Office of Consumer Information and Insurance Oversight

State Planning and Establishment Grants for the Affordable Care Act's Exchanges

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Project Detail

Since March 23, 2010, the Alabama Department of Insurance (DOI) has dedicated resources focused on implementation of the Affordable Care Act. The DOI worked closely with key staff of the Alabama Medicaid Agency, the Alabama Department of Public Health (ADPH) ALL Kids (CHIP), the Alabama Department of Mental Health (ADMH), and the Information Services Division (ISD--which serves as the IT (information technology) agency for the State). The DOI conducted the background research necessary to narrow the decisions state leaders will need to make in order to create the foundation and blueprint for an Alabama Exchange.

On June 2, 2011, Governor Robert Bentley signed Executive Order No. 17 establishing the Alabama Health Insurance Exchange Study Commission. The Commission served as an advisory committee and made recommendations on:

- Where an Alabama Exchange should be housed;
- The structure of the Exchange governing board;
- How to create a financially sustainable Exchange;
- Delineation of functions of the Exchange; and

- How the Exchange will affect the insurance market and existing health programs and agencies including Public Health and Medicaid.

To further the State's efforts, the Governor established the Office of the Health Insurance Exchange to assist the Study Commission and named Richard Fiore as Executive Director. He was empowered to build a core staff of highly focused professionals to further Exchange planning in Alabama.

As the November 2012 elections approach, the leadership of Alabama has placed further plans on hold until a more definitive direction on the future of the Affordable Care Act and its Exchanges is determined. Once the elections are over, it is expected Alabama will make final decisions regarding its Exchange participation.

Core Areas

- **Background Research**

Alabama utilized its Planning grant to conduct substantial background research on the current insurance marketplace and the State's uninsured and underinsured populations. This work was conducted through a contract with LMI and its subcontractors, Public Consulting Group (PCG) and Mathematica Policy Research (Mathematica).

Current health insurance markets

As one of its projects, LMI and Mathematica designed and conducted a formal analysis of the current health insurance market, including a review of information currently reported to the DOI, available plan designs and payment models, and modeling the impact the Affordable Care Act (ACA) changes will have on the market. The study also looked at enrollment in grandfathered plans within the State, the premium impact of reforms, and the present breadth and anticipated future of the limited medical benefit plan market.

(a) Individual market
Blue Cross Blue Shield of Alabama (BCBSAL) is the dominant carrier in the individual market, accounting for approximately 86 percent of enrollment (measured as member months) in 2010. Other significant carriers in the individual market (though much smaller than BCBSAL) include Golden Rule (4 percent of enrollment), United Healthcare Insurance Company (almost 3 percent), and Humana (2 percent). In the past 5 years, enrollment in BCBSAL's individual products more than tripled.

Most products sold in the individual market are preferred provider organization (PPO) products, although some carriers also offer indemnity and point-of-service (POS) products. No health management organization (HMO) products are offered in this market.

Seven carriers—including BCBSAL, Golden Rule, and Humana—reported writing grandfathered products in 2010, which are exempt from some (but not all) ACA requirements as long the benefit design and plan administration remain substantially unchanged.

A review of benefits packages offered by BCBSAL, Golden Rule, and Humana in the individual market suggests that all carriers will need to develop and offer new products to meet the ACA's requirements related to cost-sharing and coverage of essential health benefits, such as maternity care, behavioral health care, and prescription drugs. In addition, many smaller carriers might need to reduce their premium levels to meet the ACA's 80-percent minimum medical loss ratio for individual products which became effective January 1, 2011. If the ACA's minimum medical loss ratio had been in effect in 2010,

approximately 23,000 individually insured Alabamians (assuming full-year enrollment) would have received an average premium rebate of 35 percent, or $595 per person.

(b) Small group market

At present, the small group market in Alabama serves employer groups of 2 to 50 full-time employees. BCBSAL is the dominant carrier in this market as well (accounting for more than 95 percent of insured small group enrollment), followed by United Healthcare Insurance Company (about 3 percent).

Among carriers that historically reported as health companies (BCBSAL, Healthspring of Alabama, and United Healthcare of Alabama), enrollment in the group market (including both large and small groups) fell sharply over the past 5 years. Group enrollment in BCBSAL products fell approximately 18 percent, while average premiums per member per month rose 29 percent (from $238 in 2006 to $307 in 2010).

Most products available in the small group market in 2010 were PPO products; typically these were products open to new enrollment and available statewide. United Health Care of Alabama and Viva Health (licensed in Alabama) offer the only HMO products in the small group market.

BCBSAL's most popular small group products, as well as those offered by United Healthcare Insurance Company, generally provided comprehensive coverage for a range of services that included maternity care and behavioral health care. However, while BCBSAL's small group products covered prescription drugs, United Healthcare Insurance Company offered only a separate prescription drug product. Both BCBSAL and United Healthcare Insurance Company offered several products with deductibles and out-of-pocket maximums that were higher than the ACA will allow in 2014, suggesting that these carriers (and potentially others as well) will need to modify these products to meet ACA standards for qualified coverage.

In addition, some carriers in the small group market might need to reduce premium levels in order to comply with the ACA's 80-percent minimum loss ratio effective January 1, 2011. If the ACA's minimum medical loss ratio had been effective in 2010, approximately 13,400 insured small group workers (assuming 12-month enrollment) would have received an average premium rebate of 8 percent or $252 per person.

(c) Other products and the changing marketplace

A number of carriers in the individual and small group markets, including BCBSAL, write multiple employer welfare arrangements (MEWAs), association health plans (AHPs), or both. Alabama's current regulation of AHPs is minimal: AHPs must submit rates and forms, but Alabama currently does not have the authority to approve rates, and it approves forms only for in-state AHPs. In addition, many carriers in Alabama provide administrative services only or also write stop loss coverage for self-insured plans in Alabama or elsewhere. In light of the presence of carriers in Alabama that are already active in these lines of business, the potential to divert individual and small group business from an exchange to the large group or self-insured market through AHPs or MEWAs would appear significant.

In Alabama, carriers that currently operate open products in the individual and small group markets may be the most likely candidates for participating in an individual or a Small Employer Health Options Program, or SHOP, Exchange. Such carriers include at least five carriers in the individual market and at least four carriers in the small group market.

However, whether or not these carriers would participate in either an exchange (for individuals) or the SHOP exchange, most apparently will need to reduce premium levels relative to medical benefits paid and also alter benefit designs in order to be qualified plans, or otherwise comply with the ACA. In 2010, many carriers failed to meet the ACA's minimum medical loss ratio requirements which have

subsequently become effective in 2011. Moreover, many offered products that would appear not to comply with the ACA's cost sharing and essential health benefits requirements for qualified health plans, effective in 2014. While expanded benefits likely will improve the value of coverage in 2014, they might also drive premiums higher if the many Alabamians who will newly enter the market are not younger and healthier than those currently enrolled, and if carriers and providers do not also pursue strategies to improve the effectiveness and efficiency of health care services provided while also reducing their administrative costs.

A number of factors could affect enrollment in coverage offered through either the individual Exchange or SHOP exchange in Alabama. These include the extent to which carriers market and write products outside of the Exchange; whether they would encourage the movement of individuals and/or small groups into AHPs or MEWAs; and whether they would encourage small groups, AHPs, or MEWAs to become self-insured. The degree to which Alabama's regulations apply uniformly across all sources of individual and small group coverage—and also clarify the distinction between insured groups and self-insured groups with stop loss or reinsurance coverage—could greatly affect the level and stability of enrollment in the individual Exchange and SHOP exchange.

Finally, it seems likely that carriers with open products, and that are actively marketing individual or small group coverage in Alabama, would probably participate in either or both the individual Exchange and the SHOP exchange. However, it seems unlikely that new carriers would enter Alabama's individual or small group markets soon, due to the difficulty of gaining the name recognition and reputation necessary to build a sufficient consumer base and strong provider networks when BCBSAL is so dominant, the uncertainty of a market where BCBSAL is carrying so much individual business, and the presence of so many carriers in Alabama—including BCBSAL—that currently write MEWAs or AHPs.

One potential opportunity for new entry might be through the national health insurance plans that the ACA requires the federal Office of Personnel Management to make available in every state exchange.

However, notwithstanding the potential for new national plans, the absence of new carriers entering Alabama's individual and small group markets is not necessarily a problem for either the individual Exchange or the SHOP Exchange. A larger and more transparent market in Alabama seems likely to offer existing carriers substantial opportunities to grow over time, especially if carriers that now compete in either the individual or small group market can be encouraged to cross into the other market. If successful, this crossover could offer individuals important new plan options—including HMO options that do not currently exist in the individual market—and deliver more competition to the small group market as well.

The uninsured and underinsured

With LMI, Mathematica also developed a report to assist the State in understanding the population that may purchase health insurance through an Exchange. The study utilized existing survey data including the Alabama sample of the American Community Survey (ACS), the Alabama sample of the Current Population Survey (CPS), the Alabama Behavioral Risk Factor Surveillance System (BRFSS) and the south-region sample of the National Health Interview Survey (NHIS).

In 2010, 84 percent of Alabama's 4.1 million residents under age 65 reported having some form of health insurance coverage—private health insurance, Medicaid, ALL Kids, or Medicare. When the ACA is fully in place in 2014, it will provide new coverage opportunities for an estimated 2 million Alabamians—49 percent of the non-elderly population—in Medicaid or ALL Kids, the HIX, or the SHOP exchange. One of the decision points which will need to be made, however, is whether or not to expand Medicaid to accept many of these newly eligible individuals. Depending on whether the state decides to take

advantage of the now optional Medicaid expansion, the number eligible for insurance coverage could change significantly.

Those with access to new sources of coverage include every Alabamian who is currently uninsured, as well as many low-income individuals or families of workers employed in small firms who are currently insured.

In 2010, the majority of Alabamians were covered by employer-based plans. Altogether, 59 percent of all adults and children received coverage through an employer or union. Most will not experience changes in coverage in 2014. Insurance coverage may, however, change for workers at small businesses, because employers with up to 100 employees will be eligible to participate in a SHOP exchange in 2016 (or in 2014 if the State elects to expand its current definition of small business prior to the 2016 requirement). In 2010, about one-third of residents with employer-based coverage were employed at small businesses with less than 100 employees.

Nineteen percent of Alabamians under age 65 received coverage through public programs in 2010, with 17 percent covered by Medicaid or ALL Kids. These programs were particularly important for children, providing coverage for 45 percent of Alabamians under age 19. In 2014, the number of people eligible for Medicaid will double as eligibility is extended to all adults and children with incomes below 133 percent of the federal poverty line (FPL) should the program be expanded. In total, 38 percent of Alabamians under age 65 would meet the eligibility standards for Medicaid or ALL Kids under the ACA.

Over 16 percent of Alabamians under age 65 were uninsured in 2010, the majority of whom were adults. More than half of the uninsured had incomes low enough to qualify for Medicaid or ALL Kids under the ACA, and 38 percent had incomes that will qualify for federal tax credits towards the cost of private coverage in the individual Exchange. Eight percent had incomes above 400 percent FPL, and these higher-income individuals will be eligible to participate in the individual Exchange but will not qualify for federal tax credits. Altogether, the population eligible to participate in the individual Exchange (excluding those eligible for public programs or receiving employer-based coverage) is one-and-a-half to two times larger than the population currently purchasing policies in the individual market.

In 2010, seven percent of Alabamians were underinsured (defined as foregoing needed medical care due to cost despite having private coverage). Ten percent of the underinsured had individual policies purchased directly. Under the ACA, roughly half of this group will be eligible for public programs and the other half will be eligible to purchase policies in the Exchange. Ninety percent of the underinsured had employer-based coverage; the majority of these individuals work for large employers and will not qualify for new sources of coverage under the ACA, unless the coverage offered is unaffordable or does not meet the 60% actuarial value standard.

The population eligible for Medicaid or ALL Kids under the ACA includes proportionately more adults than the population currently eligible for those programs. Children newly eligible for Medicaid or ALL Kids reported about the same number of health conditions and risk factors as currently eligible children, while newly eligible adults reported fewer health conditions and risk factors than currently eligible adults.

Compared with Alabamians who currently have individual coverage, those eligible to purchase coverage through the Exchange are less likely to be children and more likely to be adults over age 30. Children eligible for individual coverage in the Exchange reported about as many risk factors and health conditions as those currently insured with individual policies. In contrast, adults eligible for the Exchange were more likely to report having health risk factors but less likely to report having chronic conditions or cancer than adults currently insured in the individual market.

- **Stakeholder Involvement**

The DOI, the HIX office and its partners are keenly aware that stakeholder engagement is a key component of the planning process for establishing an Alabama Health Insurance Exchange.

To engage key stakeholders, DOI and LMI convened a meeting of the State-established, 110-person stakeholder task force, which had been meeting since Fall 2010. Approximately 75 task force members attended a general forum on May 10, 2011, to review the Exchange planning process and design options. During this forum, participants also had an opportunity to share feedback and preferences concerning the options presented.

Following this forum, the State recruited insurers, brokers, small employers, providers, and advocacy group representatives to participate in separate focus group sessions. Throughout June 2011, LMI facilitated six individual focus group sessions to gather group preferences for general Exchange options, as well as feedback on stakeholder-specific Exchange issues.

A 10-question survey gathered stakeholders' opinions on intervention in the Alabama insurance market and broad Exchange design options, including the following:
• Governance model, administrative structure, and appropriation process;
• Plan selection model (market organizer, active purchaser, or selective contractor);
• Program integration, application, and enrollment process;
• Outreach, education, and consumer assistance; and
• Long-term financing.

Throughout this process, several strong preferences surfaced across stakeholder groups. These congruencies reflect that stakeholders think the current level of uninsured and underinsured Alabamians is a serious problem and that state intervention is essential to address it. Stakeholders identified affordability as the greatest barrier in both the individual and small group markets, and support the use of federal funds to make insurance more affordable.

Stakeholders agree that a key priority for an Alabama HIX should be to increase competition in the individual and small group insurance markets. They strongly prefer an independent Exchange governance structure with the authority to facilitate greater competition in the short term and the authority to become more selective over time. They also agree that the Exchange governance board should include knowledgeable experts and stakeholder representatives and believe they should be consulted regarding representation in the appointment process.

Stakeholders universally agree that the State's ALL Kids program is a successful model. In addition to an integrated application and enrollment system, stakeholders support a robust outreach and education effort. They acknowledge that consumers will need considerable assistance in determining eligibility, selecting appropriate plans, and using resources available through the Exchange.

Stakeholder input did not stop there. Public input was essential to the Study Commission success as well. During the tenure of the Study Commission, all meetings were open to the public and stakeholders were notified by email about upcoming meetings. As the Study Commission work progressed, those in attendance increased significantly. At each meeting, the co-chairs invited comments from those in attendance. Interested parties had an opportunity to address the Study Commission.

- **Program Integration**

As Alabama continues to plan for implementing the ACA, expanding the State's Medicaid program, and establishing the Exchange, the State will need to coordinate a number of activities across Medicaid, ALL Kids and the Exchange. The DOI has been working closely with staff from Medicaid, ISD, ADMH, ALL Kids and, now the HIX office, to develop a vision of program integration and the "no wrong door" approach for Alabamians seeking insurance through the Exchange. A steering committee of key staffers from each agency met bi-weekly to discuss both policy level and operational implementation issues within and across the agencies. Specific examples of existing program integration that can be leveraged follow.

States must offer consumers multiple access points to apply for coverage—web-based, phone, paper, in person—with eligibility for all publicly subsidized medical assistance programs based primarily on the applicant's MAGI (Modified Adjusted Gross Income). Alabama has already established a single application form for determining eligibility for Medicaid and ALL Kids. Applicants can choose to manually complete a paper form and either submit it by mail or drop it off at a district office or county health department. An electronic version of this form can be completed and submitted online. Although the State has established a single application for both programs, each program has its own eligibility process and rules—that is, no single system determines eligibility for both. An application might first be processed by Medicaid to determine eligibility under Medicaid, and then sent to the ADPH to determine eligibility for ALL Kids, or vice versa. The state is also establishing 120 kiosks across the State that will allow more applicants to complete the eligibility process via the Web.

Additionally, Alabama will need to establish a process for handling complaints and appeals by individuals and families found ineligible for Medicaid, ALL Kids, or premium subsidies through the Exchange, or those who disagree with the determination of eligibility for a particular program or the amount of their subsidy.

In contrast to eligibility, centralizing and coordinating customer service for Exchange consumers who have questions about benefits may be more difficult. Unlike the Medicaid and ALL Kids programs, which have virtually identical benefits—except for the Early Periodic Screening, Diagnosis and Testing (EPSDT) program and long-term care—the qualified health plans available from the Exchange will offer consumers a broad range of plan designs.

Although the qualified health plans offered through the Exchange will be required to cover essential health benefits, they will have differences in cost sharing for services across the plan levels (copayments, coinsurance, deductibles), and there likely will be variances within each plan level. To field benefits questions about the plan packages offered through the Exchange, customer service workers will likely need to be well-versed in commercial insurance. This will be particularly important given the likelihood that many Exchange purchasers will be newly insured and will have never obtained health insurance directly themselves before using the Exchange.

- **Governance**

One of the key decisions the Study Commission and the HIX office will address in the coming weeks is the governance structure for the Exchange. LMI and its subcontractor PCG completed a comprehensive exchange design options analysis based on the key policy goals identified by the State.

The analysis took into account the background research and stakeholder input described above as well as Alabama's existing programs and IT infrastructure. Definitions for various governance models were

developed and pros and cons of each model were considered consistent with stakeholder input and state feedback.

Once the 2012 elections are complete, it is expected that Alabama will address the future of a state-based exchange for the state at that time.

- **Finance**

The Exchange staff, in conjunction with LMI, developed an initial written analysis of sustainable financing options for a self-sustaining Exchange. This analysis included budget estimates for the Exchange and recommendations. More work needs to be done and will be completed in future funding requests. This includes developing volume estimates, benchmarking costs, and a staffing plan which would determine the types of positions and salaries needed.

Additionally, a preliminary written assessment of financial functions was completed. This accounted for a variety of finance-related functions of an Exchange, such as: development of accounting and auditing systems, standards and controls; collection and safeguarding of premiums; reconciling tax credits and cost-sharing subsidies; control of waste, fraud and abuse; creation of transparency and financial reporting mechanisms for the public; and development of the technical infrastructure to comply with Federal reporting requirements.

- **Technical Infrastructure**

The Information Services Division as well as lead IT staff from all applicable agencies have been fully engaged in initial IT systems discussions. As part of the IT gap analysis process, Alabama has begun to assess opportunities to leverage its existing Medicaid and ALL Kids systems as well as its Health Information Exchange (HIE) and MyAlabama.gov web portal to support core functions of the Exchange.

An initial meeting was held on August 16, 2011, to identify all existing IT systems that could support Exchange functions and subsequent interviews were conducted with system owners to identify capabilities and gaps. The gap-analysis summary provided substantial additional information on Alabama's systems and initial thinking on IT systems development.

In addition to the IT Gap analysis, the Alabama Office of the Health Insurance Exchange (HIX) investigated numerous information sharing models to help carry out its commitment to adopting and implementing a standards-based approach to information sharing. This included using the following standards (described in more detail below) as design templates for creating the Exchange: National Information Exchange Model (NIEM), Global Federated Identity and Privilege Management (GFIPM) and Exchange Reference Architecture (ERA). Additional data sharing opportunities are also being explored building on existing state capacity, demonstrations and federal guidance (also described in more detail below).

National Information Exchange Model (NIEM) – NIEM is a partnership of the U.S. Department of Justice, Department of Homeland Security, and Department of Health and Human Services. It is designed to develop, disseminate and support enterprise-wide information exchange standards and processes that can enable jurisdictions to effectively share critical information in emergency situations, as well as support the day-to-day operations of agencies throughout the nation. NIEM enables information sharing, focusing on information exchanged among organizations as part of their current or intended business practices. The NIEM Exchange development methodology results in a common semantic understanding among participating organizations and data formatted in a semantically consistent manner. This means that data from legacy systems can be re-purposed to share with external persons and organizations in a

manner that ensures consumers receive information in an understandable format. Because it is unlikely that all (if any) records management systems will be completely replaced as a result of the Exchange, it is important to develop a data sharing approach that allows data that is formatted and stored in widely disparate systems to be shared seamlessly.

According to the NIEM program office, the health and human services sector is very likely to be the next domain added to the data model. While there are a number of existing standards for sharing patient data, there are no current standards to facilitate health insurance exchanges. As a result, NIEM could provide an ideal framework for creating such standards as states move forward to implement the ACA.

Global Federated Identity and Privilege Management (GFIPM) - The GFIPM framework provides organizations with a standards-based approach for implementing federated identity. This is extremely important to the Exchange as a number of distinct user groups will be accessing some level of data through the Exchange – insurance providers, health management organizations, Medicaid, ADPH, DOI and members of the public seeking to qualify and enroll through the Exchange website. GFIPM allows for the necessary interoperability by providing globally understood metadata across a federation of systems. Just as NIEM uses a common Extensible Markup Language (XML) data model for data interoperability, a standard set of XML elements and attributes about a federation user's identities, privileges, and authentication can be universally communicated.

Exchange Reference Architecture – Through the ERA, CMS has provided guidance to the public sector on how to plan and design information sharing technology solutions based on a Service Oriented Architecture (SOA). SOA is a methodology for integrating systems while maintaining as much of their independence and autonomy as possible. That is, it allows multiple systems to share information, but in a way that still allows the systems to function independently. As indicated earlier, it is not anticipated that legacy systems in place in Alabama will be (or should be) replaced to facilitate the Exchange. The ERA presents a technical framework that can allow an efficient and cost-effective solution for integrating data from disparate systems into the Exchange.

MyAlabama - In recent years, Alabama has been developing a streamlined approach to facilitating enrollment in human services. What this means is that a single portal – MyAlabama – is being piloted which allows Alabama citizens to fill out a simple web-based questionnaire that can be used to determine state-run programs for which they may be eligible. The form captures basic information – such as applicant information, family size, income level, employment status, etc. – all of which help formulate a complete picture of the needs of the individual and/or family. The information entered can then be used to "pre-populate" the agency-specific information needed for enrollment in a particular program. Once fully operational, this could be the gateway into a wide array of state services.

In short, the goal of the MyAlabama approach is to allow Alabamians to have a simple way to receive services to which they are eligible without having to navigate through a complex maze of bureaucratic forms and procedures. The object of MyAlabama is to get people the assistance they need in an effective and efficient manner which should improve overall outcomes for enrollees. Importantly, once the user completes the initial questionnaire, this information is retained in the MyAlabama repository. Additional information provided for enrollment in specific benefit programs will also be transferred back to the repository. Ultimately, this will provide a detailed "picture" of individuals participating in various state programs. It is conceived that the information contained with MyAlabama could also be used by the Exchange to determine if existing beneficiaries would qualify for participation in the Exchange.

Additionally, this concept of sharing beneficiary information among various state agencies could assist the State in fraud detection and prevention efforts. Because state agencies' databases are so compartmentalized in individual "silos," it can be difficult to determine with great precision the number

of programs in which a person is participating. As discussed below, another goal of the HIX is to apply business intelligence (BI) tools into the State's integrated enrollment portal. BI can not only assist in evaluating outcomes by providing better aggregated information concerning services delivered, length of enrollment, etc., but it can also assist with fraud prevention and detection by identifying potential "double dippers" within the system.

Business Intelligence and Analytics - Alabama's HIX is committed to building BI capabilities into its Exchange solution from its inception. Many Medicaid agencies around the country have been able to improve efficiencies in medical services delivery, enhance business and reporting processes, streamline enrollment procedures while detecting and preventing fraud by developing BI data warehouses. BI will allow program administrators at HIX to establish metrics that can be evaluated to support the life cycle development of the Exchange. Such metrics may include beneficiary information and interaction with the Exchange (e.g. calls to call center, calls handled by call center, wait times for callers, website inquiries, etc.). They could also include customer satisfaction reports for qualifying health plans, the eligibility determination process, the HIX enrollment website or other critical aspects of the Exchange. BI could also be used to measure shifts in the qualifying population that may create the need to re-evaluate the essential benefits offered by qualifying health plans. Last, but not least, BI tools will allow HIX staff to quickly perform ad hoc queries to respond to specific informational requests from state and federal policymakers, CMS, and members of the HIX governance structure.

The CMS Technical Reference Architecture Business Intelligence Supplement was authorized and approved by the CMS Chief Technology Officer on March 18, 2011. The supplement provides the authoritative Technical Reference Architecture (TRA) for all CMS stakeholders who plan, acquire, implement, use, and maintain CMS BI systems within the CMS Production Environments. This architectural guidance will be followed by Alabama as it develops its BI capacity.

- **Business Operations**

LMI and its subcontractor PCG prepared an assessment of Exchange financial functions including cost estimates. The initial assessment analyzes various finance-related functions, such as development of accounting and auditing systems, procedures, standards and controls; collection and safeguarding of premiums; reconciling tax credits and cost-sharing subsidies; control of waste, fraud, and abuse; creation of transparency and financial reporting mechanisms for the public; and development of the technical infrastructure to comply with Federal reporting requirements. In future funding opportunities, business operational costs will be further fleshed out to provide a clearer picture of financial functions of the Exchange.

- **Regulatory or Policy Actions**

The DOI worked with outside experts to develop rate review legislation in order to create the authority necessary for Alabama to conduct rate review that will meet HHS standards. The State has also analyzed the need for additional internal and external review authority as well as other health insurance reforms as required under the ACA. Future funding will provide for the comprehensive development of draft legislation to address these areas.

Needs Assessment

A complete needs assessment including a final budget, a staffing plan, upcoming procurements and assessment of the information technology and system build to establish an Exchange will become

complete after the November 2012 elections. In November, 2011, the DOI was awarded a Level One cooperative agreement to further complete these tasks.

Technical Assistance

There are still major decision points which remain to be made. Many of these are on hold until after the November 2012 elections. Some decision points cannot be even considered until the federal government releases more information. In order to determine if Alabama will create its own state-based exchange, participate in a partnership exchange or defer to the federally facilitated exchange, the following guidance should be released:

- Essential health benefits rule
- Market reform rule (i.e., age bands, geography, etc.)
- Multi-state rule
- Federal exchange details (i.e., funding, rules, etc.)
- Federal Risk Adjustment parameters
- Federal Reinsurance Parameters
- Full inventory of the services to be exposed through the federal data services hub– including the cost to states to consume these services where applicable
- User fee sharing structure for states participating in a partnership model (i.e. How will the per member per month fees collected for each plan sold through the Exchange be split between the state and federal government?)
- Medicaid guidance

Final Project Work Plan

The final work plan remains fluid as the November 2012 elections reach their culmination. At that point, the leadership of the state will determine Alabama's next steps toward compliance with the Affordable Care Act and Exchange establishment as it stands today. Future cooperative agreement applications will include a work plan.

Final Evaluation Report

The final evaluation plan remains fluid as the November 2012 elections reach their culmination. At that point, the leadership of the state will determine Alabama's next steps toward compliance with the Affordable Care Act and Exchange establishment as it stands today.

Exchange Deliverables

All reports developed as part of this grant may be found at the Department of Insurance's website: www.aldoi.gov/Consumers/HealthInsReform.aspx. Due to the volume and number of reports generated, only the link will be provided as part of this final report.