Proposed Health Benefit Exchange Board Policy Decision Timeline

The following provides a potential high-level overview and timeline of important and timely policy decisions. This is not meant to be an exhaustive list, but highlights proposed timelines for decisions that will need to be made over the next several months. While this document describes the anticipated timing for decisions, updates and information will be shared with the Board prior to final recommendations.

September 2012

Exchange Market Structure

In order to create a functional and sustainable Exchange, the Insurance Subcommittee developed the following recommendations related to the structure of the District's insurance market:

- Consolidated Market: All small group and individual plans should be sold through the DC HBX.
- Minimum QHP Requirements: All plans sold in the DC HBX must meet the minimum requirements in the ACA.
- Merged Risk Pools: The risk pools of the small group and individual markets should be merged into one single risk pool within the DC HBX.
- Expanded Small Group Size: Change the definition of small group size from 50 or fewer employees to 100 or fewer employees.
- Shared financial programs: DC should use the federally administered risk adjustment and reinsurance programs.

These recommendations were discussed with stakeholders in the Insurance Subcommittee before being provided to the Exchange Executive Board in July 2012 and discussed at the August 21, 2012 Board meeting.

October 2012

Qualified Health Plan Criteria

Based on the Insurance Subcommittee market structure recommendations, it is assumed that the Exchange will use the minimum criteria laid out in the ACA for certifying criteria for Qualified Health Plans (QHPs). However, the Insurance Subcommittee has been working to determine how new requirements should be implemented, including certification, quality, and network adequacy. The Subcommittee has been discussing options related to these new requirements with carriers and other stakeholders over the summer of 2012. Recommendations will be discussed with stakeholders in September before they are brought to the Board in October.

Navigator Program

The Navigator program is a grant program that provides individuals and organizations with funds to help people understand the Exchange, assist with the application process and help to pick a

health plan. The Exchange will administer the Navigator program, which means the Exchange will have to create an infrastructure, a payment model, a training program, and performance measures for Navigators.

The Exchange will also have to determine the best organizations to participate in the Navigator program, representing a wide variety of individuals and small businesses likely to use the Exchange. The goal is to have Navigators who are able to assist the range of consumers and small businesses that will use the Exchange, including those used to working in the commercial market as well as those who currently help people enroll in Medicaid.

The Crider Group has completed an analysis of the District's options for structuring the Navigator program. Initial finding have been shared with stakeholders and the full analysis will be discussed with stakeholders in September 2012 through the Operations Subcommittee before recommendations are brought to the Board.

November 2012

Exchange Financial Sustainability

The Exchange needs to be self-sustaining by January 1, 2015 when federal grant funds are no longer available. Multiple revenue options are available to support Exchange operations, although it is likely that the Exchange Authority will need to charge fees in order to collect the majority of required revenue.

An analysis of the costs to operate the Exchange has been completed by Compass Solutions, as well as initial analysis of potential fees. The Operations Subcommittee began discussions with stakeholders in August 2012 on all potential revenue options. The Operations Subcommittee will further explore options and discuss recommendations with stakeholders in September and October 2012 before they are brought to the Board.

Dental Plans

The ACA allows for stand-alone dental plans, but the District's authorizing legislation requires that stand-alone dental plans be offered in the Exchange. There are no criteria for qualifying dental plans to be offered in the Exchange in the ACA or in state law. Therefore, the Board is responsible for developing the criteria for dental plans, creating a process for approving plans, and structuring fees for paying for the administrative costs of offering dental plans.

The Department of Insurance, Securities, and Banking has had conversations with dental carriers about dental plans in the Exchange. In addition, Compass Solutions has completed an analysis of dental plan options for the District's Exchange. The options and recommendations will be discussed with stakeholders in the Insurance Subcommittee in September and October 2012 before they are brought to the Board.

Individual Premium Aggregation

The Exchange must decide whether it will take on the role of aggregating premiums for the individual market. This means the Exchange would receive tax credits from the U.S. Department of Treasury (Treasury), as well as individuals' premium contributions, and send them on to issuers. Otherwise, both tax credits and individuals payments would be paid directly to the issuers. Regardless, individuals have to be given the choice to pay their premiums directly to the carrier, and tax credits would be received by carriers directly from Treasury.

In the Small Business Health Options Program (SHOP), the ACA requires that the Exchange aggregates premiums, so the system will be built to accommodate the SHOP premium aggregation. If the Exchange decides to perform premium aggregation functions for the individual market, it will be responsible for the ongoing administrative costs of providing those services. If it is left to the carriers, it will likely be built into the premium costs.

Background research on the cost and technical requirements of providing individual premium aggregation is complete. The Insurance Subcommittee will explore this issue with stakeholders in September and October of 2012 before a recommendation is brought to the Board.