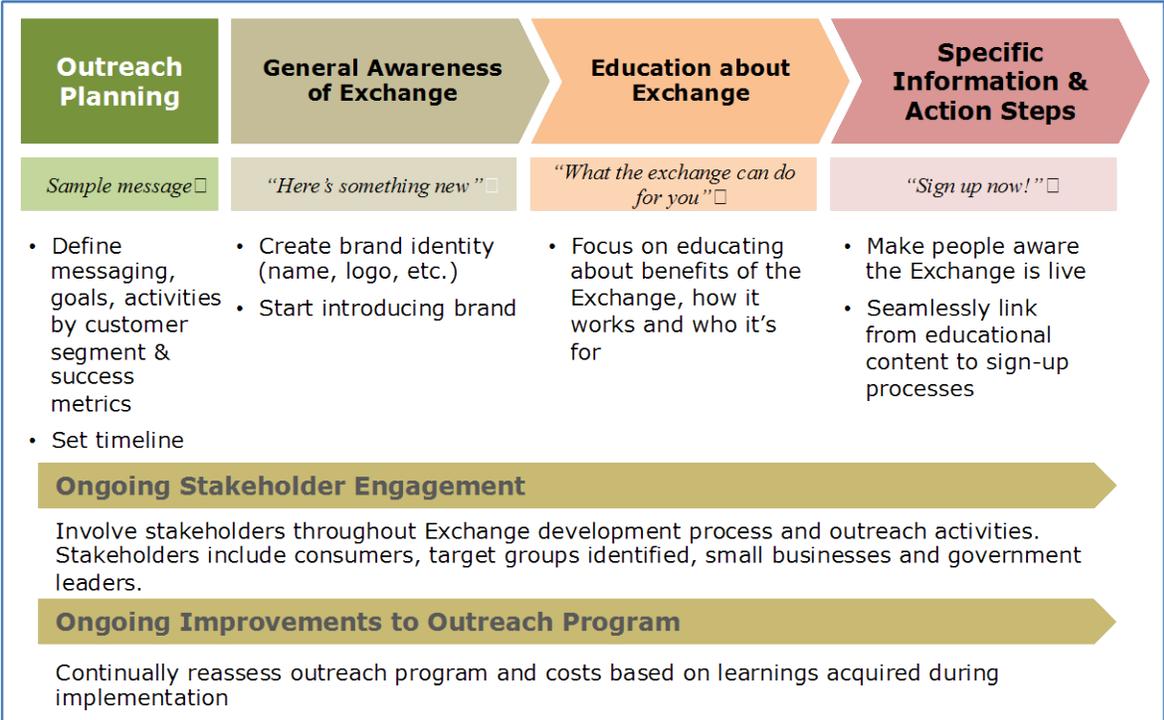
Suggested activities are provided by HHS that fit into this phase include doing market analysis to determine needs, and defining target areas and specific market segments, such as the uninsured, small businesses, Indian Tribes, etc.. It may be advisable to plan particular activities intended to assist vulnerable and underserved populations.

This phase is where the exchange may decide to use a minimalist communication strategy, taking advantage of existing advertising and communication venues, versus defining a comprehensive strategy that could include expensive advertising in many new venues. It is also the phase to determine the key timeline and expenses to drive the activity during the startup phase and to develop a mechanism for defining the ongoing strategy once the exchange is well-established.

The **General Awareness Phase** is the opportunity to introduce the concept of exchanges to the public. The key messages during this phase include an introduction to the concept of

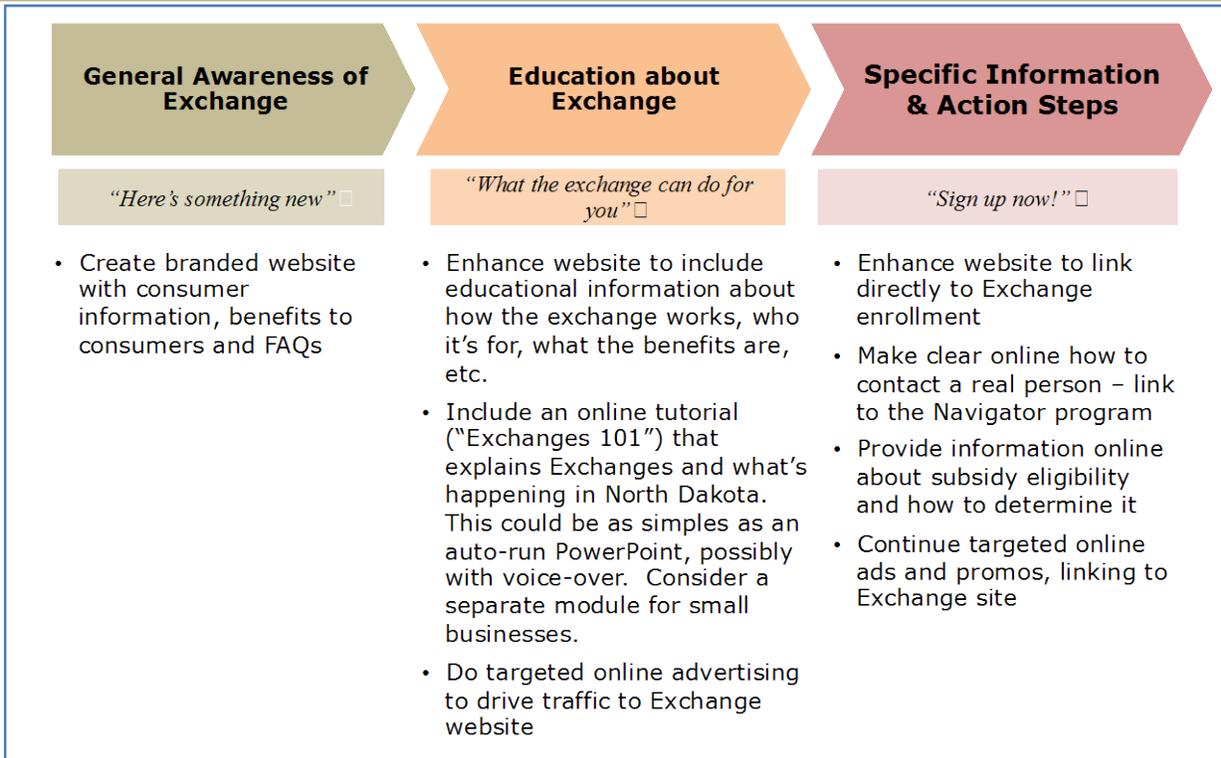
exchanges and the approach decided upon specifically for North Dakota. The **Education Phase** provides more specific information about the key functions and benefits of an exchange so people begin to have an understanding of what it will mean for them. And, finally, the **Action Phase** is geared to specific steps that need to be taken for individuals to sign up with the exchange. Individuals are unlikely to complete the steps in the final phase if they have not had an introduction and education related to the exchange in advance.

Figure 6.2: Phases of Outreach Planning



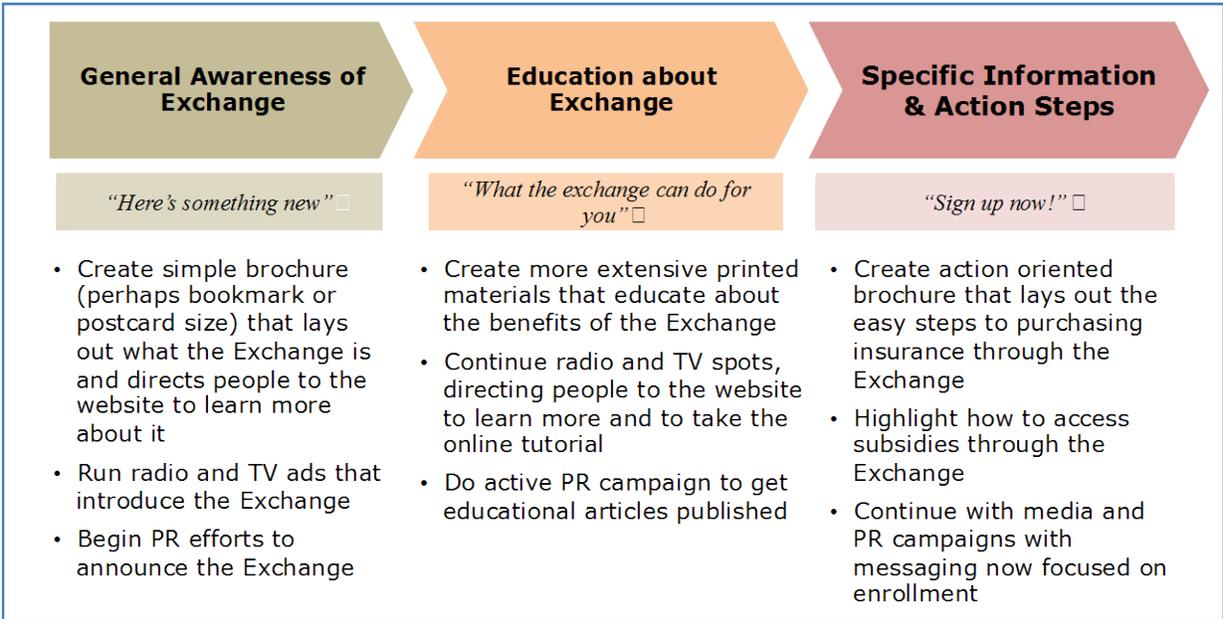
Each of these phases will have strategies related to online communications, printed collateral, media outlet, and in-person activities. Examples of activities in each of these phases is outlined in the diagrams that follow. The specifics for each of these would be further defined in the planning phase, and then refined and executed overtime as each phase takes place.

Figure 6.3: Possible Online Activities by Phase



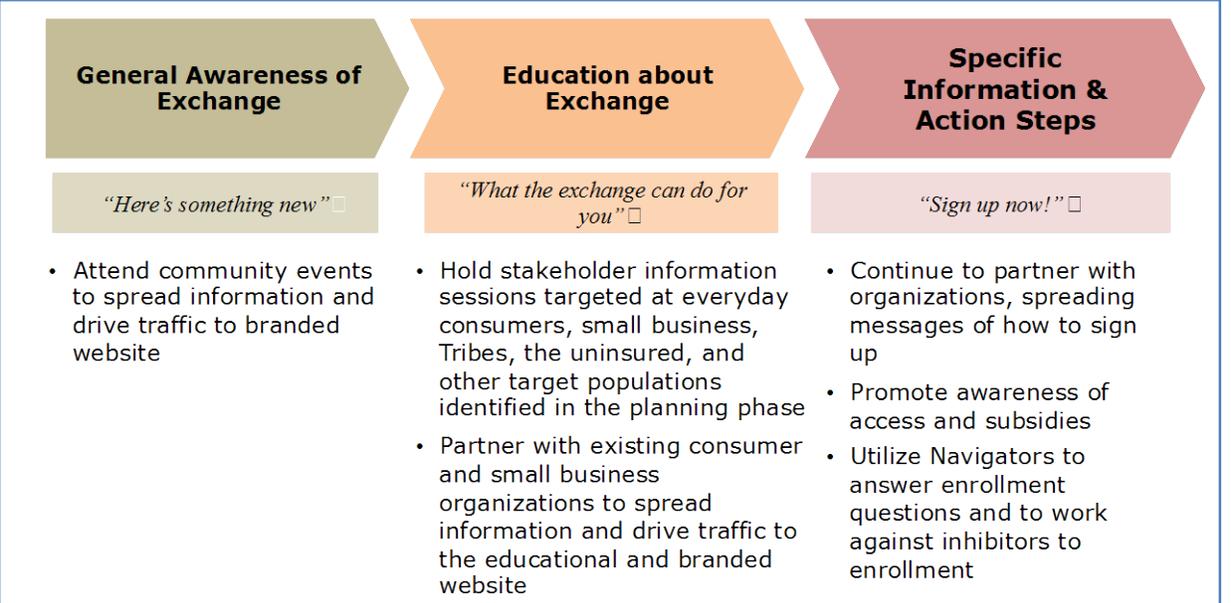
Investment in high-cost printed collateral can be kept to a minimum to keep expenses down. While there may always be a need for some written communications, this kind of collateral can be focused upon driving traffic to a fully enriching web experience for branding, education, and enrollment. This web-based training can be more interactive, targeted, and scalable. For people who may not have access to or interest in web-based communications, this liaison function can be an important function for agents, brokers, navigators, customer service representatives, eligibility workers, and other advisors.

Figure 6.4: Possible Collateral and Media Outreach by Phase



Lastly, the outreach planning work may determine that these types of in-person activities are the best to implement. This can include identifying the right forums for reaching target segments of the population. Having a well-researched and planned effort in this area will be critical in keeping down costs.

Figure 6.5: Possible In-Person Activities by Phase

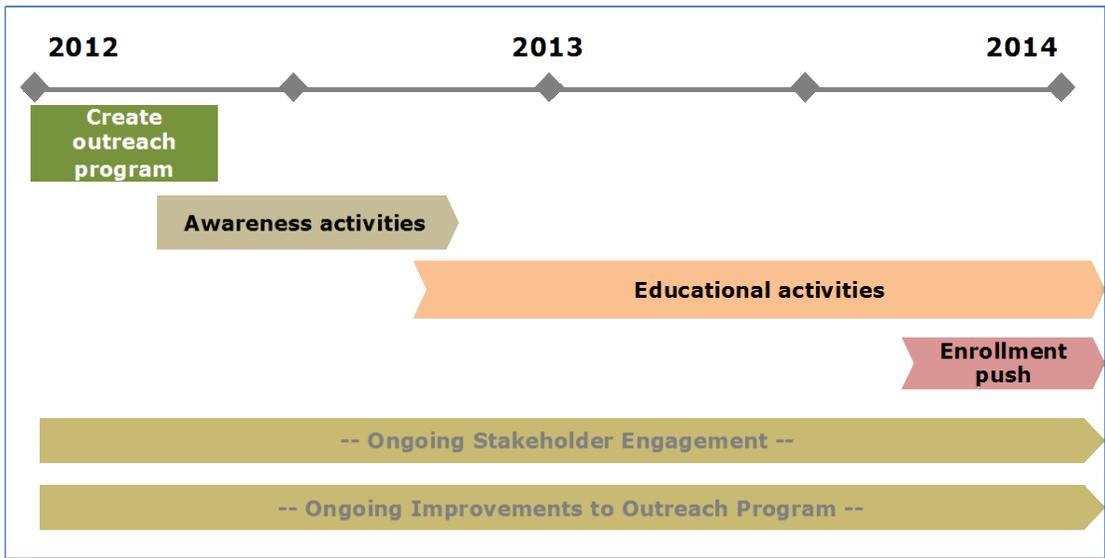


Project research with small businesses showed how important it is to reach this busy audience where they already are, rather than through setting up new, separate channels of communication. Outreach efforts need to utilize this finding and take advantage of existing

in-person opportunities with small businesses. This could include working through relevant small business and trade groups.

All parts of the outreach plan – from planning to awareness, into education and enrollment, and including stakeholder engagement and ongoing improvements – should be mapped onto an actionable timeline. A sample timeline is given below:

Figure 6.6: High Level Timeline

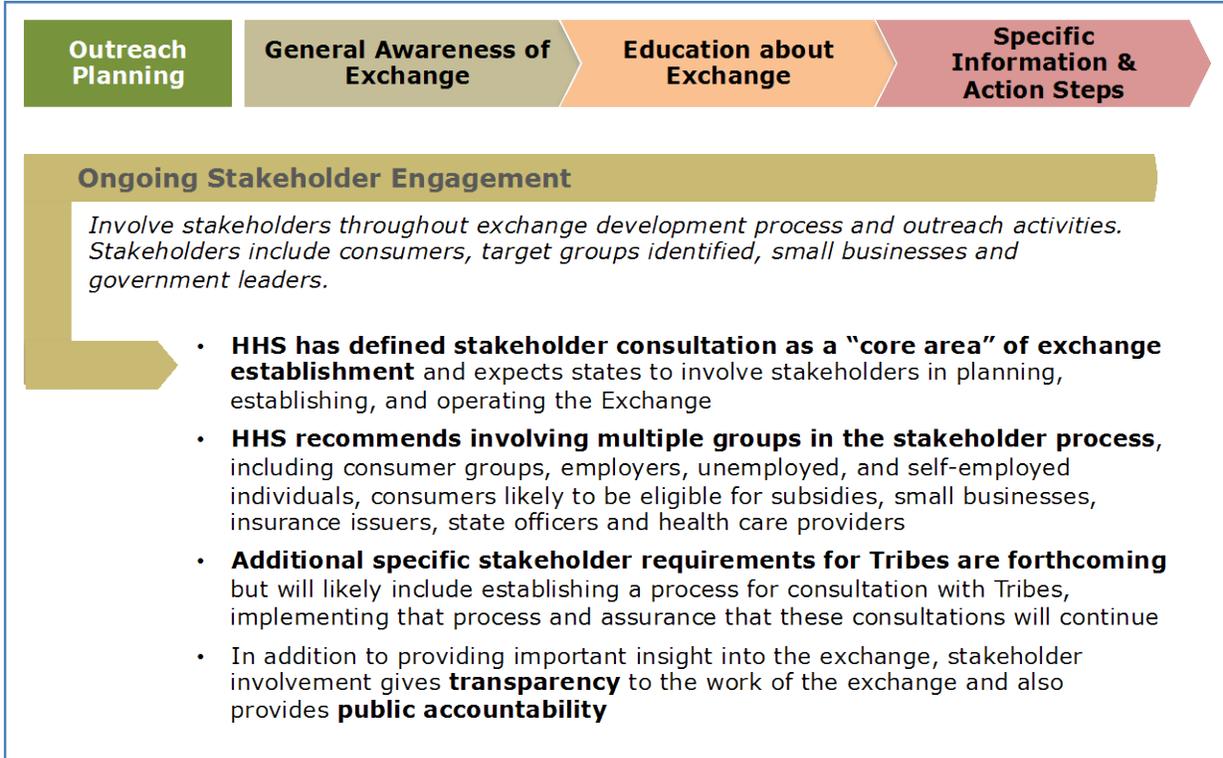


A more detailed timeline is an outcome of the outreach planning phase.

Stakeholder Engagement:

Another important aspect of outreach is stakeholder engagement, which should run throughout all phases of the outreach work (from planning through awareness, education, and action). HHS has also provided guidelines for what a stakeholder engagement plan should include¹⁰²:

Figure 6.7: Stakeholder Engagement Guidance



Many stakeholders should be involved in the engagement process, and an appropriate schedule for meeting with each group needs to be established.

A sample engagement schedule is provided in Figure 6.9 below. Further work in partnership with state agencies and stakeholders is needed to prepare a final proposed schedule.

Coordinating stakeholder engagement requires significant effort since the schedule can very easily become crowded. Additionally, effective stakeholder engagement requires resources with skills and training in this specialty. Providing the balance between education, soliciting opinions, and generating questions in a format that will provide the needed feedback and engagement are considerable skills.

¹⁰² H.R.3590: The Patient Protection and Affordable Care Act. 111th Cong., 2nd Sess. (2010).

Figure 6.8: Sample Annual Stakeholder Engagement Schedule:

Constituency	Q1	Q2	Q3	Q4
Consumers	█	█	█	█
Small Businesses	█	█	█	█
Tribes	█	█	█	█
Agents	█		█	
Providers	█		█	
Insurance Issuers		█		█
Consumer Groups		█		█

HTMS research revealed that it is important to create a stakeholder engagement plan that connects with various groups on where they naturally congregate, in addition to other channels.

Examples of best practices for achieving stakeholder engagement include:

- Becoming involved in scheduled events or annual meetings of different groups such as the North Dakota Hospital Association, North Dakota Medical Association, Small Business Association, and other constituent and trade groups.
- Seeking representatives from these groups to serve as representatives or liaisons between the exchange and their own communities.
- Ensuring that constituents have the information they need to provide relevant input into the process. Even those constituents who consider themselves to be educated about exchanges may have limited or incorrect information.
- Developing communication strategies that are accessible and engaging – seeking methods of communication that do not rely on “bullet-points and talking heads.”
- Multiple channels over time are required to ensure a message is heard. This notion does not require heavy investment in advertising and media, but requires a specific and targeted outreach schedule that seeks to get information to constituents in a range of settings.
- A continuing environment of transparency and information sharing to gain public trust and maximize the impact of any effort.

There are several implications for North Dakota's exchange outreach efforts from the outreach work taking place in other states:

- **Planning for outreach work:** Outreach efforts are often a bigger project to define and manage than anticipated. States need to ensure that they have allocated sufficient resources to this activity.
- **Staffing outreach work:** It is not uncommon for states to define roles in their HBE plans who are fully devoted to exchange outreach efforts.
- **Supporting outreach work:** Outreach efforts are viewed as significantly important, and oversight of outreach work and accomplishments is assigned to the highest levels of the exchange.