

Virginia Health Benefits Exchange

State-based Exchanges (SBEs) give states more control over their individual insurance markets versus the states that utilize the Federally Facilitated Marketplace (FFM), as Virginia does. **States that have SBEs have been able to strengthen the individual market and reduce premiums by growing and maintaining enrollment, fostering greater competition between plans, and enrolling younger and healthier populations¹.** However, moving to an SBE is not without risk. The state must ensure a smooth transition from the FFM to an SBE, provide adequate financial support to the SBE to ensure better service than the FFM, and engage with all stakeholders, including consumers and consumer advocates, in the development process.

Benefits of a State-based Exchange to Virginia

- Gain more autonomy over the individual and small business insurance markets.
- Implement enrollment supports and stabilizing measures to reduce premiums.
- Analyze exchange data in real time to react to consumer needs in a nimble manner and develop a better understanding of Virginia's individual insurance landscape. Data currently shared by CMS is described as too aggregated and too delayed to be useful².
- Keep insurer fees that are currently being paid to the federal government to fund administrative costs, outreach and enrollment assistance efforts, and other market stabilizing efforts. Current bills ensure insurer fees will be used for exchange purposes only.
- Develop interagency strategies and collaborations to ensure Virginians are aware of their coverage options.
- Have the flexibility and infrastructure to pursue additional health insurance reform measures now, such as integrating the Medicaid and Marketplace eligibility systems, and in the future³.

Benefits of a State-based Exchange to Consumers

- Flexibility to extend annual open enrollment periods and simplify special enrollment periods for consumers experiencing qualifying events.
- Integrate Medicaid and the Marketplace eligibility systems for smooth transitions between programs resulting in fewer verification requests from the consumer.
- Increased funding and scope of outreach, education and enrollment assistance, and targeted marketing efforts, including advertising.

See reverse for VPLC Recommendations

¹ Rilet, T., *State Marketplaces Outperform the Federal Marketplace*, (National Academy for State Health Policy), https://nashp.org/wp-content/uploads/2019/04/SBM-FFM-Comparison-Data_4_1_2019.pdf

² Corlette, S., Lucia, K., Keith, K., & Hoppe, O., *States Seek Greater Control, Cost-Savings by Converting the State-based Marketplaces*, (Robert Wood Johnson Foundation and Urban Institute, October 2019), p.5. <https://www.rwjf.org/en/library/research/2019/10/states-seek-greater-control-cost-savings-by-converting-to-state-based-marketplaces.html>

³ Corlette, S., Lucia, K., Keith, K., & Hoppe, O., *States Seek Greater Control, Cost-Savings by Converting the State-based Marketplaces*, p.8.

For more information contact:

Jill Hanken, (804) 351-5258 jill@vplc.org

Sara Cariano, (804) 332-1432, sara@vplc.org

VPLC Recommendations

Structure and funding of state-based exchange

- Ensure adequate funding through insurer fees from plans sold on and off the exchange and use available Medicaid dollars for Medicaid-related functions.
- Ensure insurer fees and other exchange generated funds fully support the functioning of the exchange and promotion of a healthy individual market.
- Consider use of exchange funds for state-based subsidies to make premiums more affordable for those not eligible for federal subsidies.
- Establish an independent **governing** board with stakeholder and consumer representation that meets on a monthly basis and has oversight authority.
- The federal Small Business Health Options Program (SHOP) covered only 39,000 people over the 26 states in 2017. Several SBEs don't offer a SHOP exchange due to low participation. It may be an unnecessary expense given the minimal use of the federal SHOP exchange and heavy reliance on brokers for this piece of the Market.
- Toll-free call center should be available 24-hours a day, be accessible to persons with disabilities, and provide meaningful access for persons with limited English proficiency.

Improve the application process for consumers

- Include language that the annual open enrollment period will be no less than ten weeks.
- Ensure “no wrong door” application processes by utilizing integrated eligibility systems for Medicaid and the Marketplace. This will enable universal verification, coordinated notices and language access, and streamline transitions between programs, including automatic transitions where the only change is a change in income. (Today, many consumers encounter challenges that result in either a loss of coverage or duplicate coverage when transitioning between programs.)
- Have a case resolution process that is accessible to both Medicaid and Marketplace populations and informed about both programs' eligibility rules.
- Include language that ensures robust funding for outreach, education and enrollment assistance, and marketing to uninsured/hard-to-reach populations.
- Clearly define the role of Navigators
 - Navigators should be community-based, in-person, and year-round.
 - Ensure Navigators have access to any broker portal and dispute resolution processes that are created so they can fully assist consumers.
 - Add post-enrollment activities to the list of required navigator duties.
- Exchange website should include current drug formularies for all health plans.
- To simplify plan comparison for consumers, give the exchange the authority to limit the number of plans offered (e.g. each carrier could only offer 2 plans in each metal level).

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