health policy institute of ohio

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Final rules and key stakeholder considerations regarding exchange establishment and functions

Introduction

Through the Patient Protection and Affordable Care Act (ACA), qualified individuals and small businesses will be able to purchase private health insurance through Affordable Insurance Exchanges (exchanges) beginning on Jan. 1, 2014. Under the ACA, the Department of Health and Human Services (HHS) is charged with implementing exchanges and has begun to do so through rulemaking.

On March 27, 2012, HHS published an exchange establishment and eligibility final rule which codifies standards relating to operating an exchange, eligibility for enrollment in an exchange and insurance affordability programs, qualified health plan (QHP) participation in an exchange and the Small Business Health Options Program (SHOP). These regulations are effective May 29, 2012.

This policy brief summarizes major provisions of the final rule regarding exchange establishment and exchange functions and highlights key issues and considerations regarding these provisions. This brief is the first in a series of policy briefs that the Health Policy Institute of Ohio will issue over the next few months to examine various areas of the exchange.

Exchange Rules Analysis Committee (ERAC)

The Health Policy Institute of Ohio (HPIO) convened an Exchange Rules Analysis Committee (ERAC) comprised of a diverse group of stakeholders including representatives from provider, consumer, agent and broker, health plan, academic, small business and local government sectors to analyze the exchange rules and assess the implications of these rules on Ohio and Ohioans. Feedback from this group is reflected in this document.

inside

What are affordable insurance exchanges?	**2**
What are the exchange models?	**2**
Exchange development in Ohio	**2**
What is a qualified health plan?	**3**
How are exchanges established?	**3**
State-based exchange	**3**
Partnership and federally-facilitated exchanges	**3**
Regional or Subsidiary exchanges	**4**
Who can operate a state-based exchange?	**4**
How will a state-based exchange be governed?	**4**
What are the functions of an exchange?	**5**
Key stakeholder considerations regarding exchange establishment and functions	**6**
How are exchanges funded?	**8**
Sources	**8**

WHAT ARE AFFORDABLE INSURANCE EXCHANGES?

Under the ACA, qualified individuals and small businesses will be able to purchase private health insurance through Affordable Insurance Exchanges (exchanges). Exchanges are comprised of both "American Benefit Exchanges" serving individuals and "Small Business Health Option Programs" (SHOP) serving small businesses (with up to 100 employees).

Structured as competitive marketplaces, exchanges are designed to enable consumers and small businesses to shop for, select and enroll in qualified health plans. As legislated, exchanges aim to improve competition in the health insurance market, increase choice of affordable health insurance coverage and provide small businesses with the same purchasing leverage as larger businesses.

WHAT ARE THE EXCHANGE MODELS?

On Jan. 1, 2014, exchanges must be in operation in each state. A state may defer to a federally-facilitated exchange, opt for a partnership exchange or elect to establish a state-based exchange. A partnership exchange is a variation of a federally-facilitated exchange under which HHS would have ultimate responsibility and authority. The partnership exchange model enables states to leverage both state and federal resources.

Each of these exchange models must be comprised of both an American Benefit Exchange and a SHOP.

Exchange development in Ohio

Citing a lack of clarity and guidance from the federal government, Ohio officials have taken a "wait-and-see" approach to deciding whether to establish state-based insurance exchanges.

Lt. Gov. Mary Taylor, who also serves as Director of the Ohio Department of Insurance (ODI), the agency charged with overseeing exchange implementation, has indicated that the state remains open to all possible approaches to setting up and operating exchanges.

Speaking at HPIO's forum on exchanges in February, Taylor said, "Let me be clear, like many other states, we are evaluating all of our options in order to do what's best for Ohio consumers and Ohio job creators."

Taylor added that, "This lack of clarity and the constantly changing rules make decision-making on our part very difficult."

States seeking to operate a state-based exchange or electing to participate in a partnership exchange must submit a complete Exchange Blueprint (essentially an application) by Nov. 16, 2012. HHS will review and potentially approve or conditionally approve the exchange no later than Jan. 1, 2013, so it can begin offering coverage on Jan. 1, 2014.

In September 2010, ODI received a $1 million federal exchange planning grant. The Kasich administration also signed a letter of intent to apply for a federal Level One establishment grant by June 30, 2011. However, the state has yet to apply for the funding. The original deadline to apply for establishment grants was June 29, 2012, but HHS in February announced that grant funds would be awarded through the end of 2014.

As administration officials continue to weigh options, a group of Democratic lawmakers has crafted legislation to establish state-based exchanges through the formation of the Ohio Health Benefit Exchange Program. The bill, which is sponsored by Rep. John Carney and Rep. Nickie Antonio and co-sponsored by 14 other Democrats, will face difficulty passing the Republican-controlled Ohio House. However, Reps Carney and Antonio have incorporated amendments from stakeholders into a Substitute Bill in an effort to reach a stakeholder consensus document. Democratic Sen. Mike Skindell has introduced a companion bill in the Republican-controlled state Senate.

Also speaking at the HPIO exchange forum in February, Carney said, "There's a time for politics, and there's a time for policy. We need to be working on this now so we understand the implications, understand the cost."

On May 16, 2012, HHS also released additional guidance further detailing its planned federally facilitated exchange (FFE), which will be available to residents of states that do not opt for a state-run exchange.

HOW ARE EXCHANGES ESTABLISHED?

State-based exchange

To establish a state-based exchange, states must provide HHS with an "exchange blueprint" comprised of a declaration letter and exchange application. The blueprint must outline that a state-based exchange can: (1) carry out required exchange functions and information reporting and (2) cover the entire geographic area of the state. States must also demonstrate operational readiness to execute their blueprint by undergoing a readiness assessment conducted by HHS.

To operate a state-based exchange by Jan. 1, 2014, a state must submit a blueprint to HHS by Nov. 16, 2012 and receive written or conditional approval of its exchange blueprint and readiness assessment performance from HHS by Jan. 1, 2013. Notably, HHS may consult with other federal government agencies in determining whether to approve a state-based exchange. States must notify HHS in writing prior to making a significant change to their exchange blueprint. Significant changes to exchange blueprints are not effective until HHS provides written approval of the request or until 60 days after HHS receives the request. HHS has authority to extend the review period to 90 days and may deny requests made for significant changes to an exchange blueprint.

States may elect to operate a state-based exchange after Jan. 1, 2014. However, states must work with HHS to develop a plan to transition from a federally-facilitated or partnership exchange to a state-based exchange. States are also required to obtain full or conditional approval from HHS at least 12 months prior to the exchange's first effective date of coverage.

States with existing state exchanges will be presumed compliant with the federal rules if their exchange (1) was in operation prior to Jan. 1, 2010 and (2) insures a percentage of its population no less than the percentage of the population projected to be covered nationally after the implementation of the ACA (based on the Congressional Budget Office estimates for projected coverage in 2016 published on March 30, 2011).

Partnership and federally-facilitated exchanges

States electing to participate in a partnership exchange for the 2014 plan year must also submit an exchange blueprint by Nov. 16, 2012. States opting for a partnership exchange will have to work with HHS on a partnership arrangement and agree to perform functions within certain parameters as agreed upon by the state and HHS. HHS has emphasized that state-federal partnership arrangements will be structured in a manner to ensure a seamless consumer experience for individuals and employers.

What is a qualified health plan?

A qualified health plan (QHP) is a health plan that meets certain certification requirements and minimum standards of quality, value, and benefit design. Specifically, QHPs are required to cover an essential health benefits package that includes the provision of:

- Ambulatory services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Pediatric services including oral and vision care

QHPs must be offered by a health insurance issuer that is licensed and in good standing in each state in which the issuer offers coverage. A QHP issuer must offer at least one silver and one gold level QHP through the exchange. Health plans have four designated levels of coverage: bronze, silver, gold and platinum. Platinum-level coverage provides the most generous value of benefits with the least cost-sharing while bronze-level coverage is less generous with higher cost-sharing.

Furthermore, HHS has provided guidance that states entering into a partnership arrangement will be able to choose whether they operate exchange plan management, in-person consumer assistance functions or both.

If a state does not elect to operate a state-based or partnership exchange, then the state will be subject to a federally-facilitated exchange. HHS must directly or through an agreement with a not-for-profit entity, establish and operate an exchange within the state.

Regional or Subsidiary exchanges

A state may establish regional or subsidiary exchanges. A regional exchange can span two or more states and is required to submit a single exchange blueprint to HHS. A state can establish one or more subsidiary exchanges within a state as long as each exchange serves a geographically distinct area that is at least as large as a rating area. The individual market and SHOP for regional and subsidiary exchanges must encompass a geographic area that matches that of the regional or subsidiary exchange.

States deciding to cease operation of a state-based exchange after Jan. 1, 2014 must provide HHS with at least 12 months notice and work with HHS to develop and execute a transition plan. HHS released additional guidance on federally-facilitated exchanges, partnership exchanges and the exchange blueprint on May 16, 2012.[1]

WHO CAN OPERATE A STATE-BASED EXCHANGE?

A state-based exchange must be operated by a governmental agency or a non-profit entity established by the state. Notably, a state can elect to enter into an agreement with eligible entities to carry out one or more responsibilities of the exchange. Eligible entities include the state Medicaid agency and other state agencies or entities that are (1) incorporated under the laws of a state (2) have experience on a state or regional basis in individual and small group health insurance markets and coverage and (3) are not considered health insurance issuers.

HOW WILL A STATE-BASED EXCHANGE BE GOVERNED?

State-based exchanges must have a clearly defined governing board. The governing board must:

- Be administered under a formal, publicly-adopted operating charter or by-laws
- Hold regular public governing board meetings announced in advance
- Make publicly available guiding governance principles that include standards relating to ethics, conflict of interest, accountability, transparency and disclosure of financial interest

Exchange governing boards must be comprised of at least one voting member who is a consumer representative. A majority of voting members must have experience with health care benefits administration, finance, plan purchasing, delivery system administration, public health or policy and have no conflicts of interest. Conflicted interests include individuals who are representatives of health insurance issuers or those licensed to sell health insurance.

States may elect to create separate administrative and governance structures for the individual and SHOP exchanges given that states can ensure coordination between the governance structures. However, HHS indicates that there are economies of scale and natural benefits that may arise from integrating the individual exchange and SHOP.

Both federally-facilitated and state-based exchanges are required to regularly consult with a number of stakeholders to ensure that the needs of the state in which the exchange is operating are met. Exchanges are required to regularly consult with the following stakeholders:

- Educated health care consumers enrolled in qualified health plans
- Individuals and entities with health care coverage enrollment experience
- Advocates for enrolling hard to reach populations
- Small businesses and self-employed individuals
- State Medicaid and CHIP agencies
- Federally-recognized tribes
- Public health experts
- Health care providers
- Large employers
- Health insurance issuers
- Agents and brokers

1 "General Guidance on Federally-facilitated Exchanges", Center for Consumer Information & Insurance Oversight, Centers for Medicare & Medicaid Services (May 16, 2012) available at http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf. See also "Draft Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges" Centers for Medicare & Medicaid Services (May 16, 2012) available at http://cciio.cms.gov/resources/files/Exchangeblueprint05162012.pdf.

WHAT ARE THE FUNCTIONS OF AN EXCHANGE?

Exchanges are required to perform a core set of minimum functions including providing QHP access to qualified individuals and employers through a SHOP and the operation of risk adjustment, risk corridor and reinsurance programs to lessen the financial risks for issuers participating in the exchange.

Other required exchange functions are outlined below.

Function	High Level Overview
Certificates of exemption	Exchanges are required to issue certificates exempting certain individuals from the individual responsibility and payment policy under the ACA. The individual responsibility policy requires that applicable individuals maintain minimum essential health care coverage or be subject to a monetary penalty. Standards outlining the exchange process for issuing certificates of exemption will be addressed in separate rulemaking.
Oversight and financial integrity	Exchanges are required to keep an accurate accounting of all activities, receipts, and expenditures and submit to the Secretary of HHS an annual report of such accountings. Exchanges will be subject to annual audits and may be subject to investigations and periodic reporting of exchange activities to the Secretary of HHS.
Quality activities	Exchanges are required to evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality outcomes, information disclosures and data reporting.
Consumer assistance tools and programs	Exchanges are required to operate a toll-free consumer assistance call center, maintain an up to date website and conduct consumer outreach and education activities. Website content must include standardized comparative information on QHPs, a calculator to facilitate the comparison of QHPs, certain financial information on exchanges and information regarding exchange consumer assistance programs. QHP information displayed must include: • Premium and cost-sharing information • A summary of benefits and coverage • Identification of plan level (i.e. bronze, silver, gold or platinum) • Enrollee satisfaction survey results • Quality ratings • Medical loss ratio information • Transparency of coverage measures • A provider directory Exchange websites must also allow for eligibility determinations and selection of QHPs.
Navigator program	Exchanges are required to establish a navigator program which awards grants to eligible public or private entities and individuals to serve as navigators. Navigators are expected to guide consumers through the exchange system by conducting public education activities to raise awareness about exchanges, facilitate QHP selection, assist consumers in applying for advanced payments of the premium tax credit and cost-sharing reductions and provide referrals for consumers with grievances or complaints.
Eligibility determinations	Exchanges are required to determine consumer eligibility for enrollment in qualified health plans and insurance affordability programs (i.e. Medicaid and CHIP, advance payments of the premium tax credit and cost-sharing reductions and the Basic Health Plan). Notably, under an interim final rule, exchanges are provided with the option to: 1. Execute eligibility determinations directly, through contracting arrangements or a combination of both. 2. Choose to conduct an assessment of eligibility for Medicaid and CHIP rather than eligibility determination. 3. Implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions or rely on HHS to carry out this function Exchange final rules emphasize that there must be coordination across the exchange, HHS, state agencies and other exchange related public programs and entities.
Enrollment in QHPs	Exchanges are required to facilitate the enrollment of consumers in QHPs. Specifically an exchange must accept a QHP selection from an applicant determined to be eligible for enrollment in a QHP and then (1) notify the issuer of the applicant's selected QHP and (2) transmit the necessary information to enable the QHP issuer to enroll the applicant. The initial open enrollment period for applicants runs from Oct. 1, 2013 through March 31, 2014.
QHP certification	Exchanges are required to certify health plans as QHPs to be offered in the exchange. Exchanges are responsible for determining that a QHP meets federal standards and that offering the QHP through the exchange is in the interest of qualified consumers and employers. To be certified as a QHP, health plans must meet minimum standards of quality, value, and benefit design and be offered by a health insurance issuer that meets specific accreditation requirements. Exchanges are also required to establish a process to monitor the continued certification of QHPs and decertify QHPs that fail to meet certification requirements.

Key stakeholder considerations regarding exchange establishment and functions

Issue	Summary of rule
Exchange operation	• State-based exchange must be operated by a governmental agency or a non-profit entity. • States can enter into agreements with eligible entities to carry out one or more responsibilities of the exchange. Eligible entities include the state Medicaid agency and other state agencies or entities that are: ◦ Incorporated under the laws of a state ◦ Have experience on a state or regional basis in individual and small group health insurance markets and coverage ◦ Not considered health insurance issuers
Exchange approval process	• State must receive written or conditional approval of their exchange blueprint and readiness assessment performance from HHS by Jan. 1, 2013 to operate a state-based exchange by Jan. 1, 2014. • Significant changes to exchange blueprints are not effective until a state receives HHS written approval of the completed request or until 60 days after HHS receives the completed request. HHS has authority to extend the review period to 90 days.
Regional and subsidiary exchanges	• States may establish regional or subsidiary exchanges. • Regional exchanges can span two or more states. • Subsidiary exchanges within a state must serve a geographically distinct area that is at least as large as a rating area.
Governance	• State-based exchanges must have a clearly defined governing board. • Exchange governing boards must be comprised of at least one voting member who is a consumer representative and a majority of voting members with relevant health care experience and no conflicts of interest. • States may elect to create separate administrative and governance structures for the individual and SHOP exchanges.
Funding	• State-based exchanges must have sufficient funding to support ongoing operations by Jan. 1, 2015. • There will be no federal grants awarded for state exchange establishment after Jan. 1, 2015 • Funding may be generated through assessment of user fees on QHP issuers participating in any function of the exchange. • The final rules clarify that states have substantial flexibility in establishing a funding mechanism for exchanges and are not restricted to user fees.
Federally facilitated and Partnership exchange	• States not electing to operate a state-based exchange will be subject to a federally-facilitated exchange. • States may opt for a partnership exchange which is a variation of a federally-facilitated exchange under which HHS would have ultimate responsibility and authority. • States ceasing operation of a state-based exchange after Jan. 1, 2014 must provide HHS with at least 12 months notice and work with HHS to develop and execute a transition plan.

Stakeholder considerations

- Existing state agencies are likely to have accountability structures in place, whereas non-profit entities are not. For this reason, some have advocated that state-based exchanges should be operated solely by governmental or quasi-governmental entities.
- Non-profit entities may encounter political isolation, increased bureaucracy and have difficulty coordinating and integrating with state agencies to provide the services required by an exchange.
- Non-profit entities may have difficulty performing exchange functions that are typically performed by government agencies.
- States are afforded discretion in determining which entities are governmental to ensure deference to existing state classifications.
- The state may need to establish or revise conflicts of interest standards for eligible contracting entities.

- HHS has not set a timeframe for revoking conditional approval of a state-based exchange which may impair the implementation of exchanges in a state by Jan. 1, 2014 and create transitory issues during the open enrollment period to start Oct. 1, 2013.
- Conditional approval allows for state flexibility in meeting exchange development timelines.
- Disputes between HHS and states as to when a "completed" request for a change to an exchange blueprint was received by HHS may arise.

- Consumers may be inclined to transition between multiple exchanges existing within a state thereby impacting the stability of the exchange market.

- Some have suggested that the threshold for having one consumer representative as a voting member is too low.
- A state may choose to establish an exchange with a higher threshold of non-conflicted board members.
- Currently, the minimum standards for conflicts of interest do not apply to spouses or immediate family with a conflict of interest.
- Flexibility in the final rules governance standards of exchanges can decrease potential inconsistencies and conflicts with existing state standards.

- States deciding to operate a state-based exchange after Jan. 1, 2015 may not have adequate funding to establish and maintain a state-based exchange.
- The broad definition of QHP issuers may extend to Medicaid managed care plans, basic health programs plans and CHIP. The rules do not address non-participating issuers which may give exchanges discretion to assess user fees on non-participating issuers as well.

- There is concern regarding the variance of federally-facilitated exchanges from state to state in regard to overall structure, governance, oversight and related standards.
- Consumer advocates and other state stakeholders have expressed concern over the ability to engage in the governance and oversight of a federally-facilitated exchange.
- Exchange final rules do not establish an alternative process for providing interim coverage to consumers in states that terminate exchange operations with less than 12 months notice.

HOW ARE EXCHANGES FUNDED?

By Jan. 1, 2015, state-based exchanges must have sufficient funding to support ongoing operations. The final rules clarify that states have substantial flexibility in establishing a funding mechanism for exchanges and are not restricted to user fees. However, to support operations, both federally-facilitated and state-based exchanges have the option of generating funding through assessment of user fees on QHP issuers participating in any function of the exchange. User fees can be set based on a broad or narrow set of issuers, on enrollment volume including enrollment outside of the exchange or without regard to enrollment.

States can apply for federal grants to help to establish exchange functions and operating systems and test and improve systems and processes over time. Federal grant funding for exchange establishment will only be awarded through 2014. Technical assistance and establishment grant funding are available to states opting to establish a state-based exchange, states electing for a partnership exchange and for states wanting to build linkages to a fully federally-facilitated exchange. However, there will be no federal grants awarded for state exchange establishment after Jan. 1, 2015. Notably, exchanges must include a funding plan in their exchange blueprint in order to receive HHS approval.

references

The Patient Protection and Affordable Care Act, Pub. L. No.111-148, §1311(b) (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 11-152 (2010), is referred to herein as the "Affordable Care Act" or "ACA."

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