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May 4, 2011

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On behalf of Hewlett Packard, I am please to convey to you the attached response to the West Virginia Insurance Commission Request for Information for Health Insurance Exchange (HIX). Over a year ago, HP was fortunate to meet in Charleston with representatives of the West Virginia Insurance Commissioner's office. HP submitted a "vision document" with high-level, conceptual discussions representing our perception of the direction of the states and the Federal government in those early days. Subsequently, HP sponsored a webinar and real-time discussion of the concepts and implications contained in that white paper.

It was clear at that time, and continues to be evident, that West Virginia is a leader in the pursuit of HIX capabilities. We were impressed then, and continue to be impressed now, with the breadth and depth of the Commission's investigation into the state of the art of Health Insurance Exchanges. Under Commissioner Jane Cline's leadership, West Virginia is out in front and this RFI will serve to further define what the industry, interested vendors, Federal regulations and other states can provide.

HP, the largest technology company in the world, has teamed up with AON Hewitt, a leading human resources consulting firm doing business worldwide in over 120 countries, to bring a thorough preliminary response to the West Virginia RFI. Headquartered in Chicago, Aon Corporation is the leading provider of risk management services, insurance and reinsurance brokerage and human resources consulting and outsourcing. As regards this RFI response, the key word is preliminary, since it is our combined opinion that the information sets are naturally limited by the format.

The HP/AON Hewitt team respectfully recommends that vendors be given the further opportunity to expand upon the answers given to the state's inquiry. It is our fervent hope that this additional "exchange" would be soon, and on-site so that the concepts addressed in our response can be detailed and our mutual understanding of these important issues can be thereby increased.

Once again, we are grateful for this opportunity to respond. The HP/AON Hewitt team fully supports the West Virginia Office of Insurance Commission's energetic pursuit of

knowledge about the possibilities, the parameters and the promise of an effective Health Insurance Exchange. Upon review of our attached response, if you have any questions or desire additional information, please do not hesitate to contact me via the information below.

Sincerely,

C. Kent Durso
Client Sales Executive, Americas Healthcare Industry

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Introduction

HP Enterprise Services, (HPES) and Aon Hewitt are pleased to submit our response to the Request for Information (RFI) published by the West Virginia Offices of the Insurance Commissioner (OIC) with respect to implementation of a health insurance exchange (HIX). In responding to this RFI, HPES and Aon Hewitt draw on our experience delivering commercial and government health and human services solutions, the breadth and depth of our expertise in the health care industry, and our experience helping employers comply with state health care reform mandates. In this section, HPES and Aon Hewitt summarize our capabilities including our industry and domain expertise, applications knowledge, and strategic planning capabilities to efficiently address the new Health Insurance Exchange mandates.

HP Enterprise Services

HP Enterprise Services is a proven leader in the global delivery of application services, including application maintenance in a production environment, hosting services, and business process outsourcing. Our extensive experience with service integration projects brings a strong focus on implementation and organizational change management. HPES is the world's largest healthcare IT company.

For more than 40 years, HPES has provided IT outsourcing, business process outsourcing, and application services to the health plan segment, which includes commercial health plans, Blue Cross Blue Shield Plans, managed care organizations, and third-party administrators. One of our core solutions for commercial payers is MetaVance, a claims administration service. It is based on an open architecture and is designed to scale for payers from 50,000 to millions of covered lives. MetaVance automates core administrative processes for health plans with multiple companies, lines of business, and products—such as indemnity, preferred provider organization, and health maintenance organization.

For federal, state and local government, we offer a diverse portfolio of Medicare, Medicaid and related services, including MMIS development and maintenance, documentation, fraud and abuse detection, call center operations, claims processing, provider outreach, immunization registries, e-prescribing, and education. We also provide services that address critical industry issues, including health information exchanges, eligibility, informatics, and care management.

Our history as the leader in human services and healthcare IT services positions HPES at the forefront in addressing the fast paced changes of health care reform.

Aon Hewitt

Aon Hewitt is unique in its ability to provide proven services across the full range of human capital management. As a combined organization, Aon Hewitt has been in business since October 1, 2010. Separately, Aon

Consulting, Inc. has been in business for over 40 years and Hewitt Associates LLC has been in business for over 70 years. Our three business segments—Benefits Administration, HR Business Process Outsourcing, and Consulting—help clients develop, implement, and deliver strategies and programs that embed effective human resources business process design, administration, and technologies into their business environment.

We have strong breadth and depth of experience, expertise, and capabilities in the areas of actuarial work/studies, state exchange knowledge, and the application of our methodologies and best practices in the health arena. Aon Hewitt has closely followed every development in health care reform, and has continually developed new solutions to enable government clients to effectively respond to the new requirements. For example, we are experienced in helping employers comply with state health care reform mandates. Working with states such as Massachusetts and Utah, we have established best practices and lessons learned.

Aon Hewitt has a deep working knowledge of the public sector. We currently work with more than 400 clients in the public sector including 30 states on benefits plan strategy, design, analysis, and management. The insight and expertise Aon Hewitt has acquired regarding how states operate in the insurance arena with respect to their own employees has given us a deeper understanding of how they will view exchanges for individuals and small employers. It has also given us the ability to be creative in solving difficult problems such as resource allocation, identifying money-saving features in the plans, and negotiating with carriers and pharmaceutical benefit managers over pricing and quality of services.

In the following sections, HPES and Aon Hewitt present our perspective on the questions presented by OIC. Given the inherent response constraints, we have attempted to provide OIC with high-level options based on our expertise and strategies that other states are implementing. Our response is presented in the following order: Section 1.4.3, Section 1.4.4 and Section 1.5.

Technical Discussion

Question 1: Likely take-up of Exchange ...incomes... 139 percent and 400 percent poverty?

Take–up among people with incomes between 139 percent and 400 percent could be significant for West Virginia. A recent study conducted by the Urban Institute[1] indicated that West Virginia would experience a higher than average increase in the 138 to 400 percent range along with a significant increase in the Medicaid population. With the addition of self-service options and streamlined processing, consumers will be able to use web portals to shop, compare, and purchase insurance. This ease of access will encourage many consumers who would not otherwise be interested in applying. As an example of a successful web access initiative, we recommend review of the Oklahoma Online Enrollment process developed by HP that became operational in

[1] Urban Institute, March 2011; *Timely Analysis of Immediate Health Policy Issues* by Matthew Buettgens, John Holahan and Caitlin Carroll

September 2010 for certain categories of Medicaid recipients. Today, one-half of all Medicaid applicants are totally self service via the Internet with less than 10 percent paper applications. A key component to support "take-up" will be an effective media-based outreach effort.

Question 2: Should the State establish a basic health program for people up to 200 percent of poverty?

Yes. The upside is considerable with potential higher enrollment and there would be little risk presented by establishing a basic health plan. Designing and promoting a basic health plan can be an effective enrollment strategy for individuals under 200 percent of the federal poverty level as well as for higher income individuals above the 200 percent threshold.

Question 3: How can the Exchange ensure continuity of care for individuals who fluctuate...?

Consumers will be much less likely to enroll in the exchange if they have to change insurance plans each time they become eligible for a different program. If a consumer straddles the eligibility line between Medicaid and other coverage and there is no omnibus eligibility accommodation, the consumer is more likely to drop coverage once classified as ineligible for their current program. When that happens, there may be greater potential for exchange eligibility.

We recommend that exchange enrollment for former Medicaid members be monitored. One way to do this is to create automatic enrollments. An exchange website should have a familiar design that is easy to navigate and educational. In our experience, this is the most effective way to encourage use of the site. The state should also present multiple ways to integrate the delivery of health care in both public plans and the exchange for migrating members. These ways include the following:

- Requiring insurance carriers to design products for the exchange that will incorporate plan coverage features of the public plans (for example, Medicaid)
- Requiring insurance carriers to include exchange products with provider networks that seamlessly serve both the commercial exchange and public plan marketplace
- Facilitating the inclusion of providers in the exchange and public plan markets

Question 4: Using spreadsheet and micro-simulation consider time, financial resources, personnel, and adaptability of the model for future state modeling needs...

We recommend the use of econometrics modeling, involving a "micro simulation" approach, to identify and model each uninsured individual's options in the insurance marketplace. This would include assessing each uninsured individual's options for coverage given their economic status and eligibility for different programs and

PPACA subsidies. In addition, each uninsured individual's likely choices of coverage (or continued lack of coverage) in the programs for which they are eligible should be assessed, given their demographic characteristics, insurance coverage history, availability of affordable coverage in their residential coverage area, and behavioral choices based on trade-offs such as paying the individual penalties or electing ESI that is offered.

As part of the forecast, project potential changes in the ESI market and how those changes will impact the uninsured marketplace, including the likelihood of employers continuing to offer coverage should be addressed.

Econometric Modeling for Purposes of Understanding the Uninsured

For the State to make informed decisions regarding the exchange design that best fits the needs of the uninsured population, there are several data points that must be synthesized from available baseline data and projections on that data. These data points must then be integrated to portray a complete picture of the markets in 2014 and beyond.

Modeling Considerations

The first step that must be taken is to understand what the insurance markets, public and private programs, and the State population will look like in 2014 and beyond. Analysis needs to include examining how the individual and group markets may change in magnitude, composition, and cost based on certain "stressors." Using assumptions such as household income, increases in health care costs in the state, plans offered to consumers, and employee turnover, multiple scenarios are generated. Behavioral patterns should also be incorporated into the projections. For instance, the concept of "moral hazard" can impact plan usage (that is, a person tends to use a plan more often because he or she is paying for it).

The following considerations can subsequently affect the State's decision regarding the consolidation of markets.

Projected size of each of the small group and individual markets in 2014—Information on the number of insured consumers in the individual market and data on the residents covered in the employer market will be collected to understand how many people are covered in the 2–50 employee market and in the 51–100 employee market.

Projected aggregate costs of health insurance in the individual and group markets up to 2014—Although the average individual insurance premiums in several states (especially states without guaranteed issue) are lower than average small group premiums, this will belie the true cost of health care coverage in the individual and small group markets in the exchanges. For instance, in some states, the per capita cost of coverage in small employers exceeds that of individuals, due to higher risk profiles, older workers, and sicker dependents. However, once the exchange is operational, individuals can no longer be rejected based on the health status; high-risk individuals may be included in a single individual pool, and rating rules will change. From this, the cost of a merged market can be estimated and the resulting increase/decrease presented.

Projected aggregate costs of health insurance in the individual and group markets after 2014 on separate and hypothetically merged bases—This analysis is performed to assess market stability under each market basis. The relative stability in health insurance costs under each market basis is then compared. In scenarios where instability is more extreme, the econometric model should simulate increased instability that might realistically occur from more consumers searching for other options due to unpredictable or unaffordable costs. These data points will offer the State valuable information on potential market instability.

Projected size and composition of the uninsured and underinsured populations—We assume that in most scenarios this population would not enter the group market, since it is unlikely in 2014 that they will be offered employer coverage or will elect employer coverage that they have declined to date. It is also unlikely that the underinsured population will shift coverage within the group market, for the same reasons. The underinsured population will most likely enter the individual market or remain underinsured (for example, limited benefit plans/mini-med plans).

Projected costs associated with the uninsured and underinsured—Costs of insurance will be associated with each uninsured and underinsured resident that enrolls for or changes their coverage. In the simulations, uninsured residents should be placed in the program where they are most likely to enroll. Depending on the relative health of these populations, and their likelihood of entering the insurance markets, they may either improve or compromise the State's ability to merge the individual and small-group markets.

Model Process and Inputs

The econometric modeling process is at the heart of the results that will be used by the State to make critical decisions about effectively and efficiently covering the uninsured, merging the markets, expanding the market size, handling high-risk consumers, and other key structural issues. Econometric results should be presented to the State with granular results at the county level. The key components of good modeling inputs are described below.

Agent-based modeling conducted with dynamic simulation capabilities to simulate the State's current insurance markets and how they are projected to change through (at least) 2016. Agent-based modeling for this project will involve analyzing the forecasted actions (based on economic and behavioral factors) of individuals, families, and employers, and their interactions, with a view to assessing the effects of those actions and interactions on the State's entire health care system. The fact that decisions on health insurance coverage choices are analyzed at the decision-making unit level (individuals, employers, families, for example) gives rigor to the analytical process that cannot be replicated with an alternative approach.

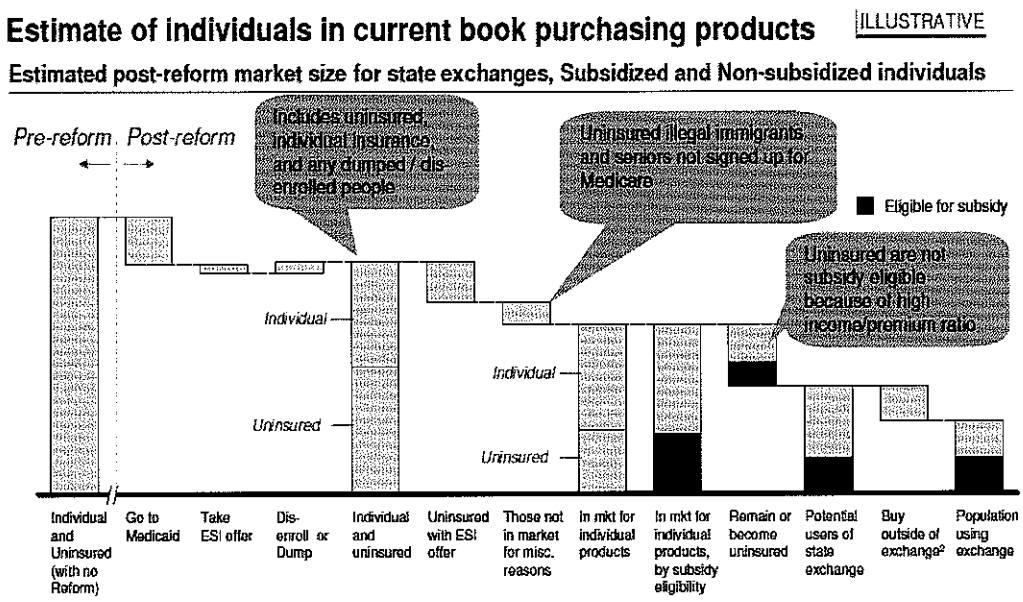
Behavioral and economic factors forecast individual decision making. Environmental factors include items such as premium levels, availability of subsidies, impact of penalties, accessibility of coverage, if high risk or

previously denied, affordability of coverage, and actuarial value of the plans offered. You should also consider the propensity to purchase insurance and related propensity to choose between different types of coverage, if eligible, using the following geo-demographic factors: geography, age, legal status, smoker status, gender, ethnicity, and income and health status.

Simulation of virtual employers is accomplished using data from the Census Bureau and Bureau of Labor and Statistics. The model should simulate the employers that offer ESI and then forecast the propensity of employers to dump coverage or retain coverage for their employees. In addition to using the standard databases from national sources, use selected State data. For example, you can use State premium data, household income data, State-specific employer data, and average medical trend data.

From the output you gather as a result of multiple scenario simulations, you can analyze the results and integrate them with the qualitative findings regarding the insurance marketplace, existing policy, and regulation. Then, you should synthesize the data into observations, conclusions, and preliminary recommendations for the State to consider.

The following figure illustrates the econometrics modeling that would typically be completed as part of a modeling engagement.



Actuarial Services and Economic Modeling

In this section, we address the questions in Section 1.4.4 related to understanding the uninsured and underinsured populations.

Open Enrollment Strategies

Members will have the option to enter basic identifying information and view their available options. This will allow them to anonymously "shop" without completing the formal enrollment process. Throughout the process, the member would have the ability to access decision support services embedded in the exchange (for example, primary care physician search, cost estimator), access to the exchange "navigator," and access customer service experts within the exchange.

Risk Adjustment Methodologies

To maintain a competitive insurance market through the exchange, we recommend establishing rules which will balance the potential for adverse selection against any specific health plan. Having an effective risk adjustment process will incent health plans to complete for customers based on "health and risk management" as opposed to identifying and avoiding enrolling prospective members with higher health risks. We suggest allowing plans to compete on the basis of their ability to provide high quality care coordination and the design and management of their provider network. The risk adjustment and reinsurance models will work together to be part of an integrated risk management system, whose primary purpose is to help insurers focus on the business of covering consumers, grant reasonable access to care management and enhance consumers' opportunities for improving their health. Our recommended actuarial approach to risk management includes implementing a risk adjustment mechanism based on currently available health-risk measurement software, such as that used by the Medicare Advantage programs. It will be important to the State to obtain feedback from the insurance markets on the design of the risk adjustment process, since risk adjustment in a "slice environment" is critical to obtaining carrier participation in the exchange.

Reinsurance Options

We recommend the consideration of a reinsurance pooling system, where all insurance plans pool individual claims which exceed a limit specified by the exchange. Our reinsurance model pools the highest cost individual claims, but still leaves the health plans at some risk for dealing with the management of long-term chronic conditions through the proper insurance product structure. However, there is an active U.S. reinsurance market that regional health plans and national health insurance firms utilize for transfer of select specific or aggregate risk. In regard to Accountable Care Organizations, we expect ACOs will partner with national and regional health insurers to assume some of the insurance risk involved in underwriting an exchange based plan option. We

expect that a new reinsurance solution may be necessary to attract and sustain the participation of smaller insurers and regional health plans.

Impact of Reform on Premiums

Health plans offered in the state based exchanges will be individual plans with guaranteed issue, guaranteed renewability, 3:1 age banding, and additional rating guidelines for tobacco users. While these changes are designed to improve access to coverage and provide continuity of coverage for enrolled members, they represent significant changes in underwriting practices of insurance companies in the individual medical market and are likely to result in higher premiums for exchange policies.

In addition, the Affordable Care Act mandates compliance with the minimum medical loss ratios (MLRs) which were developed and approved by NAIC and HHS. The health insurance industry is still evaluating the potential impact of MLRs on the pricing of insured individual and small group policies, such that a definitive impact analysis cannot be projected at this point. The MLR regulations may lead to fewer carriers offering coverage in the individual and/or small group market; may lead carriers to modify or reduce select administrative services used in individual or small group insurance products; and may result in higher carrier premiums in 2012 and beyond (including the exchange market in 2014).

Measures of Success

Health insurers are not required to participate in state-based Insurance Exchanges; thus, one measure of success is creating broad carrier participation to ensure a competitive insurance market within the exchange. Secondly, we recommend that carriers design and underwrite products in the exchange that will fully engage members to improve their health status. These policies will contain features to emphasize wellness and preventive care, reduce unnecessary or inappropriate care, and use smaller provider networks with reimbursement tied to improvements in quality of care. Thirdly, exchange policies need to be designed to achieve mid-single digit increases upon renewal. The ultimate measures for success of the West Virginia Exchange are the percentage of citizens of the state covered by health insurance; renewal increases in exchange products in 2014 and beyond, and financial sustainability.

Options for Actuarial Valuation

Plans will need to be evaluated based upon the average share of total health spending reimbursed by the plan. To calculate this ratio, all the components of benefit plan design must be analyzed. This will include 1) member cost-sharing provisions such as deductibles, co pays, and coinsurance amounts; 2) covered and excluded benefits and services; and 3) assumed utilization pattern changes based on both cost-sharing and covered

benefit provisions. For example, high cost-sharing can lead to lower utilization of certain types of services. This lower utilization should be reflected in the overall valuation.

Equally important to evaluating the benefit plan is understanding the health service utilization patterns of the underlying population. This is the pattern that will be the basis for plan design valuation. This utilization pattern can be established through historical claims analysis. However, the member population for state health exchanges is likely to be a unique combination of those currently covered by private insurance, those in government health programs and the uninsured. The differences between the utilization patterns of these sub-populations will significantly impact the actuarial valuation of plans. We will model the likely membership scenarios to determine the relevant range of actuarial values for plan designs. In the first year of the program, we will conservatively use an average of these scenarios. Once the exchange is operational, the actuarial valuation will be calculated using actual historical utilization patterns.

Medical Loss Ratio Requirement

Minimum medical loss ratio requirements (MLRs) are an important mechanism to ensure all carriers charge a reasonable premium for the benefits provided and that the largest percentage of the premium dollar is allocated to the payment of member claims and quality of care programs. The proper implementation of these requirements can help create a level playing field that rewards carriers to invest in activities that are in the long term interest of policyholders. For example, cost containment expenses such as case management and fraud prevention save much more in terms of reduced claim costs than they cost in administrative expenses. The State should indicate to the insurance markets that compliance with MLR regulations is a key priority and that carrier MLR reporting will be carefully examined for any pattern of non-compliance. Other considerations include ensuring the following: a claims period definition sufficient to minimize variability and that corresponds to the premium; premiums are adjusted for taxes; capitation payments are adjusted for the administrative expenses of the provider; and loss ratios standards of smaller plans that will not be completely credible are appropriately adjusted.

Implementation of minimum medical loss ratios may need to be phased-in so carriers will have sufficient time to file policies and premiums that can comply with enacted requirements. We will also need to evaluate the ongoing impact of MLR on carrier competition in the individual and small group markets to consider waivers on the enforcement of MLRs as required by the State.

Adverse Selection Impacts

Our focus to minimize adverse selection is on developing strategies and tactics to encourage the purchase of a subsidized exchange plan from at approximately 30 percent of the uninsured population who are either young or in good health. The penalty for noncompliance with the individual mandate is relatively low and there is

considerable risk that younger and healthier citizens may choose not to enroll and pay (or be at risk for paying) the in-force penalty. The weak individual penalties for non-compliance with the individual mandate indicate that other strategies will be needed by the State to obtain a balanced risk pool. Some combination of the following strategies can be used to achieve this balance.

Strategies to Balance Risk Pools	
Mandate insurer participation in the exchange as a condition of participation in the commercial market	Bridge eligibility for consumers whose eligibility for the exchange may change to and from another insurance system, such as Medicaid
Mandate participation in the individual market as a condition of participation in the small group market	Create open enrollment periods for exclusive entry of exchange-eligible individuals
Increase the eligibility for exchange plans from 50 to 100 employees	Develop and implement risk adjustment mechanisms (both prospective and retrospective)
Work with the insurance markets to develop innovative plan designs that promote member accountability and engagement in prevention and wellness services	Require participation in wellness programs or use of centers of excellence as a condition for lower premium, cost-sharing, or out-of-pocket costs
Limit the availability of the commercial market solely to those ineligible for the exchange, such as large groups, until 2017	Design products that "bake-in" chronic care management features that can be integrated with the benefits payable
Carve out high risks and place them in a separately rated and financed pool within the exchange	Impose price controls and subsidies

Implication of Merging Markets and Small Group Markets

A detailed analysis of potentially merging exchanges is merited to make decisions concerning what is best for both the State and the consumers. Determining whether individual—such as AHBE—and small group— such as SHOP—markets should be merged or maintained separately will depend on many factors. This includes evaluation of the regulatory environment and existing statutes regarding the insurance market, demographic and geographic composition, relative costs, and stability. Consumer risk profiles (including how high-risk consumers will affect market stability), carrier participation in the case that markets are combined or remain separate and network coverage – including access and network pricing if markets are combined are assessed will also be evaluated along with factoring in consumer migration among public and private insurance plans and the overall effect that being uninsured has on adverse selection.

We see a great advantage with one single combined exchange, comprised of the individual and small group markets. The many benefits include increased pooling of risks; creating better risk distribution and sharing; decreased administrative and regulatory costs because of similar rating rules and operational efficiencies; equity between individual and small group markets for similar geo-demographic risk profiles; and enhanced facility for

"list rating" in which premiums could be banded by age, geography and plan. Consumers would also receive a considerable benefit as there would be one consistent site to serve them and less difficulty in understanding the exchange for which they are eligible.

Changing Definition of Small Group Market

The considerations involved in expanding the definition of the small group market from 50 to 100 employees involve many of the issues discussed above. It also requires the analysis of markets outside the fully insured realm of the exchange. Specifically, the self-insured marketplace needs to be analyzed in the econometric model for its effects on the potential increased size of the risk pool; impact on carrier participation and product/pricing structuring as some of their business shifts from self-insured to fully insured status; pricing stability as certain employers choose to migrate to the exchange; related impact of adverse selection; and additional premium taxes payable for employers that choose to become fully insured in the exchange. Expanding the definition of small groups from 50 employees to 100 employees requires discussions with key stakeholders such as business groups, the insurance trade group, and the broker community who may have strong viewpoints on an expended definition. Additionally, in some states professional/trade association plans operate as self-funded entities. The impact of employers in the 50–100 employee market migrating out of their trade association plans to the exchange could impact the exchange and the trade association plan. An understanding of the State's laws in this regard is required in order to analyze this issue fully.

Pooling Practices to Maximize Benefits

To ensure a successful and solvent health exchange, the participating pool of policyholders needs to be sufficiently large and represent a good cross-section of the population. A pool of the riskiest, least healthy policyholders would drive premium rates so high they would be unaffordable. Therefore, the exchange must be structured to attract both healthy and unhealthy participants. We suggest doing this by ensuring the premium rates follow the same structure inside and outside the pool. We will also ensure that carriers cannot select better risks outside of the pool in the non-exchange market through underwriting. If a carrier can select good risks outside the pool, the premiums outside of the pool will decline relative to premiums inside the pool – thus, the pool will only include the worst risks. An assessment of the influence of brokers to steer small groups to the exchange or non-exchange market would be warranted.

Implications of Market and Policy Changes

While other responses within this document address aspects of this question, without further clarification we do not feel significant value will be provided in responding.

Self-Insured Market Impacts

In 2014, the potential users of the West Virginia Insurance Exchange will be uninsured citizens of the state and employees of small firms with 50 or fewer employees. Small groups with fewer than 50 employees rarely self fund their group medical benefits and instead purchase insured coverage. Larger employers who self fund their group medical coverage are taking a 'wait and see' attitude about exchange based coverage and are likely to defer exchange participation until 2017 when it is permitted by states. Looking at self funded groups should be a consideration in the decision to expand the definition of the small market from 50 to 100 employees.

Impact of Migration between Plans

To be successful, a public health exchange cannot operate in a vacuum, but must consider all the external options a consumer has to obtain health benefits. Individuals will do what they perceive to be in their best interests. Therefore, the State must clearly understand the role it plays in the broader health market and how consumers are likely to use the exchange. Simulations using agent-based models to demonstrate the potential impacts of selection and migration among different plans and programs will be shared to guide decision-making. Regulations, tax structures, and plan offerings will all impact the decisions individual consumers will make, which will ultimately impact the viability of the public exchange.

Measuring the Cost of State-Mandated Benefits

The Affordable Care Act requires the definition and provision of essential health benefits and requires the State to fund the cost of any state mandated benefits above and beyond the essential health benefits. The State will need to model the additional costs the State would need to fund if they chose to require some, or all of the State-mandated benefits in the West Virginia Insurance Exchange.

Standardized Benefit Plans

We strongly recommend the use of standardized plan designs for the exchange environment. These allow the prospective enrollee to focus on other parts of the insurance policy such as the provider network, wellness and care management programs, and member decision making tools. Those features are often ignored if members spend much of their time understanding plan design differences among carrier offerings. Many public and private plan sponsors prefer to purchase customized health plans specifically tailored for the organization's workforce. However, customized benefit plans create complexity for insurance companies to administer leading to increased claims problems, and higher administrative costs. Standardized plan designs improve service quality and result in both fewer administrative errors and lower administrative costs.

Financial Sustainability

HPES and Aon Hewitt have broad experience in providing systems and processes that support options for long-term sustainability and understand that each state has different resources available and different ongoing cost structures to operate its exchange. The following approach can assist the State in gaining a complete perspective on its operating costs and the financial self-sustainability of its exchange. With the availability of planning grants, we advise states to use that opportunity to consider their options for sustainability with careful upfront planning.

Inventory of State resources and requirements

Our experience has found that one of the first steps is to conduct an inventory of State resources and requirements. These resources and requirements would serve to identify the mechanisms for achieving long-tem sustainability. The inventory would be based on the following fundamental precepts:

- Quantify unknown variables such as anticipated start up and ongoing exchange expenses, anticipated carrier and consumer participation rates, and the state budget. Caution must be exercised to not over-estimating revenue or under-estimating expenses.
- Transparency and accountability are critical – There must be clear and sound justification of expenses and supporting revenue sources. This must be an element of exchange program integrity.
- Clarify the purpose of the exchange including establishing the business model, define and categorize costs, and model revenue sources
- Confirm viability of the funding options. This will include confirmation of the given magnitude of revenue to be derived, legal issues to be resolved, political feasibility of implementing new legislation/regulation, and stability of revenue sources.

The previous inventory activity will help identify cost categories such as start-up costs (technology, infrastructure, office set-up, and communication) and ongoing operating costs (for example, personnel costs, advertising and PR, rent). As part of this financial modeling process, operating costs beyond 2014 needs to be projected and the pattern of these costs assessed given that improvements and changes will be made in exchange operation over time.

All possible sources of revenue would need to be assessed. These sources will be matched to the extent possible against corresponding cost patterns. While providing specific recommendations would be premature at this point, there are several potential sources of revenue that would need to be assessed during this planning phase. Potential sources include an assessment on participants in the health care system, exchange participants

(carriers) fees, gain-sharing program built on health care cost reductions by exchange participants and state government funding.

Barriers

Impact of Exchange on Medicaid, Medicare and Other Government Programs

There are a number of impacts on Medicaid and other government programs such as the Children's Health Insurance Program (CHIP) from the implementation of the Affordable Care Act. The two most critical are the sheer volume of newly eligible participants in the Medicaid program and the second is managing the interaction between the exchange and the Medicaid/CHIP programs.

With projections of over 16 million newly eligible Medicaid participants nationwide, states are facing significant increases in their Medicaid populations. Traditional methods for processing applications and legacy Medicaid eligibility systems will need to be significantly transformed to accommodate this volume come 2014. In particular, traditional case-worker based processes will need to be replaced with a consumer driven process. This new model will rely on automated verifications and use of a rules engine to determine eligibility in a "straight through" process that is supported by customer service assistance to help the consumer use the system and uses a case-worker only for exceptional situations.

How this process and supporting system interacts with the exchange is also important. Individuals need to be able to apply for Medicaid through the exchange and CMS goal is for a common user experience regardless of the type of insurance coverage (Medicaid, CHIP or private insurance). As consumers enter the exchange, their experience shopping for insurance coverage, receiving information about premium subsides for which they are eligible and their enrolment in a health plan should be broadly similar to the screening for potential Medicaid and CHIP eligibility and enrollment in care plans provided by those programs.

To the degree that these processes can be aligned, the potential impacts of transferring between public and private coverage options may be minimized. This is a lesson learned from efforts to improve access to CHIP under the CHPRA of 2008. Process and policy options of the Act allowed agencies to minimize administrative churn through coordinated enrollment periods, aligning of policies on things like assets, using a joint application and streamlining renewal. A policy using a fixed enrollment period for coverage is probably the best option for managing unnecessary transfers between public and private coverage.

Another consideration is linkage to Health Information Exchange. Access to health care information as people move between coverage types can help improve health outcomes. For example, facilitating the sharing of clinical information around a disease management plan for a chronic condition as someone moves from Medicaid into a private plan can ensure the continuity of care and reduce costs.

Impact of Federal Subsidies and Cost Sharing

One impact of federal subsidies and cost sharing provisions for private insurance on Medicaid, CHIP and other government programs is on those individuals between 100 percent and 133 percent of poverty. Consumers in this income range may have a choice between a government plan and a commercial plan with a subsidy. These consumers will weigh different considerations in making this choice, but likely the most significant will be the access to specific providers. Medicaid services will likely have a different provider network and in some cases a more restricted one than some commercial plans. This could also vary by geographic region within a state. It is also possible that benefit packages could be different between the Medicaid option and an insurance option for this income range. This may also impact the choices an individual consumer will make.

Another potential impact might be more global in nature, which is that increased access to insurance coverage through the exchange will result in better health care outcomes for those who could not get access in the past. While increased numbers seeking service may put pressure on some providers, costs for uncompensated care within the delivery system should go down.

Response Requirements

In this section, we address the following areas identified in *1.5 Comments* related to recommendations on governance of the exchange, evaluative comments on the RFI's project description and requirements, and describe an approach for the project.

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Governance Recommendations

The Affordable Care Act permits states a range of governance models to choose from when setting up the exchange. It is our understanding that WV has chosen to place responsibility for the exchange within the Offices of the Insurance Commissioner and have an appointed board as part of the governance model. The Exchange Board will have autonomy to make policy decisions independent of the regulator.

In the previous section, "Implications of Merging Markets," we provided information on governance models including several factors for consideration when defining your exchange model. We also provided guidance on establishing one exchange within the state that merges the individual and small group markets – our preferred model; creating separate exchanges for the individual and small group markets or creating a regional/multi-state exchange with adjacent states.

Project Description – Evaluative Comments

The RFI as written provides broad descriptors of OIC's current direction but does not provide sufficient detail to allow us to provide specific evaluative comments. In general, OIC is taking the right steps to engage various stakeholders in the process including seeking input from sources outside of government. Your planned structure for the exchange is defined at a high-level including some key factors associated with governance.

While seeking input through this RFI process will enhance preparation of an RFP, the critical missing elements are specifics on the planned business delivery model and technology requirements. Successfully determining concise, understandable, and measurable requirements—then managing project scope of those requirements—are key factors to the success of any project. If, during the requirements phase of a project, the focus is more on validation of detailed requirements rather than refining ambiguous requirements, it is less likely that there will be a need to re-think the core solution and less likely later in the project that there will be a need for any design rework, development delays, or increased costs arising from imprecise requirements. When projects are failing

and rework must be done, the majority of the effort is related to poor or ambiguous requirements. Besides clearly defining the requirements, incorporating activities as part of the overall project such as ongoing requirements management and visible and robust traceability and tracking are important. In addition, validation through modeling techniques (model early and often), iteration and product release strategy, defining quality control checklists, holding formal inspection reviews, and conducting requirements-based testing and finally putting in place the processes, tools and methods to manage tracking and change control will add to successful project completion.

Project Approach Recommendations

While meeting many of the Healthcare Reform requirements will be challenging, doing so also provides significant opportunities to make system changes that have long been desired. In particular, these opportunities include taking advantage of the exchange planning and implementation grants and the potential rule change for time-limited availability of 90/10 funding for Medicaid eligibility. The intent of the proposed rule is to provide enhanced funding to assist states in modernizing their eligibility determination systems to meet the requirements associated with establishing Health Insurance Exchanges (HIX) under ACA.

The direction provided by Centers for Medicare & Medicaid Services (CMS) on this enhanced funding emphasizes an extension of Medicaid Information Technology Architecture (MITA) standards and compliance within the State for improved access. Thus, your technology vision and direction must include emphasis of common standards, interoperability, web-based access and integration, and software reusability. We highlight the following for consideration when planning for an improved eligibility system for Medicaid, CHIP and tax credits.

Open new service channels—Make eligibility services available 24 x 7 through standard Internet browsers. Potential members can take an eligibility self-assessment or submit an online application. Additionally, the Exchange Portal becomes the central source for general healthcare information as well as personalized real-time status and coverage details.

Open and scalable technical architecture—A Service Oriented Architecture (SOA) solution based on MITA framework increases flexibility, enabling development and integration of future features and functional capabilities with existing capabilities.

Improve Accuracy—Capture policies into a business rules engine to provide a central and universal driver for all eligibility workflow processes. Business rules will support accurate determination, benefits level, and compliance by encapsulating the latest policies.

Streamline processing- Move from a paper-driven, manual process to streamlined processing with enhanced data-sharing and use of content management systems that eliminate the need to maintain paper copies.

Systems integration and data sharing—Increases communication with relevant and related systems—such as public (IRS and SSA) and private agencies and provides for real-time data exchange to support eligibility determination.

Business intelligence and ad hoc reporting—Develops a business intelligence and ad hoc reporting system that improves the flow and use of data and increases business intelligence and reporting capabilities.

Other functionality to consider when planning the HIX includes the following core components, tools to operate the Exchange, and opportunities to improve quality and cost of healthcare reform.

Pre-screen or Pre-enroll: This component supports the user experience prior to actual enrollment to Medicaid, commercial insurance health plan, with or without subsidies. The consumer may shop and compare health plans, screen for Medicaid, and then save their shop and compare information or screening results securely for later retrieval, and subsequently choose a health plan option.

Security: Tools, methods, policies and procedures to ensure the confidentiality, integrity and availability of data. Security programs must meet applicable standards and laws such as the Health Insurance Portability and Accountability Act of 1996 (HIPAA). A wide range of techniques is used including data encryption, authentication, authorization, firewalls, and anti-virus protections.

Health Information Exchange (HIE): Health information technology (HIT) references the infusion of technology to support health-related functions. The mechanism used to collect and store relevant patient information—including clinical, demographic, and other information across the patient's lifetime and from a variety of providers—is known as the electronic health record (EHR). The "traffic cop" or engine known as the health information exchange (HIE) executes sharing of patient information electronically between source entities. Consider that by 2014, the HIEs will be in place as connection points to all providers of service, with member access. HIE is the 'distribution layer' and provides starting information on the patients. States are looking at leveraging the investment in their HIE platform - infrastructure, functions and operations - to meet HIX demands.

Business Intelligence: A consolidation and integration of data processed through the Exchange from various sources including health plans, transaction processing and exchange administration. This functionality provides state decision makers with the analytics needed to manage the exchange and provides the ability to monitor program statistics, identify trends, and make recommendations.

Electronic Data Interchange: (EDI) transaction translation services to monitor transaction processing, research failed transactions and identify re-transmission requirements. EDI services also include help desk and operational support for health plans and enrollment transactions. EDI Benefit Enrollment and Maintenance (834) transactions will be submitted as a result of exchange operations.

Consulting
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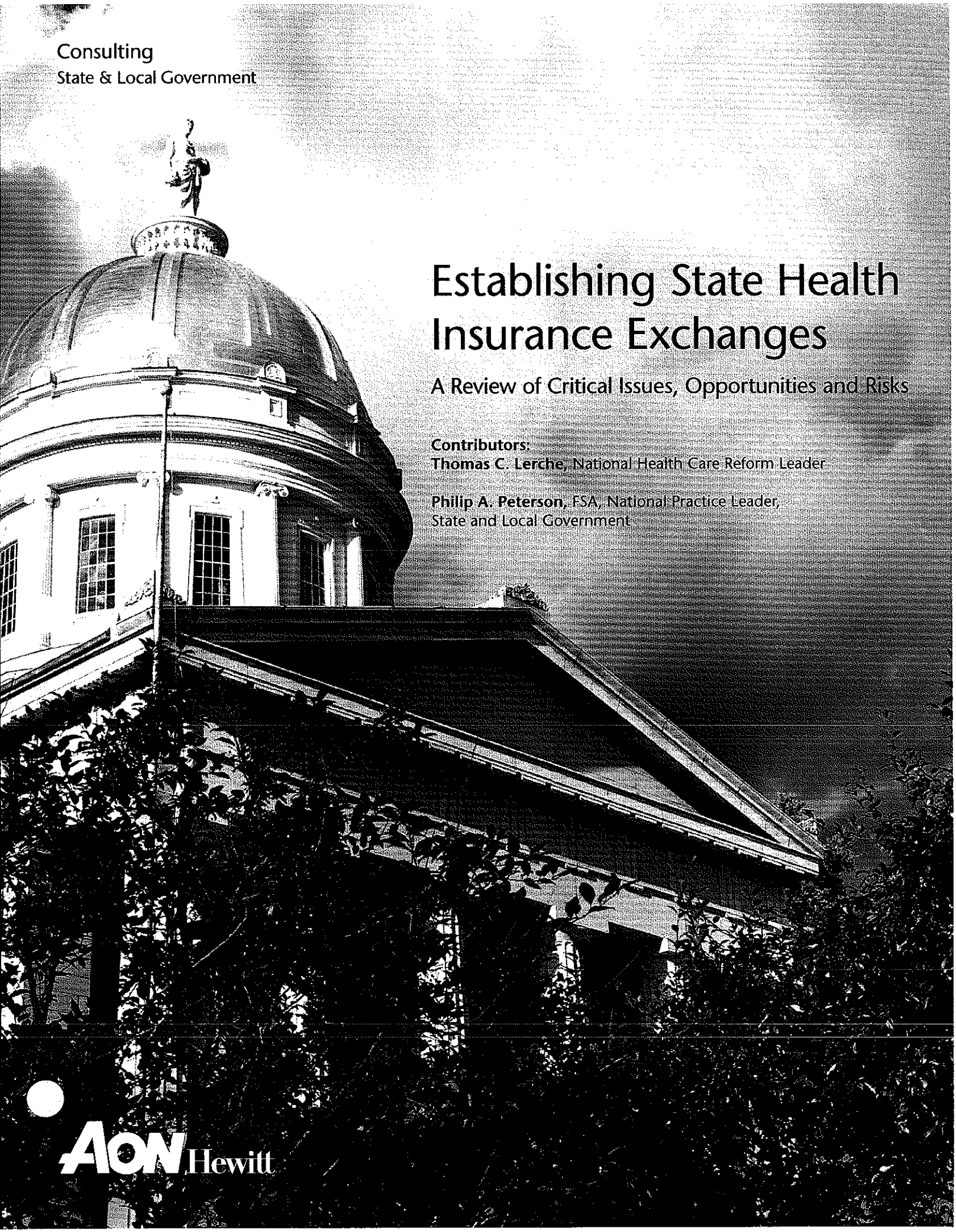

Establishing State Health Insurance Exchanges

A Review of Critical Issues, Opportunities and Risks

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Background

State-based Health Insurance Exchanges ("Exchanges") have the potential to transform the health insurance market for individuals and small businesses and, longer term, large employers. If correctly designed and successfully implemented, they offer many advantages: expanded competition for health insurance programs, improved transparency of health care quality metrics, increased use and value of wellness programs, and expanded options for consumers in their health plans.

Designing, implementing, and operating an Exchange is a challenging undertaking, however. Numerous issues and risks must first be addressed. This paper highlights a few of the most critical.

Key Considerations

Certain states (Massachusetts and Utah) have already formed Insurance Exchanges, and others are actively exploring the possibility, in part based on ideas discussed in framing national health care reform and in response to state-level concerns.

We believe there are three key areas for states to consider before taking action to establish an Exchange:

1. Develop a value proposition for establishing an Exchange
2. Determine critical success factors for an Exchange
3. Establish a structure for Exchange creation, management, and governance

1. Develop a Value Proposition for Establishing an Exchange

While the health care reform movement will drive state action, the question remains as to how states should plan and construct their Exchanges in order to best serve potential customers and satisfy the forthcoming regulations.

We believe that the value for states in creating an Exchange includes the following:

A more competitive health care insurance market for participants – This is a compelling long-term reason to establish an Exchange, but only if it can gather and retain a significant market share. If enrollment is large and stable, the Exchange should be able to leverage that to drive innovation and more competitive premiums that will improve the value and affordability of health insurance for the entire state. A well-operated Exchange could deliver substantially greater value than any individual members or employers could obtain independently.

Reduced administrative expenses and processes – For employers, particularly small employers, and health insurers, an Exchange provides a great opportunity to reduce administrative costs. At the broadest level, the cost reductions may come from:

- Administrative fees charged by health insurers, such as marketing expenses, new policy issue expenses, and ongoing administration. There also are opportunities to negotiate reduced sales fees (including broker commissions), further reducing costs for policies.

- Internal time spent by small employers on administrative processes, including benefit plan enrollment, employee communications, monthly billing process, annual regulatory filing requirements, etc.

Since small employers are traditionally the engine of job growth, implementing an Exchange could make the state more attractive to the business community by stabilizing the cost of employee health coverage and the administrative burden of sponsoring coverage. Employers would be more likely to add new employees if their indirect business costs of health insurance coverage were lower.

Innovation in health care management – We believe that Exchange formation will necessarily speed the convergence of health care delivery toward an integrated platform. The current health care arena contains multiple types of vendors: health insurers, pharmacy benefit managers, utilization review firms, disease management/wellness and employee assistance program (EAP) providers, data warehousing companies, home health care firms and others, each operating independently under traditional health plans. There is a considerable degree of inefficiency and waste in this approach.

With an Exchange, these elements of health care delivery can be collected and coordinated more effectively, leading to improved understanding of insurance and health management programs, better access and efficient use of program services, and a more knowledgeable membership that can access health care services efficiently.

Since 60% of the costs of employer-based health coverage are driven by medical claims from lifestyle-related and chronic diseases, Exchanges provide a great way to encourage innovative wellness and prevention programs, which will moderate premium increases over time.

More effective distribution channels for benefit options – Exchanges can be effective distribution channels for a wide range of health care services and insurance products. Examples include options in life insurance, ancillary health services, disability, voluntary benefits, personal lines, etc. In addition, approved products and services that are congruous with the theme of healthy lifestyle enhancement (e.g., nutrition and exercise products/services) could reinforce the proper use of core offerings.

An Exchange's ability to offer its membership products and services through a single point of access can both reduce the purchase costs of all benefit plans and facilitate improved oversight.

Improved service delivery – An Exchange's ability to standardize core programs and consolidate delivery through a single delivery point/portal makes it easier to advocate and resolve member disputes and appeals associated with insurance programs. Appeals outcomes can be documented on a standard basis across all members, allowing participating health insurers and other health care organizations to adopt similar administrative processes and reduce overall expenses.

2. Determine Critical Success Factors for an Exchange

While there are numerous elements that need to be present for a state-based Exchange to be completely successful, we believe that any state considering an Exchange should concentrate on the following critical factors to promote long-term success.

Enrollment and coverage – Market share, as determined by the total number of members enrolled and covered through the Exchange, is perhaps the most critical success factor. The Exchange must first attract and maintain a critical mass of participants (both employers and individuals). Secondly, it must grow that membership consistently over time.

Like many new technologies, Exchanges have high startup costs to deploy the infrastructure but low marginal costs for adding new members. The ability to leverage cost advantage is thus highly dependent on enrollment. The decreasing costs associated with a growing membership will in turn help underwrite other programs that the Exchange may want to add to attract new members.

Market dynamics are likely to create a momentum effect, e.g., the Exchange that attracts the greatest initial interest and generates the largest initial enrollment is likely to experience a spiral of success; awareness feeds new interest and membership. Of course, all elements that drive consumer satisfaction will need to be present from the start to maintain high program retention.

Health insurer/service provider participation – The Exchange should be designed to attract a sufficient number of high-quality health insurer participants. Health insurers/service providers need to understand how the Exchange affects the markets in which they do business and the rules that apply to marketing and selling the business. They will want to understand the Exchange-dictated conditions under which they will be bound contractually and how that affects pricing.

Health insurers/service providers will need to be assured that the underwriting and administrative rules of the Exchange provide them with a fair opportunity to obtain profitable enrollment. For health insurers, the underwriting and enrollment rules are critical, as health insurers will be concerned about the risk of adverse selection. Underwriting rules for member selection must provide a reasonable assurance that health insurers will not be exposed to high selection costs. Depending on the extent to which open competition is permitted among Exchanges, health insurers will be concerned about premium rates and how they vary among underwriting groups and over time.

Risk pooling and insurance rate stability – One of the most critical steps in setting up an Exchange is to ensure that insurance carriers or brokers do not adversely select against it. An Aon study of private insurance exchanges found that adverse selection can quickly lead to market failure.

States can take the following steps to guard against selection problems:

1. Establish the Exchange as the exclusive market for individual and small group insurance. This would constitute a single risk pool for the entire state, effectively precluding the potential for adverse selection.

2. Require all insurance carriers to participate in a statewide high-risk pool. This would reduce the likelihood that any particular insurance carrier would be disproportionately hit by adverse selection. Spreading the impact of high-cost claims across all insurance carriers would improve the stability of insurance premiums across all insurance carriers and allow the Exchange to focus on achieving its natural competitive advantages, superior consumer service, and lower administrative fees.

3. Along with use of a high-risk pool, the state can consider redistributing the risk using the concepts of reinsurance/stop-loss risk, therefore bringing greater rate stability to the Exchange. If the majority of business comes from individuals and small groups, it is especially important to construct a risk redistribution model for high-cost claims to protect Exchange members.

Administrative platform and processes – The administrative systems and processes must be able to manage the volume and complexity of the Exchange transactions. They also must set the foundation for maintaining relatively low operating costs.

The complexity of transactions and the number of data interfaces in an Exchange will dictate the need for robust systems. Exchanges can potentially serve as the "central hub" around which all health transactions are integrated. For instance, states will want to look at their current use of electronic medical records (EMR) technology in both the private sector and public plans (e.g., Medicaid, CHIPS) and make decisions on three fronts.

1. Whether it is realistic to expect to make use of EMRs in an Exchange environment over the short-term

2. Whether/how existing platforms can support the development of and use of EMR technology and bolster the Exchange's value

3. Which clinical and other prerequisites need to be in place to transition successfully to the use of EMR

Building streamlined administrative processes is likely to be the key factor in managing operating costs. To be successful, the Exchange needs to deliver most of the capabilities of a traditional employer benefit department at a far lower cost. The way to meet this objective is to automate the vast majority of transactions through the Exchange's technology platform, where the transaction costs are a fraction of traditional paper and people processes. Given that most small to mid-market businesses have limited internal administration capabilities, the Exchange needs to establish a standard process for a very wide range of administrative tasks.

Exchanges should allow the integration of all types of services, including:

- Sharing of eligibility data for service provision, billing, and reporting/disclosure
- Warehousing of clinical data for assessing risk more accurately in order to manage costs and member health
- Delivering services to employees through a single access point, using call center and portal technology. This single point of access for all vendors is a critical factor in delivering "large employer" health plan management strategies to smaller employers

Exchanges also can have an impact on other technologies needed to improve the health care system. Many hospital and physician providers believe that policymakers should encourage the evolution of EMR technology to include capabilities that support care coordination. If the Exchange becomes the consumer's "health home," it can help expand acceptance of EMR technology.

3. Establish a Structure for Exchange Creation, Management, and Governance

Exchange Structure, Operation and Chartering
Current law/regulation, as well as the likelihood of newly adopted state policy, will shape how Exchanges are organized. Each state will create a regulatory framework for building and operating Exchanges to reflect the realities of current policy and practice and the political environment. The following areas must be addressed.

Design, develop, and implement an effective governance and management "system" at the Exchange leadership level. This includes:

- Optimal structural formation
- Executive roles and responsibilities
- Policies and standards for decision-making
- Governance, monitoring, and control processes
- Consumer decision-making tools and methods

Implementing these steps requires an understanding of several factors.

- The state and federal regulatory climate and where changes should/can take place to accommodate Exchanges
- The markets in which health care purchasing takes place (i.e., retail, public plans, uncompensated care)
- The makeup of the insurance and health care organizations that are likely to participate in the Exchange, how the service areas of these organizations align with the targeted member populations, the health risks associated with those member groups, and the ability of insurers to deliver a quality continuum of locally-based care (core medical, mental/behavioral health management, case management EAP, etc.)
- A foundation for maintaining Exchange risk pools to create a competitive market and a self-sustaining financial structure for both health insurers and health care providers
- An administrative and operational analysis regarding the state's ability and desire to self-administer the Exchange as a state entity or whether to focus on establishing the regulatory standards of the Exchange and organize a private entity to operate it
- Public policy relating to "competition" through the Exchange. For example, will Exchanges be allowed to negotiate directly with health insurers, or will they be limited to a "price taker" role, accepting whatever rates are proposed by the health insurers
- Public policy decisions and regulatory requirements on Exchanges being owned/operated privately or as part of the public domain
- The ability to offer programs through an Exchange to include coverage options such as core dental or vision or employee paid options
- A position on whether Exchange membership will be limited to citizens of the state or whether to partner with adjacent states

Once these and other issues are considered, the state will need a process to determine the best way to establish the Exchange within the state's direction and budget.

Economic analysis and testing of preliminary models can then occur, with the goal of identifying the best operating model for the Exchange, with perhaps a pilot to stress-test the model.

Support definition, alignment, and communication of strategic priorities to all parties, including recruiting and aligning key participants in the Exchange. These include:

- Federal agencies (HHS, Department of Labor, etc.)
- State agencies (Department of Insurance, Department of Commerce, etc.)
- Markets/health insurers
- Health care and disease advocacy groups
- Vendors/health insurers

- Employers
- Potential members
- Policy and market experts (health policy, actuarial, consumer advocacy and education, etc.)

Identify and define critical linkages between the regulatory structure and the Exchange management, including:

Legal status – Requirements for licensing, reporting and disclosure, marketing, distribution, pricing, contracting, etc.

Operational structure – Requirements for negotiating and contracting with vendors (health insurers and health care providers), developing and selling multiple product lines sensitized to different audiences (e.g., culturally-based medical care), financial stewardship (product/marketplace viability profitability, etc.), IT infrastructure and grids (use/proliferation of EMR, etc.)

Management structure – Requirements for executive authority, lines of accountability, decision-making, and linkage of Exchange business strategy to "next-down" levels through translation of strategic precepts to clear accountabilities and expectations

Exchange Marketplace Exclusivity and Choice

Regulations yet to be issued under the new national health care reform law may allow individuals and small employers to continue to purchase health insurance outside of the Exchange. Assuming states develop their own approaches, they will need to address the market implications of dictating exclusivity in using Exchanges or allowing member choice between multiple Exchanges and/or traditional insurance sources.

In states with Exchanges, experience has shown that when participation is voluntary, the insurance programs offered are vulnerable to adverse selection. This can drive up the cost of insurance and ultimately cause the Exchange to fail.

Since successful insurance programs involve pooling of health risks, it is necessary to develop strategies to prevent adverse selection. States may also want to create affordable plan designs and network plans to allow lower income residents to purchase Exchange policies that fit their family budgets.

Despite certain provisions aimed at minimizing adverse selection, if enough insurers decide to "opt out" of the Exchange and continue to sell health insurance directly, the Exchange could fail to gain sufficient membership and enter a "death spiral."

The state also may want to facilitate forming "accountable-care organizations" in which groups of hospitals and physicians that improve patient quality of care are allowed to retain a portion of the "savings." These provider-led entities can serve as an additional plan option in the Exchange beyond traditional health insurance plans.

To minimize the risk of adverse selection, states will need to develop Exchange policies to ensure the continued participation of all (or almost all) of those health insurers operating in the state.

Exchange Insurance Regulation and Compliance

States will need to establish appropriate Exchange rules and whether federal mandates apply with a variety of regulatory requirements. Some regulations, such as certifying that health plans meet the applicable coverage requirements, could be handled directly by the Exchange or by the state Insurance Department. Other requirements, such as risk adjustment programs for determining pricing models, could be administered separately by the states.

Prior to startup, the states will need to acquire the expertise to manage the actuarial and certification duties required under the reform legislation.

Exchange Communication and Education

Communicating the Exchange's purpose and value to the state's eligible population will be a major challenge. States will need to use multiple communication channels and enlist the support of a wide range of community and public organizations to reach the full range of individuals and businesses impacted. Gaining and maintaining enrollment is critical to long-term success.

Given the high fixed cost of implementing the Exchange and the relatively low transaction cost to enroll new participants, gaining significant enrollment is key to having enough operating income to be self-sustaining. Therefore, without sufficient enrollment, states may be forced to provide unplanned additional funding.

The states will be challenged to find creative ways to educate the public and market their Exchange. Consumer protection and advocacy groups will need to operate at unprecedented levels. While existing law can serve as a foundation, consumer protection relating to health information privacy and discrimination, combined with robust appeals processes, must be enhanced.

Exchange Administrative Complexity

The administrative considerations of choosing and enrolling in a health insurance plan are already complex and confusing to consumers. Exchanges will need to reduce this complexity and offer consumers an easier way to obtain health insurance. Administrative processes need to be mapped in all areas of Exchange activity as well as interfaces with outside entities (e.g., the federal government).

Key components include:

- A comprehensive IT strategy to assess the state's current capabilities while prioritizing needs that cannot be met, all within budget. Enforcing strict requirements around IT is the single most important fiscal factor in avoiding runaway costs

- Determining the eligibility status (including eligibility for member subsidies) for individuals will be challenging.Public plans such as Medicaid can testify to the difficulty of obtaining timely and accurate information on plan eligibility, especially when such factors as income, assets, and family status are constantly changing. Given the high levels of employee turnover among many small employers, keeping track of eligibility and participation is significant work

- In addition to data integration with insurers, integrating record-keeping capabilities with multiple state agencies and programs (Medicaid, CHIP, etc.) on a real-time basis

- Managing various federal requirements such as "minimum essential coverage" and "qualified health plans"

- Looking at best practices and lessons learned from states such as Massachusetts and Utah, which have previously designed and implemented state-based Exchanges

While the potential benefits from a successful Exchange are significant, states will need to plan and implement these programs carefully.

Recommended Next Steps

We believe the merits of availing more Americans of quality, affordable health care can be achieved through state-based Exchanges. At the same time, the work of establishing these Exchanges is complex.

We recommend the following steps for any state exploring the possibility of creating an Exchange.

1. Select an individual to lead the effort. Ideally, he or she should have working knowledge of the state's insurance markets, have the capacity to call on and organize resources from around the country, and be able to lead a coalition of different parties in the construction effort. The leader should be directly accountable to the state's governor.

2. Build an Exchange Advisory Working Group (EAWG) representing parties throughout the state who have a vested interest in the Exchange's success. Members should be seasoned leaders in their respective fields and be able to make the time commitment to ensure an optimal solution. They should come from the following areas:

   - State government – Insurance Commissioner's office, Health & Human Services, Information Technology, Attorney General's office, Treasurer's office

   - State health insurers (e.g., state AHIP chapter)

   - Hospital and physician providers

   - Care management providers (e.g., case management, utilization review, EAP, chronic care management, pharmacy benefit managers)

   - Consumer advocacy experts – state government and respected private groups

   - Selected employer professional/trade associations

The person selected to lead the Exchange effort would chair the EAWG.

3. Initiate a feasibility study to explore and resolve the issues outlined in this paper. The EAWG should lead it and ultimately produce a work product that includes:

   - Setting goals and objectives

   - Collecting all necessary and available data for current and future state analysis

   - Understanding, analyzing, and endorsing the value proposition for creating an Exchange

   - Assessing the state's ability to create the proper conditions for achieving the critical success factors identified in this paper

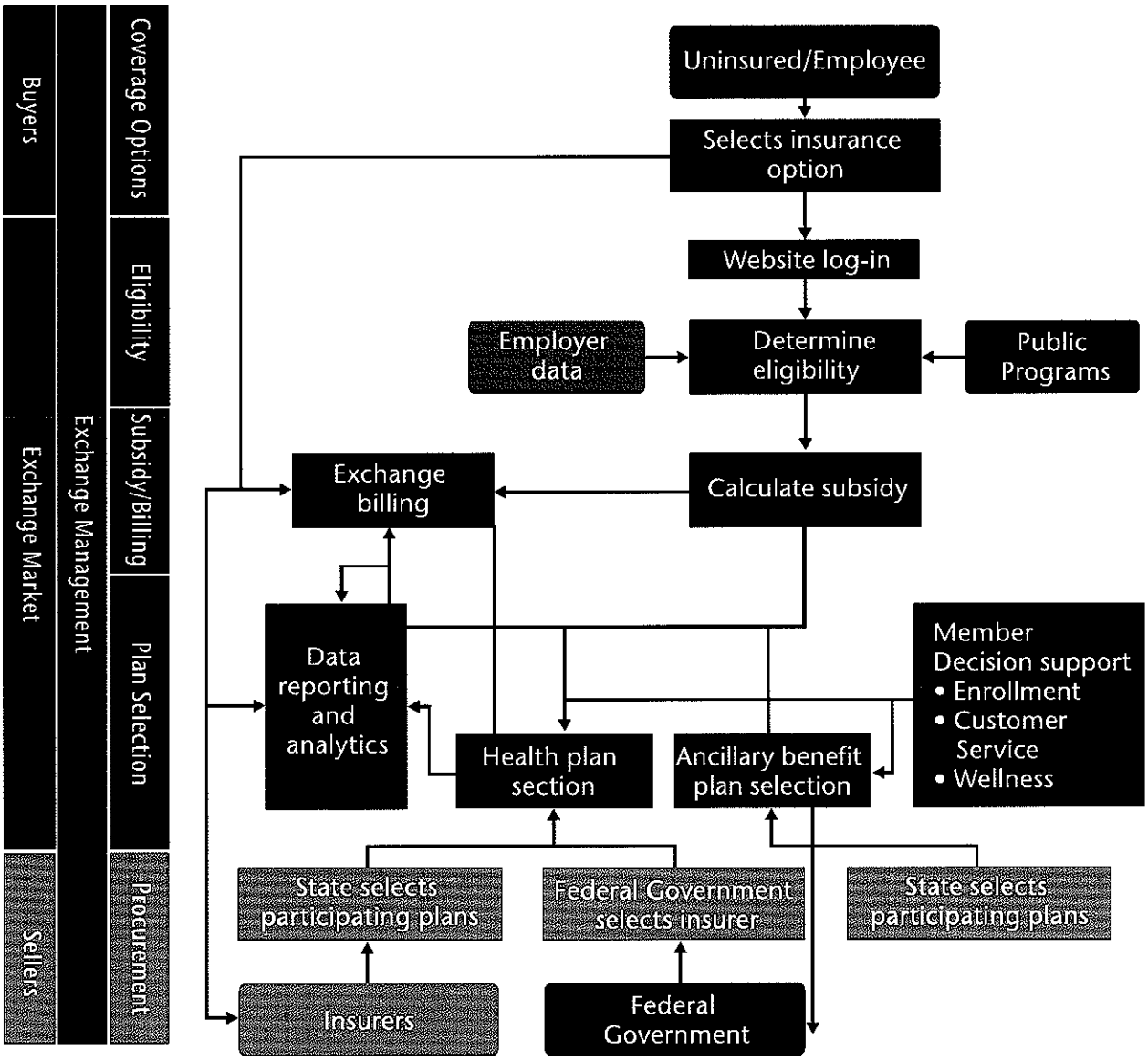
   - Assuming the EAWG recommends moving forward with creation of an Exchange, constructing a preliminary baseline model representing approaches to Exchange creation, management, and governance

The feasibility study would be submitted to the governor for his/her review and approval, and possibly to the legislature for chartering and funding. Next steps would include actual construction of the Exchange.

Exhibit 1

The following flowchart depicts Aon's understanding of how potential Exchange members will be directed through the process of qualifying and choosing their Exchange.

State Health Insurance Exchange – High Level Process Map



**PMPM –Per member per month*
***Firms with <100 employees*
****Firms with >100 employees*
Source: Aon Government Affairs team, H&B practice, team analysis

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