October 4, 2010

The Honorable Kathleen Sebelius
Secretary, U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

Mr. Jay Angoff
Director, Office of Consumer Information and Oversight
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Washington, DC 20201

File Code: OCIIO-9989-NC

RE: **Planning and Establishment of State-Level Exchanges; Request for Comments Regarding Exchange-Related Provisions in Title I of the Patient Protection and Affordable Care Act Comments from National Consumer, Labor, and Employer Organizations**

Dear Ms. Sebelius and Mr. Angoff,

The following comments reflect the perspective of a coalition of organizations that represent and advocate on behalf of small and large healthcare purchasers in the state of California: the Pacific Business Group on Health, Small Business California and Small Business Majority. The nonpartisan research institution, The New America Foundation, has acted as an advisor to this process.

The Pacific Business Group on Health (PBGH) is a coalition of 50 purchasers that seeks to improve the quality and availability of health care while moderating cost. This organization was the last administrator of the small business purchasing pool, PacAdvantage, that began as a government program vey much like the exchange envisioned in federal healthcare reform. Small Business California is a proactive, non-partisan business advocate whose only agenda is the well being of California's 3.2 million small businesses. Scott Hauge, president of Small Business California is also President and owner of CAL Insurance Associates, a well-established insurance brokerage. Small Business Majority is a national nonprofit organization focused on solving the biggest problems facing America's 28 million small businesses. Small Business Majority is headquartered in California, but, as a national organization, is involved with advising other states on the establishment of their health insurance exchanges. John Arensmeyer, President and CEO of Small Business Majority and Terry Gardiner, the organization's National Policy Director, successfully grew and sold small businesses in the e-commerce and seafood industries.

The following comments represent, therefore, a set of perspectives that are deeply informed both by the day-to-day experience of purchasing healthcare on behalf of businesses of various sizes as well as running an insurance exchange targeted specifically at the small business market. Our responses focus state exchange operations and aspects of the exchange design that relate to quality/cost and driving delivery system reform and employer participation.

Though our feedback is relevant to the design of both individual and small employer exchanges, we believe that small employer exchanges (SHOP) face additional challenges and complexities beyond those facing individual exchanges. The individual exchange has the advantage of individual tax credits and subsidies that will ensure a large exchange participation from the outset.. We strongly urge HHS and states give special attention to the unique challenges and issues facing the establishment of effective small employer exchanges.

Our study of the challenges and issues facing states point to several key recommendations:

- ✓ It is critical that State Legislatures enact exchange enabling legislation no later than 2011 so state exchanges can be operational in 2013 and effectively functioning January 1, 2014.

- ✓ The exchange must be capable of and prepared to deal efficiently deal with very large numbers of the smallest employers that do not have sophisticated HR departments (92% of employers have fewer than 25 employees).

- ✓ A major issue for small employer pools in the past, including PacAdvantage in California in the past, has been their relationship with insurance brokers. While working reducing administrative overhead for plans offered within the exchange, the larger efforts to design an insurance market that works for small business should take advantage of the capabilities and relationships of brokers, particularly for outreach and enrollment.

- ✓ Price information should include, to as great an extent as possible, total costs (premium and OOP costs) by procedure or service, information that is vital both for individuals and employers.

- ✓ One factor that is important for determining the employer size limit (e.g., 50 versus 100) for participation in a given State's Exchange is the current definition of small group market in each state including groups that already have guaranteed issue. Risk selection is introduced if groups are not qualified for guaranteed issue outside the exchange but are guaranteed in the exchange.

C. STATE EXCHANGE OPERATIONS

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

2011 State Legislative Action: All experts that have reviewed the exchange implementation issue have concluded the tasks ahead are complex and the necessary timetable is tight to meet the ACA deadlines. Therefore, it is critical that State Legislatures enact exchange enabling legislation no later than 2011 so state exchanges can be operational in 2013 and effectively functioning January 1, 2014.

Governance:. The fundamental mission of the exchanges is to create a well-functioning health insurance marketplace providing an array of affordable, high-quality health insurance plans to individuals and small businesses, which is a role that is much different from the role of traditional government agencies. To provide the needed agility and speed to accomplish its mission the exchange should be placed in an independent state agency, which could be explicitly exempted from the requirements of specific state administrative law or government operations requirements as necessary. State laws for transparency, accountability and public participation should still be followed. The governing board of the exchange should represent state agencies with which the exchanges must work, interested parties, and persons with relevant expertise.

Transparency of exchange operations will also be essential to gain the trust of consumers, employers and insurers. This will be critical to creating a competitive market place of health plans. The Massachusetts Connector has established a good model of the necessary transparency that is needed to achieve this goal. The work, budget, spending and any outside contracting of the exchange should be publicly reported and transparent. Meetings should be open, with transcripts, agendas and meeting materials publically available.

Exchanges as independent entities should be subject to an annual public audit by qualified independent auditors.

Both governance and any stakeholder process leading to the creation of the exchange should be accountable to the public. Governing bodies and stakeholder processes must also provide the opportunity for public hearings to solicit input from the general public.

Governmental Responsibilities and Contracted Services: States must decide whether an existing state agency, a new state agency, a non-profit entity established by the state will operate the Exchange, or whether the state will participate in a Regional Exchange or the Federal Exchange.

The law envisions that the Exchanges act as critical forces in creating a well-functioning and efficient market for insurance coverage. The law delegates a number of responsibilities to Exchanges to fulfill this role. These include regulatory, administrative and judicial review functions that are "inherently governmental." Whether a state decides to set up a non-profit entity such as a public-private partnership or a public benefit corporation or operate the Exchange in a state agency, federal regulations should prohibit contracting out or privatizing inherently governmental functions.

Many of the activities carried out by the Exchanges fit the definition of inherently governmental work such as these examples:

- Establishing standards for qualified health plans offered in the Exchange;
- Negotiating with or selecting plans to participate in the Exchange;
- Administering risk adjustment mechanisms among participating insurers; or
- Determining whether individuals qualify for the federal tax credit; establishing and administering an appeals process for individuals denied eligibility for the tax credit;

While it may be appropriate to delegate some functions of the Exchange to a private contractor, such as designing IT programs, many functions of the Exchange must be carried out without bias and in the interest of the public. Furthermore, the Exchange and those carrying out its work must be accountable to the public.

Exchanges will face many complex and mechanical functions such as data processing, premium billing, collection and reconciliation that should be considered for private sector contracting where competitive markets exist and for which performance can be readily monitored. These type of functions have been successfully used by government health coverage programs.

Individual & Small Employer Exchanges: The law allows state the option to create an individual and a separate small employer (SHOP) exchange or to combine the two. A thorough study of the existing insurance market in each state needs to be considered when weighing this decision including such factors as to whether this would create rate shock for some individuals or employers currently insured. An important consideration in smaller states is whether combining the pools is needed to gain the needed advantages of a single larger pool.

Small Employer Size: States have flexibility to reduce the employer size from 100 to 50 employees to access their exchange. A detailed review of the existing state insurance market is also necessary to determine the impacts of this decision. A scheduled phase in

should be adopted to expand to employers of 100 employees if a state finds valid reasons to limit the initial exchange to employers with 50 employees.

Active Versus Passive Purchaser Role of Exchanges: An important implementation choice will be whether exchanges should, on the one hand, maximize plan participation by minimizing certification requirements or, on the other hand, use their certification authority to limit exchange participation to high-value plans.

The ultimate goal of affordable health coverage for individuals and employers can be maximized by an exchange acting in a balanced role as an active purchaser using its authorities to only offer plans that enhance value and consumer protection. Plans that drive towards delivery system reform away from fee for service should be incentivized and promoted through the exchange.

SHOP – Small Employer Exchange Design: Exchange planners are generally aware that they must design an exchange capable of dealing with thousands in some cases millions of individuals. But the exchange must be capable of and prepared to also deal efficiently deal with very large numbers of the smallest employers that do not have sophisticated HR departments (92% of employers have fewer than 25 employees). Existing small business pools for example report their average employer has less than 10 employees. These sizes of employers have no HR departments and currently rely on brokers, distributors, insurers and others to provide the needed services related to employee health benefits.

Small employers will have four options in 2014:

- provide no coverage (today 59% of employer with 3-10 employees do not provide coverage based on 2010 KFF)
- purchase coverage from the exchange (some will qualify for the employer tax credit for 2 years through the exchange)
- purchase coverage from the outside market (these plans will be heavily marketed)
- keep their existing “grandfathered” plans (existing insurers that provide these plans will have a large incentive to lobby employers to keep these plans)

To successfully compete for and attract large numbers of small employers to the exchange it should be a single point of entry for small employers and provide the following:

- All necessary information for employer and employees to make decisions on coverage
- one application

- one premium payment (where the exchange allocates the appropriate premium amounts to the right insurers based on the enrollment of the employees)one source for enrollment changes
- qualification and calculation of the small business tax credit (coordinated with IRS)
- provide certain additional "HR" services that are typically provided to small employers
- coverage for out of state employees for small employers
- helping coordinate coverage of Medicare-eligible employees, dependents, and retirees.

Additional "HR" services that could be provided by exchanges to small employers to meet the needs of small employers and be competitive with "grandfathered" plans and the outside exchange market include:

- Certain Cobra administrative services
- Section 125 Service
- HSA/FSA/HRA
- Wellness program

For employers the exchange will need to provide a detailed accounting to the employer of each employee's individual ratings, plan choices, family tier and coverage additions. Additionally the exchange would provide a software tool that allows the employer the option to "consolidate" the premiums for employees or to individually charge employees based on their individual ratings (age, tobacco, geography).

Exchange Size Matters: A larger exchange will be more effective for several reasons – greater market power, economies of scale, more stable risk pools and stronger protection against adverse selection. Each of these reasons for maintaining as large an exchange as possible is discussed separately.

Adverse Selection: The history of insurance pools has taught us that the greatest threat facing exchanges is adverse selection. A death spiral will ensue if an exchange becomes essentially a high-risk pool - the exchange will become unattractive to insurers while coverage through the exchange will become unaffordable to individuals and to employers.

There are several features exchanges should have to minimize adverse selection:

- Chartering state legislation should give strong and clear direction to exchange governing boards and managers to create an active and ongoing process to guard against adverse selection.

- Regulate the individual and small group market identically inside and outside of the exchange.

- HHS should design a sophisticated but practical risk adjustment system that the states can use adjust to risk among insurers inside and outside of the exchange to discourage adverse selection both against and within the exchange.

- Requiring insurers to offer the same plans inside and outside the exchange. For those states instituting a more selective or competitive process to determine which plans can be offered in an exchange, states can require insurers outside the exchange to offer products in the same coverage levels (at least the Silver and Gold levels) as is required for health insurers participating in the exchange.

- Having a larger exchange generally will reduce the risk of adverse selection

Administrative Costs: Exchanges will ultimately be self-funded with exchange operational costs passed onto individuals and employers purchasing health plans. To attract and keep business the exchange must be operated efficiently and competitively with the outside market. Massachusetts provides a reasonable goal of 3 % administrative costs for other states. A large exchange will scale of economy advantages and keep costs low. Providing services for both insurers and purchasers is another way of providing value. Contracting for services can maintain efficiency.

Incentivizing Lower Costs: Qualified individuals and employees must have incentives to choose lower-cost plans high value plans, thereby driving competition. This objective could be realized by benchmarking premium subsidies and employer contributions to lower-cost plans, and by requiring enrollees to cover the cost of more expensive plans on their own. To permit accurate selection among health plans through the exchange Internet portal, health plans should be contractually bound by information they disclose on their websites.

Brokers and Distributors: Agents, brokers and distributors are expected to continue to play a role in the newly reformed health care system, but the ACA did not, unfortunately, contemplate specific regulation of these actors. To the extent that agents and brokers play a role in helping small employers and/or individuals consider different insurance plan options, however, their actions could have the unintended, yet disruptive effect of undermining many of the important provisions of the ACA without the application of clear rules and standards. For example, if agents and brokers steer, for example, young

men and/or small employers comprised of workforces comprised of such individuals to certain plans outside of the exchange – and conversely, steer older women with health issues and/or employers comprised of such individuals to plans inside the exchange, this could create adverse selection problems and threaten the long-term viability of the exchanges.

Accordingly, as states adopt complying legislation and regulations to implement the Affordable Care Act and consider a role for brokers and agents, the federal government should require that states provide oversight and regulation of broker and agent activity to ensure that the actions of agents and brokers do not undermine the exchange and other key provisions and protections of the law. Exchanges should also be required to carefully monitor and regulate the conduct of insurance agents, brokers and distributors; they should prohibit door-to-door solicitations and bar activities designed to steer, discourage or encourage enrollment in particular plans inside or outside of the exchange based on age, health status, gender or geography, and other factors should be prohibited. Finally, HHS, and states, should prohibit any agreement or arrangement between insurers and agents, brokers or distributors that would provide financial incentives or other rewards to agents/brokers to steer individuals based on age, health, gender or geography and other factors to plans outside the exchange or particular plans inside an exchange.

When reviewing the use of brokers, agents or distributors, states need to specifically examine the role of brokers/agents and distributors with the role of navigators contemplated by the law. States should also consider whether brokers are able to meet the needs of vulnerable and under-served populations which will be served by the individual exchange. Likewise, states should separately examine the cost, roles and services for brokers for individuals and small employers. Servicing the needs of individuals and small employers differ.

If brokers and distributors are utilized by the exchange, the costs and services need to be rationalized so that the goal of affordable insurance for individuals and employers is met and the exchange plans remain competitive with outside plans.

Marketing costs can be reduced by direct sale of plans from the exchange to small employers. The experience of other exchanges and pools (COSE, Pac Advantage, CBIA in Connecticut, the Massachusetts Connector) has been that there is still an important role for brokers and that it is better to have them marketing the exchange plans as well versus just being on the outside competing against exchange plans, especially for small employers, though this role should be different considering the availability of the exchange to perform some functions that brokers now provide. Brokers will continue to sell other non-health coverage products to employers even if excluded from marketing exchange products.

If brokers/agents and distributors are not utilized, a state exchange should ensure that navigators are available to perform these functions for both individuals and small employers.

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

Uniformity is essential for the following functions:

- Determine eligibility for exchange participation, individual tax credits and Medicaid/SCHIP using a single portal.
- Determine exemptions from the individual responsibility requirement.
- Provide information to the federal government on individual exemptions, tax credits, etc.
- A standard risk adjustment mechanism used by states for insurers operating inside and outside the exchange.

Uniformity is preferred for the following functions, but HHS guidance and templates would be helpful:

- Design of single portal for eligibility determination and enrollment
- Develop a standardized format for displaying plan options to consumers.
- Manage the open enrollment process for individuals and employees in the Exchange.
- Publish information about the Exchange's administrative costs
- Grade participating insurers on quality, cost, enrollee satisfaction, etc.
- Develop a website that allows consumers to easily compare health plan options.
- Provide an electronic calculator to determine the cost of coverage, and potentially other decision support tools for individuals.
- Design an enrollee satisfaction survey.
- Establish a Navigator program for outreach and enrollment support.
- Provide consolidated billing and premium payment by employers.

- Establish an electronic interface and facilitate the flow of funds between insurers, employers, and employees, including subsidies and the use of "free choice vouchers"

- Provide plan enrollment information to employers

State flexibility is preferred (within the explicit constraints of PPACA) for the following:

- Determine governance principles and legal structure for the exchange

- Determine whether to create one or multiple exchanges within a state.

- Determine whether to develop joint exchange with other states.

- Determine whether to make the exchange the sole marketplace for the small group and individual market(s)

- Establish standards for insurer participation, including certification of "qualified health plans".

- Determine employer size (above 50 employees) eligibility criteria for participation in the exchange.

- Determine whether to merge the exchanges for small employers and individuals

- Establish other mechanisms to reduce risk of adverse selection into the exchange, e.g., require insurers who offer coverage in the small group and individual market(s) to participate in the exchange.

- Determine minimum benefit levels (above the PPACA minimum)

- Conduct public education and outreach to consumers and small employers.

- Administer contracts with insurers, TPAs, navigators and other vendors.

- Operate a toll−free telephone hotline to respond to requests for assistance.

- Develop process for handling customer complaints.

- Financing of exchange operations.

3. What kinds of systems are States likely to need to enable important Exchange operational functions (e.g., eligibility determination, plan qualification, data reporting, payment flows, etc.), to ensure adequate accounting and tracking of spending, provide

transparency to Exchange functions, and facilitate financial audits? What are the relative costs and considerations associated with building Exchange operational, financial, and/or IT systems off of existing systems, versus building new standalone Exchange IT systems?

IT System Needs: Operational Tasks

- Determine eligibility for exchange participation, individual tax credits and Medicaid/SCHIP using a single portal.
- Determine exemptions from the individual responsibility requirement.
- Provide information to the federal government on individual exemptions, tax credits, etc.
- Manage the open enrollment process for individuals and employees in the Exchange.
- Administer risk adjustment mechanisms among the participating insurers.
- Administer contracts with insurers, TPAs, navigators and other vendors.
- Develop a website that allows consumers to easily compare health plan options.
- Provide an electronic calculator to determine the cost of coverage, and potentially other decision support tools for individuals.
- Provide consolidated billing and premium payment by employers.
- Establish an electronic interface and facilitate the flow of funds between insurers, employers, and employees, including subsidies and the use of "free choice vouchers"
- Provide plan enrollment information to employers
- Allow for member level benefits assignment

Trade-offs between building off of existing systems vs. building standalone Exchange systems:

This will need to be assessed by each state, since existing systems vary across the states. In some cases, the state's Medicaid eligibility and enrollment system can be adapted for use by the Exchange.

Commercial software products are available for many of the Exchange's administrative functions; purchasing and adapting these products is likely to be more cost effective than

building new systems. Special attention will need to be given to whether or not a system that typically administered employer benefits can do the necessary functions required by an exchange such as having each individual employee of a small group choose a different health plan and benefit plan within that health plan as well as adding ancillary services such as dental and vision benefits at the individual employee level.

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

Integration between state systems and federal databases, e.g., IRS, would be very valuable. HHS can provide a valuable service by offering guidance on system requirements, designing RFP templates, and encouraging joint purchasing of administrative systems.

The IT infrastructure to do eligibility, enrollment and all operational requirements for both the individual exchange and the small employer exchange are very complex and challenging projects. HHS could help the states by providing a template or free software to fulfill these functions. The software could be done in open source so the states could modify the software to fit their specific needs. Another alternative might be supporting a consortium of states that desired to work together on the design of such software that all 50 states (and territories) will need. The Administration team that built www.healthcare.gov might be a qualified nominee for this challenge.

Timing is critical. Kansas is proceeding currently with a new IT system that will be capable of implementing the ACA. Kansas officials have stated that they do not believe other states that have not started already have the needed time to start now to design and finance a major system similar to theirs. Most states face budgets and state expenditure cutbacks currently. These provide additional reasons for HHS to act immediately to assist states that believe their current IT systems can not be readily and easily modified to implement HHS provisions related to exchanges.

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

The exchange will have to explain many complex topics both to individuals and small employers, especially the majority of small employers that do not have HR managers and expertise. Explaining these choices without debilitating complexity will be a significant

challenge. One way to facilitate this is to utilize focus groups and other active feedback mechanisms in the web portal design process from the full array consumers, self-employed, micro employers and larger employers up to 100 employees.

Web portals also need to meet the needs of employers. Employers will utilize the same information as individuals plus additional areas:

- Cost and value of plans for employers and employees
- Employer tax credits
- Employers will have choices of maintaining a grandfathered plan and buying in the outside market. They will need to objectively understand and weigh these choices before they choose to access the exchange for their company and employees.
- The exchanges can and should offer reliable and objective ratings of the quality and efficiency of available plans on their website.
- To permit accurate selection among health plans through the exchange Internet portal, health plans should be contractually bound by information they disclose on their websites.

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

In most if not all states, it makes sense to rely on the insurance division for review and approval of rates. To create a separate review function within the exchange would be an unnecessary duplication of resources and expertise.

- Factors for reviewing justification for rate increases:
- Rates are reasonable for the benefits offered, based on actuarial analysis
- Rates are not excessive
- Rates are not discriminatory
- Rate actions are in-line with no exchange trends
- Insurer’s investment income and surplus

- Insurer's cost containment initiatives
- Insurer's administrative expenses
- Leverage/coordination of work funded by rate review grants
- States should use the grants to improve the transparency of rate reviews, including public reporting, more detailed review of service-specific expenses and administrative costs, and cost containment initiatives.

E. QUALITY/COST & DRIVING DELIVERY SYSTEM REFORM

1. What factors are most important for consideration in establishing standards for a plan rating system?

a. How best can Exchanges help consumers understand the quality and cost implications of their plan choices?

- Provide consumers with quality AND cost information, and make linkages between the two so that they can make value-based decisions about their coverage.
- Supply information about the quality for each health plan and the individual providers (e.g., hospital, physician) that are operating within its network
- Consider using elements of eValue8, which is a tool that purchasers have been using for 10 years to asses and manage the quality of their health plans (e.g., support for limited English proficiency, providing access to a PHR, providing treatment option decision support, etc.).

Quality information: Consumers need health plan and provider patient experience information, health outcomes statistics for procedures and population disease categories, and price information. Price information should, to as great an extent as possible, include total costs (premium and OOP costs) by procedure or service. An OOP calculator will allow consumers to calculate and predict their costs based on their needs, the plan's coverage and contracted rates with providers. Having cost information available in episode of care form is also helpful for individuals with chronic conditions.

- Need to educate consumers on what quality care really entails.
- Exchanges should build on the work of purchasers in helping consumers understand and use cost and quality information, as communicating quality and cost information in an effective way can be challenging.
- Customize information to meet the needs of the diverse consumers who will access exchanges.
- Balance the need for standardization to facilitate comparability with the need for innovation

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

Exchanges should require qualified health plans to place an emphasis on quality improvement strategies that build a stronger foundation for primary care and care coordination. Specifically plans should allocate certain of their health care expense dollars to rewarding providers for providing quality and efficient care aimed at moderating costs. Plans should be rewarded for continued development of innovative programs aimed at incentivizing providers to be accountable for the total cost of care of patients while reducing Fee For Service payments.

Exchanges can also help to advance cost containment in the private insurance market by facilitating collaboration between qualified health plans and employers and plans outside of the Exchange on payment pilots and other efforts. There is a limited impact that any single payer can have on providers. Through alignment, payers can send consistent signals to providers to supply safe, high-quality, and efficient care.

Where possible, Exchanges should ensure that savings from extending coverage to the uninsured are shared. Currently, private insurers must pay higher provider reimbursement rates to make up for providing care to uninsured individuals. The creation of Exchanges will reduce the uninsured population and in theory affect private payment rates and thus alter insurance premiums. For that to occur, however, doctors and hospitals would have to lower the fees they charged private health plans in response to a decline in uncompensated care or an increase in their revenues from insured patients. We encourage Exchanges to monitor whether providers are decreasing their fees to reflect lower uncompensated care costs.

Exchanges should also permit health plans to:

- Reward "high value" treatment choices and disincentivize treatments where evidence suggests such treatments will not reduce risk or improve outcomes;
- Use tiered networks that focus on high value providers using a quality and cost formula for designation;
- Employ reference pricing models that identify the appropriate costs for services and benefit designs which incentivize consumers to use providers who provide services within the reference price; and
- Require that providers use health information exchanges, registries, and clinical feedback systems support.

H. OUTREACH

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

As consumer outreach plans are developed HHS and states need to recognize that many employees will continue to receive their insurance through their employers. These functions have been traditionally performed by employers and insurance brokers. This may continue under SHOP exchanges based on individual state exchange design decisions. Therefore it is important to consider how outreach will be conducted to employees that receive health coverage through their employers. For example if brokers will be utilized in the SHOP exchange then it will be imperative that brokers learn about all of the new features of ACA and exchanges. The State of Washington new "Health Insurance Partnership" program for small businesses specifically developed programs for brokers to assist in their outreach and implementation of their new health coverage program for small employers, including broker training, employer videos, subsidy estimator and other features http://www.hip.hca.wa.gov/.

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

As states develop their navigator programs two types of small businesses need to be considered. 22 million self-employed (28% of which are currently uninsured) will have access to the individual exchanges. Many of these self-employed are in rural areas such as 2 million family farmers and thousands of commercial fishermen in coastal areas. Trade associations and other business channels should be considered to connect with these self-employed individuals.

Small employers have traditionally learned about health coverage options, enrollment and educational activities about health coverage for their employees through brokers. States have contact with employers through permitting, license and tax functions. Additionally employers belong to general business groups as well as trade associations specific to their industry type. As states develop their navigator programs it will be important to use these existing channels of communications that small employers utilize and to keep in mind that the average employer they are trying to reach has fewer than 10 employees and no HR department.

K. EMPLOYER PARTICIPATION

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

Key design features include:

- Competitive premium rates consistent with products being sold direct from health plans in the marketplace.
- Reasonably wide choice of health plans for employee choice.
- Ease of use by employees and employers.
- Capability for consolidated billing by exchanges under which employers submit premium payments to the exchanges and the exchanges allocate such payments to the appropriate insurer . This is particularly important, since the alternative – each employer paying each insurer separately as it chosen by the employees – would be tremendously cumbersome for employers.
- Establishment of an electronic interface and facilitate the flow of funds between insurers, employers, and employees, including subsidies and the use of “free choice vouchers”

- Provision of plan enrollment information to employers.

- Cal-COBRA and COBRA services

Large employers: Large employers have a significant stake in the success of exchanges for several reasons. Nearly all large employers offer health coverage to their employees and many to their retirees. As such large employers have suffered for many years the penalty of cost shifting, especially by uncompensated care. This is why premiums for employers have risen much faster than national health care expenditures. Therefore, the overall success of exchanges in driving more coverage cost effectively will have a significant benefit to large businesses.

There are other specific benefit potentials to large businesses that relate to the successful design and operation of exchanges:

- Exchanges have an opportunity if designed correctly to help drive delivery system reform and cost containment.

- In 2017 exchanges can be expanded to include employers with greater than 100 employees.

- The "free choice" voucher provision that is currently limited to "unaffordable" coverage for a limited category of employees provides and important test of this concept and utilization of the exchange by larger employers. If this pilot program proves beneficial for employers and employees this provision could be expanded.

Best practices:

- Extensive outreach and education of employers through trusted communication channels and peers

- Exchanges operate in a dynamic market and must constantly evaluate the needs of employers and the competition in the market outside the exchange.

- Requires coordination amongst all exchanges to accommodate employers with employees nationally. These exchanges should provide for the electronic transfer of enrollment and claims data.

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

Factors include:

- Current definition of small group market in each state including groups that already have guaranteed issue. Risk selection is introduced if groups are not

qualified for guaranteed issue outside the exchange but are guaranteed in the exchange.

- Mechanisms to prevent adverse selection into the exchange, i.e., high cost larger groups entering the exchange while lower cost groups stay outside.
- The exchange should apply the same rules as the market in determining group size.

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

Functions requiring collaboration include:

- Capability for consolidated billing and premium payment by employers.
- Establishment of an electronic interface and facilitate the flow of funds between insurers, employers, and employees, including subsidies and the use of "free choice vouchers"
- Provision of plan enrollment information to employers.
- Exchanges will need to establish input and feedback mechanisms for employers and understand that needs of employers differ based on size, industry and their own competitiveness with others.

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

Employers will be much more supportive of exchanges if they see their state exchange as a "partner" in controlling long-term health care cost inflation. Large employers have successfully pushed forward developing prevention and wellness programs. The Kaiser employer survey shows that small employers use these same component programs only 20-30% as frequently. Similar prevention and wellness programs that "fit" small employers and employees need to be devised based on the successful models of large employers. This will require the collaboration of small employers, insurers and exchange management. Federal grant funds are available for the development of such programs and models under the ACA.

Employers are hopeful that the exchange would be a mechanism to incubate new concepts and ideas. Pilots involving consumer, payment, benefit and delivery reform could all be tested in the exchange.