LEGISLATIVE BRIEF

Health Care Reform: HHS Issues Proposed Guidance on State Insurance Exchanges

The Patient Protection and Affordable Care Act (PPACA) requires states to operate health insurance exchanges (Exchanges) to provide a competitive marketplace where individuals and small businesses will be able to purchase affordable private health insurance coverage, effective **Jan. 1, 2014**. According to the Department of Health and Human Services (HHS), the Exchanges will make it easier for individuals and small businesses to compare health plan options, receive answers to health coverage questions, determine eligibility for tax credits for private insurance or public health programs and enroll in suitable health coverage.

Individuals and small employers **with up to 100 employees** will be eligible to participate in the Exchanges. However, states may limit employers' participation in the Exchanges to businesses with up to 50 employees until 2016. Beginning in 2017, states may allow businesses with more than 100 employees to participate in the Exchanges.

On July 11, 2011, HHS announced two notices of **proposed rulemaking**: (1) Establishment of Exchanges and Qualified Health Plans, and (2) Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. The proposed guidance is designed to help states design and implement their Exchanges in two key areas:

- Setting standards for establishing the Exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an Exchange and certifying health plans for participation in the Exchanges; and
- Ensuring premium stability for plans and enrollees in the Exchanges, especially in the early years as new people use the exchanges to shop for health insurance.

The Exchange guidance issued by HHS is **not final**. HHS is accepting public comments on the proposed Exchange guidance for 75 days to learn from states and other stakeholders how the rules can be improved. HHS expects to make changes to its proposed guidance based on the comments it receives.

This Apex Benefits Group Legislative Brief provides an overview of HHS's proposed guidance on the Exchanges. More information from HHS on the Exchanges is available at: www.healthcare.gov/law/provisions/exchanges/index.html.

ESTABLISHMENT OF EXCHANGES AND QUALIFIED HEALTH PLANS

According to HHS, the proposed guidance creates minimum standards for the Exchanges, consistent with the steps that states have already taken to implement Exchanges. The proposed guidance also gives states significant flexibility to build Exchanges that work for their unique insurance markets.

Exchange Functions

The Exchanges are to perform a wide range of functions in order to provide a competitive marketplace for affordable health insurance, including:

- Certifying, recertifying and decertifying health plans to be offered in the Exchange – called Qualified Health Plans or QHPs;
- Assigning ratings to each QHP offered through the Exchange based on quality of coverage and price;
- Providing information to consumers on QHPs in a standardized format;
- Creating an electronic calculator to help consumers determine the price of coverage after taking into account any premium tax credits and cost sharing reductions;
- Operating a website and toll-free hotline to offer comparison information on QHPs and to allow eligible consumers to apply for and purchase coverage;
- Determining eligibility for the Exchange, tax credits, cost-sharing reductions for private insurance and public health coverage programs and helping individuals enroll in those programs;
- Determining when individuals are exempt from the requirement to maintain health insurance and granting approvals to individuals for hardship or other exemptions;
- Establishing a "Navigator" program to help consumers assess their health coverage options and make choices about their coverage, including access to premium credits for some consumers;
- Implementing outreach and education programs; and
- Complying with oversight and program integrity requirements.

Exchange Structure

Local or Regional Exchange

States have the flexibility to decide whether their Exchange will be local or regional. A regional Exchange is one that operates in two or more states. States may also have more than one Exchange, as long as they do not overlap. Each state must make sure that every geographic area of the state is covered by one Exchange.

Exchange Governance and Operation

States can decide whether their Exchange will be operated by a governmental agency or a non-profit entity that is established by the state. Under either option, the governing body must be accountable for Exchange oversight and performance. When the Exchange is not run by an executive branch agency, the proposed guidance provides that it should be administered under a formal, publicly-adopted operating charter or by-laws, hold regular public meetings and offer an opportunity for public comment on the Exchange's policies and procedures. Its governance principles should include ethical and conflict of interest standards and disclosure of financial interests for board members.

State-Federal Partnership

In the proposed guidance, HHS also announced that the federal government will give states the choice to receive assistance from the federal government to make Exchange development and operations more efficient. States have the flexibility to choose to develop an Exchange in partnership with the federal government or to elect to establish and operate their own Exchange.

Qualified Health Plans (QHPs)

Health plans offered through the Exchange must be certified as QHPs. The proposed rule requires the Exchange to establish procedures for the certification of QHPs. Certification has two components. First, the Exchange must determine whether the health plan meets the minimum standards outlined in the proposed guidance. The minimum

standards include marketing, network adequacy and health plan service area. In some cases, states can choose to implement these standards beyond the minimum outlined in HHS's proposed guidance.

Second, the Exchange must determine whether offering a given health plan through the Exchange is in the interest of individuals and small business. Exchanges have discretion on how to determine whether offering health plans is in the interest of individuals and small businesses and may want to choose among one of several strategies for making this determination:

- An Exchange may choose to utilize an "any qualified plan" strategy for certifying QHPs in its Exchange. Under this approach, an Exchange would certify all health plans as QHPs solely on the basis that such plans meet and agree to comply with the minimum certification requirements;
- An Exchange could undertake a competitive bidding or selective contracting process, and limit QHP participation to only those plans that ranked highest in terms of certain Exchange criteria; or
- An Exchange may choose to negotiate with health insurance issuers on a case-by case basis. Under this strategy, the Exchange would request a health insurance issuer, upon meeting the minimum certification standards, to amend one or more specific health plan offerings to further the interest of individuals and small businesses served by the Exchange.

The Exchange must establish a process for recertification of QHPs that includes a review of the general certification criteria. The recertification process for QHPs should be less intensive than the initial certification process. An Exchange may also consider using this process to make modifications to any agreements between the Exchange and its QHP issuers.

Enrollment Process and Navigators

The enrollment process, as described in the proposed guidance, will be simple and geared toward consumers so that they can enroll in the health plan that they decide best fits their needs. All Exchanges will use the same enrollment periods and applications forms to reduce administrative burden for consumers and health insurance issuers. There will be websites, toll-free call centers and in-person offices to answer questions. State Exchanges will design a plan to ensure participants' information is safe and secure.

HHS's guidance proposes a general standard that Exchanges must select at least two "Navigator" organizations from a list and build partnerships with and award grants to these Navigators. Navigators will reach out to employers and employees, consumers and self-employed individuals to:

- Conduct public education activities to raise awareness about QHPs;
- Distribute fair and impartial information about enrollment in QHPs, premium tax credits and cost-sharing reductions;
- Assist consumers in selecting QHPs;
- Provide referrals to an applicable consumer assistance program or ombudsman in the case of grievances, complaints, or questions regarding health plans or coverage; and
- Provide information in a manner that is culturally and linguistically appropriate.

Small Business Health Options Program (SHOP)

Beginning in 2014, a Small Business Health Options Program (SHOP) will provide a way for small employers to offer their employees a choice of health plans like those offered by large employers. According to HHS, SHOP reduces a

small employer's burden by finding QHPs, providing information on pricing and benefits, enrolling employees and consolidating billing. Through SHOP, small business employers can:

- Offer employees choices of multiple insurers and plans; and
- Define their contribution toward their employees' coverage and make a single monthly payment via SHOP.

Businesses with up to 100 employees will be eligible, although states may limit participation to businesses with up to 50 employees until 2016. In 2017, states may let businesses with more than 100 employees buy large group coverage through the SHOP. Even after the Exchanges become operational, employers can still purchase health insurance coverage outside of an Exchange.

Also, starting in 2014, small employers purchasing coverage through SHOP may be eligible for a **tax credit** of up to 50 percent of their premium payments (35 percent through 2013) if they have 25 or fewer employees, pay employees an average annual wage of less than $50,000 and subsidize at least 50 percent of the premium.

HHS Approval of Exchanges

States are already working on establishing Exchanges. According to HHS, 49 states, the District of Columbia and four territories have accepted federal grants to help plan and operate Exchanges. Over half of all the states have taken additional action, such as passing legislation or taking administrative action to begin building Exchanges.

In order to be operational on Jan. 1, 2014, a state must receive HHS's approval of its Exchange plan by **Jan. 1, 2013**. If HHS determines that a state's Exchange plan meets federal standards and is ready to operational in time for **open enrollment on Oct. 1, 2013**, the Exchange plan will be approved. HHS may issue a conditional approval of a state's Exchange plan if it determines that it is likely to be fully operational by open enrollment. If a conditional approval is issued, HHS will continue to assess the state's progress to determine if the state is meeting required operational benchmarks.

If approval, or conditional approval, is not received by Jan. 1, 2013, a state may still choose to establish an Exchange in 2015 or later years. A state Exchange plan must be approved no later than 12 months prior to the first day of coverage.

STANDARDS RELATED TO RISK ADJUSTMENT, REINSURANCE AND RISK CORRIDORS

To help protect health insurance issuers offering coverage through an Exchange against risk selection and market uncertainty, PPACA established three programs to begin in 2014 – temporary reinsurance and risk corridor programs to give issuers financial stability as the insurance market reforms begin, and a permanent risk adjustment program that will make additional payments to health plans to provide incentives to cover high-risk populations by more evenly spreading the financial risk. According to HHS, these programs will make sure that health plans compete for coverage on the basis of price, quality and service. The proposed guidance creates standards for these programs, while also maintaining state flexibility and easing compliance burdens for states and issuers.

Risk Adjustment Program

The risk adjustment program's goal is to end the incentive for issuers to avoid sick persons and market only to those who are healthy by transferring excess payments from plans with lower risk enrollees to plans with higher risk enrollees. The proposed guidance suggests that a constant set of data for risk adjustment be considered, preventing a health issuer that offers QHPs in different states from having different reporting requirements. It also proposes that risk adjustment calculations occur at the state level, rather than the plan or federal level, given the states' role in the Exchange system.

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Reinsurance Program

The reinsurance program helps to even out the health insurance market, moderate premium increases and set the foundation for the establishment of the Exchanges from 2014 through 2016. All health insurance issuers, and third-party administrators on behalf of self-insured group health plans, will make contributions to a nonprofit reinsurance entity to support reinsurance payments to individual market issuers that cover high risk individuals. The proposed rule would simplify the reinsurance program by basing reinsurance on high-cost enrollees' claims. It also proposes flexibility for states, allowing them to run the reinsurance program regardless of its Exchange decision, supplement the payments, vary the thresholds for when reinsurance begins and ends, and contract with reinsurance entities to run the program.

Risk Corridor Program

The risk corridor program creates a mechanism for sharing risk for allowable costs between the federal government and QHP issuers. From 2014 through 2016, QHP's with costs that are at least three percent less than the issuers' cost projections will remit charges for a percentage of those savings to HHS, while QHPs with costs greater than three percent of cost projections will receive payments from HHS.

Apex Benefits Group will continue to monitor health care reform developments.

Source: Department of Health and Human Services

This Apex Benefits Group Legislative Brief is not intended to be exhaustive nor should any discussion or opinions be construed as legal advice. Readers should contact legal counsel for legal advice.

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