MEMORANDUM

TO: **GRETCHEN HAMMER**, CHAIR, COHBE BOARD OF DIRECTORS, ET AL
PATTY FONTNEAU, EXECUTIVE DIRECTOR, COHBE, ET AL

FROM: DIANE DUNN, HEALTH IT CONSULTANT

SUBJECT: POLICY DISCUSSION REGARDING PAYMENT OPTIONS IN THE INDIVIDUAL EXCHANGE — COMMENTS AND RECOMMENDATIONS

DATE: 3/30/12

Thank you for the opportunity to review and comment on the policy for the payment options and premium aggregation in the individual exchange.

Presenting Problem

The policy discussion (item D4) is stated as: What will COHBE's approach be to handling payment options and premium aggregation in the individual exchange? Three options were presented:

1) Individual pays directly to QHP; exchange has no role;
2) Collect but pass through without retaining any portion of the payments;
3) Collect from individuals and pay an aggregated sum to the QHP.

Recommendation

For the Individual Exchange, it is recommended that participants be given the choice of paying premiums directly to health plans (required by 45 CFR 155.240(a)) or to the Exchange (COHBE). Because of the nature of the transmission of data between COHBE and qualified health plans (QHPs), it is recommended that the premiums be aggregated prior to transmission.

An open policy question is whether to retain any of the premium payment prior to sending it on to the appropriate health plan. It is recommended the policy question of retaining a portion of the payment be addressed separately as item H1, Sustainability/ Revenue Model Determination.

An open design question is what level of aggregation is optimal. Should payments be aggregated on a daily, weekly, or monthly basis? This and other design questions may not need Board input and can be handled later than the policy decisions.

Background

Behind the scenes at the Exchange (COHBE), there will be electronic transmission of data between the COHBE and qualified health plans (45 CFR 155.270 (a) and HIPAA). Under HIPAA, all covered entities are to use standard transactions for electronic commerce. The health plans, Medicare, Medicaid, and Child Health Plan Plus (CHP+) are all covered entities.

The two transaction formats that apply to the Exchange business are the 834 Enrollment transaction and the 820 Premium Payment transaction. The 834 Enrollment transaction is the way to say to the health plans, "Here are the people who have enrolled with you and all the pertinent information about them." The 820 Premium Payment transaction is "Here is the payment and information related to the people who are enrolled with you." The 820 transaction can send the payment and information or just the information about the payment with the money being transferred separately. For example, Medicaid sends the money from the State treasury to providers and health plans but the 820 Premium Payment information is sent from the MMIS.

The key to the two transaction formats is how will they be sent to the plans? One choice is to set up a *real-time link* between the plans and COHBE. The transactions would be created and sent as soon as the information is entered into the Exchange. This means no more than one person or one family per transmission but many transmissions each day. It would require a permanent connection (electronic link) between COHBE and all the QHPs. This real-time link usage of the transactions is not widely used in the industry. Further, keeping an open linkage between COHBE and all the various health plans will increase the logistical and security risks for the information contained in the transactions.

Generally the 834 Enrollment and 820 Premium Payment transactions are handled as *batches*, usually transmitted at night when computer resources are more available for both senders and receivers. The security risks are decreased (shorter window of open communications) and the transmission of data is much more efficient for both parties. Instead of a transmission containing only a single person or family, the transmission would gather all the exchange business for the time period (day, week, or month according to design), organize it into the standard format and transmit it to the various plans. This is an aggregation of data on both the enrollment and premium payment fronts. The question remains as to how much aggregation is ideal. Should information be aggregated daily, weekly, monthly, or in some combination of those? The design does not require that question to be answered immediately and the selected vendor is likely to have recommendations for how often things should be done for each transaction type.

There are different situations that need to be considered for the enrollment and payment transactions. There are cases of initial enrollment, ongoing/continuing enrollment, open enrollment, qualifying events, and voluntary disenrollment. Involuntary disenrollment (for non-payment of premiums) is a special case and will not be considered in this discussion.

Examples

To understand these transactions and how they will work, a few examples may help.

Jake, a single adult: Jake enrolls in QHP 1. At the payment section of the online or personal interview, Jake chooses to make payments directly to QHP 1 (as allowed by 45 CFR 1555.240(a)).

At the end of the day or week, COHBE sends the 834 Enrollment transaction to QHP 1 with Jake's demographic and other enrollment information. QHP 1 enters Jake to their system and sends out a Welcome Packet and ID Card. Jake pays QHP 1 directly and COHBE has no role.

Alaina, a single mom: Alaina enrolls both her and her child in QHP 2. At the payment section of the online or personal interview, Alaina makes her first month's payment to COHBE. For the remaining months of the benefit year, she chooses to make payments directly to QHP 2.

At the end of the day or week, COHBE sends the 834 Enrollment transaction to QHP 2 with Alaina and her child's demographic and other enrollment information. QHP 2 enters them to the system and sends out a Welcome Packet and ID Cards. At the same time, or at another designated time, the 820 Premium Payment transaction is sent from COHBE to QHP 2 with the premium for the first month. The following month, Alaina pays QHP 2 directly.

Lupe, a mother with a husband and two children: Lupe enrolls herself in QHP 1. Her husband Tony is enrolled in QHP 2. Child 1 is enrolled with Medicaid and Child 2 enrolled with Child Health Plan Plus (CHP+). At the payment section of the online or personal interview, Lupe makes her first payment for all the family (her first month, Tony's first month, and Child 2's annual CHP+ enrollment fee). For the following months, because it is easier for her, Lupe decides she wants to pay the premiums for her and Tony to COHBE.

At the end of the day or week, COHBE sends 834 Enrollment transactions to QHP 1, QHP 2, Medicaid, and CHP+[1]. The Health Plans and Medicaid enter each participant into their systems and send out Welcome Packets and ID Cards. At the same time, or at another designated time, the 820 Premium Payment transaction is sent from COHBE to each of the health plans with the premium for the first month for the associated participant. The following month, Lupe pays COHBE a combined amount for her and Tony's premiums. COHBE (on a weekly or monthly basis) transmits the premium payments to the two health plans along with all the other enrollee premiums that have been gathered over the time period[2][3].

Lupe has a baby: If later Lupe has a baby, the newest child (3) will be enrolled in a plan (qualifying event). Assuming it is either Lupe or Tony's plan, the same payment arrangements could work as in the example above. However, Lupe could choose to pay directly to the health plan for just the baby (unlikely due to premium structures).

Jake moves out of state: If Jake moves out of state, he could disenroll through the exchange. Only an 834 Enrollment transaction would be needed to inform QHP 1 of his disenrollment. No 820 Premium Payment transaction would be needed because 1) there is no money involved and 2) Jake pays directly to QHP 1.

Summary

It is my opinion that the Qualified Health Plans (QHPs) would not want to maintain real-time linkages with COHBE because it would be less efficient than batch processing for the updates to their internal systems. They need to update their systems, prepare Welcome Packets and ID Cards, and other associated administrative details which can be handled more efficiently in a batch mode. The more electronic connections that are maintained in an open state, even with security layers, the more risk that is introduced. I believe only a real-time linkage would allow for non-aggregated data. Because of these considerations, it is recommended that aggregated enrollment and payment data be used by COHBE for premium transmission.

[1] There will also need to be a design decision about whether COHBE sends the Enrollment transaction directly to the chosen CHP+ health plan or if they send the transaction to the MMIS who in turn sends an enrollment transaction to the CHP+ health plan. This could also apply to Medicaid if a Medicaid managed care plan has been chosen.

[2] Another design decision is whether an 834 Enrollment transaction needs to go monthly to let health plans know of continuing enrollments.

[3] Theoretically, each family's data could be a separate 834 or 820 transaction. Because of the data structure of the transactions, this would not be a practical solution.

Although not all use cases or examples are presented above, it is not expected that other examples would change the recommendations.

The separate design question of regarding how payments will be transmitted (separate or with the 820 transaction) is recommended as a discussion topic for the Finance Committee.

Policy versus Design Decisions

As you can see from this discussion, there will be numerous design decisions that need to be made in order to implement the Exchange. The Board will not be able to make every design decision because of the sheer number of considerations there will be. Yet the policies will drive each of these decisions.

Policies state what the outcome should be. At the end of the project, how should things look and work? From policies there will come a set of guiding principles, which the Board may want to explicitly state. These policies and principles can then be applied by the staff in making decisions about the design.

For example, on this question of premium aggregation, the policy of the Board may say: Our policy regarding premium payments by individuals is to maximize the choices for the consumers to ease their ability to participate in the insurance market. A correlating guiding principle could be: If there is a choice between making something easy for the consumer, easy for the Exchange administration, or easy for the QHP to manage, the priority will first be to ease use for the customer. Next will be the ease of implementation for the Exchange, then ongoing administration of the exchange, and finally the ease of administration for the QHP.

When making policy decisions, it is recommended that the Board state the decisions in such a way as to guide future design decisions that will be associated with the policy.

Standard Language

To make sure all parties are talking about the same things, it may be helpful for the Board to state preferred standard language or terms on occasion. For example, is a person who uses the Exchange a user, a consumer, a customer, a patient, a beneficiary, a recipient, a participant, or something else?

As a point of reference, the Medical Services Board in 1996 stated that users of Colorado's Medical Assistance Programs will be called clients. This term indicates the person's right and responsibility of self-determination. Clients choose – and participate actively – with their service providers, whether they are legal services, accounting services, or medical services.

Is there a standard term or terms the Board wants to use for users of the Exchange?

If further discussion is needed, please feel free to contact me at The4and5Team@aol.com or by personal at 303-908-7705. Thank you.