
Date: November 29, 2011

Subject: State Exchange Implementation Questions and Answers

Cost to States

Q1: What funding is available to assist States in the establishment of an Exchange under a fully State-based Exchange, a Partnership Exchange, and a Federally-facilitated Exchange?

A1: The Affordable Care Act provides funding for States establishing an Exchange through grants described in section 1311. Such grants are available for establishing a State-based Exchange, to build functions that a State elects to operate under a Partnership Exchange, and to support State activities to build interfaces with a Federally-facilitated Exchange. Grants may be awarded through the end of 2014, and grant funds are available for approved and permissible establishment activities.

The process of “establishing” an Exchange may extend beyond the first date of operation and may include improvements and enhancements to key functions over a limited period of time. Generally, grants can be used to establish Exchange functions and operating systems and to test and improve systems and processes. We have determined that a State that does not have a fully certified State-based Exchange on January 1, 2013 can continue to qualify for and receive a grant award, subject to the Funding Opportunity Announcement (FOA) eligibility criteria. A State can also use grant funds to build and test interfaces with HHS to support certain functions of a Federally-facilitated Exchange, such as information needed for certification of qualified health plans. As such, HHS anticipates modifying and extending the schedule for States to apply for establishments grants in future guidance to accommodate this schedule.

Q2: What costs are States expected to assume in establishing an Exchange, and can these costs be covered by grant funding?

A2: Under the Affordable Care Act, States must ensure that their Exchanges are self-sustaining by January 1, 2015. Therefore, the costs to States for implementing a State-based Exchange and testing Exchange operations during 2014 may be allowed under section 1311(a). Additionally, grants under section 1311 may be awarded until December 31, 2014, for approved establishment activities after that date. Therefore, it is also permissible that under a Partnership Exchange, a State may receive a grant for activities to establish and test functions that the State performs in support of a Federally-facilitated Exchange.

Q3: Will States be charged for administrative expenses when a Federally-facilitated Exchange makes a Medicaid eligibility determination?

A3: State Medicaid and CHIP programs will not be required to contribute to the costs associated with the Federally-facilitated Exchange, including the costs associated with a Federally-facilitated Exchange making a Medicaid or CHIP determination. However, State Medicaid and CHIP programs will have to transfer information and cases to, and accept information and cases from, the Federally-facilitated Exchange; the costs of establishing, testing and maintaining those interfaces will be shared between the State Medicaid and CHIP programs and the Federally-facilitated Exchange, consistent with current cost allocation rules.

HHS has provided additional help to States to build and maintain a shared eligibility service that allows for the Exchange, the Medicaid agency, and the CHIP agency to share common components, technologies and processes to evaluate applications for insurance affordability programs. This includes enhanced funding under Medicaid and opportunities for other State programs to reuse the information technology (IT) infrastructure without having to contribute funding for development costs related to shared services. This additional help is available to defray State costs related to establishing an efficient and effective shared eligibility service regardless of whether a Federally-facilitated Exchange or a State-based Exchange is operating in a State.

Use of Data Services Hub

Q4: Will CMS charge States for use of the data services hub?

A4: CMS is establishing a Federally-managed data services hub to support information exchanges between States (Exchanges, Medicaid and CHIP agencies) and relevant Federal agencies. In many cases, Federal agencies other than CMS will be providing information through the hub. Additional information about the services available through the hub and the terms for accessing those services is under development. While the agency is considering the treatment of charges for fiscal year 2014, we do not anticipate charging fully State-based Exchanges for the use of the hub.

Basic Health Program Funding

Q5: Under what circumstances may Exchange planning grant dollars or the Exchange establishment grant dollars be used by a State exploring or establishing a Basic Health Program under section 1331 of the Affordable Care Act?

A5: *Planning grants:* Planning grant funds may be used to support research and explore health insurance coverage options permitted under the Affordable Care Act, including the option of a Basic Health Program.

Establishment grants: Establishment grant funds may be used for Exchange establishment activities that would coordinate or overlap with activities undertaken pursuant to the

establishment of an optional Basic Health Program. For example, a call center may provide consumer information on a range of coverage options including the Basic Health Program, and could therefore be funded through Establishment grant funds. However, funding under the Establishment grants cannot be used to support operations of the Basic Health Program or to investigate the feasibility of the Basic Health Program.

Other funding sources: States electing to establish a Basic Health Program may opt to fund administrative or establishment activities for the Basic Health Program through user fees or other State funding.

Federally-facilitated Exchange and State Department of Insurance Responsibilities

Q6: How will the Federally-facilitated Exchange coordinate with State insurance departments?

A6: A Federally-facilitated Exchange will operate in States electing not to pursue a State-based Exchange. To the greatest extent possible, HHS intends to work with States to preserve the traditional responsibilities of State insurance departments when establishing a Federally-facilitated Exchange. Additionally, HHS will seek to harmonize Exchange policy with existing State programs and laws wherever possible.

For example, qualified health plans (QHP) that will be offered in the Federally-facilitated Exchange must meet State licensure and solvency requirements and be in good standing in the State (section 1301(a)(1)(C) of the Affordable Care Act). Accordingly, States continue to maintain an important responsibility with respect to health plans licensed and offered in their State, regardless of whether the Exchange is Federally-facilitated or fully State-based.

With respect to review of network adequacy, which is commonly a responsibility of State insurance departments or State health agencies in consultation with State insurance departments, HHS would rely on the State for advice and recommendations regarding network adequacy standards where HHS is operating a Federally-facilitated Exchange. Network adequacy standards must ensure enrollees a sufficient choice of providers, consistent with HHS regulations. We expect that if a State has not adopted such a standard, HHS would develop it for the purposes of the Federally-facilitated Exchange using a commonly recognized and accepted standard such as the National Association of Insurance Commissioners (NAIC) Network Adequacy Model Act.

Similarly, HHS is also currently working to determine the extent to which activities like the review of rates and benefit packages are already conducted by State insurance departments and how these responsibilities could be recognized as part of the certification of QHPs by a Federally-facilitated Exchange. For example, most States currently have an effective rate review program in place and HHS will rely on such processes to the extent practicable and where legally permissible.

In States with a Federally-facilitated Exchange, HHS will also apply existing State standards on marketing materials, assuming issuers will be required to convey information about premiums, benefits and cost sharing that flow from data used for plan approval, and

HHS will work with States to harmonize procedures for responding to consumer complaints. We recognize that most State insurance departments already have procedures in place for addressing consumer complaints, and we will work with States to utilize existing processes for consumer complaints as efficiently as possible to the extent practicable.

Pursuant to our goal to preserve the traditional responsibilities of State insurance departments when establishing a Federally-facilitated Exchange, we are planning to establish one or more working groups with representatives from State insurance departments to start working through issues related to plan management functions in the coming weeks.

Successful operation of the Federally-facilitated Exchange will depend on successfully harmonizing State and HHS workflows so that the annual QHP certification process can be effectively completed in time to adequately support open enrollment including preparation and release of an insurance web portal. We look forward to conversations with and suggestions from States in pursuit of this harmonization.

Eligibility under a Federally-facilitated Exchange or a State-based Exchange

Q7: The Affordable Care Act prescribes a seamless, streamlined eligibility process for consumers to submit a single application and receive an eligibility determination for enrollment in a qualified health plan (QHP) through the Exchange, advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program, if applicable.

- Under a Federally-facilitated Exchange, can a State retain authority over Medicaid eligibility determinations?
- Under a State-based Exchange, can the Federal government perform activities related to advance payments of the premium tax credit and cost-sharing reductions, including the verification of employer-sponsored minimum essential coverage? Can the Federal government perform the eligibility process for exemptions from the individual responsibility requirement for State-based Exchanges?

A7: Section 155.305 of the proposed rule on Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers (Exchange Eligibility NPRM available [here](#)) proposes that the Exchange will make eligibility determinations for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the Basic Health Program, where applicable, based on modified adjusted gross income (MAGI). The Exchange Eligibility NPRM does not distinguish between a State-based Exchange and a Federally-facilitated Exchange in this regard. Based on comments to the Exchange Eligibility NPRM, however, we intend to modify this original proposal in the final rule to permit additional options for determining eligibility under a State-based and Federally-facilitated Exchange.

Federally-facilitated Exchange

In response to comments to the Exchange Eligibility NPRM, we are planning to revise the options that are available for the responsibility for the determination of eligibility under a Federally-facilitated Exchange to include the following:

1. The Federally-facilitated Exchange will conduct initial assessments of applicants for Medicaid and CHIP eligibility based on MAGI, as part of the determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions. However, the State Medicaid and CHIP agencies make final Medicaid and CHIP determinations under this option. In order to ensure an optimal consumer experience, a State electing this option would agree to make these determinations consistent with general guidelines and the terms of an agreement established between the State and the Federally-facilitated Exchange to ensure that applicants are not required to submit redundant documentation and that timeliness standards are met.
2. Alternatively, if a State does not choose to retain Medicaid and CHIP eligibility determinations as set out in paragraph 1 above, the Federally-facilitated Exchange may determine Medicaid and CHIP eligibility using State eligibility rules and standards in conjunction with determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.

State-based Exchange

Similarly, States that operate a State-based Exchange but do not wish to operate all eligibility functions as described in the Exchange Eligibility NPRM would have additional options under our intended revisions:

1. A State-based Exchange could be approved if it conducted all eligibility functions.
2. Alternatively, a State-based Exchange could be approved if it uses Federally-managed services to make determinations for advance payments of the premium tax credit, cost-sharing reductions and exemptions from the individual responsibility requirement.

In all cases, a State could decide to have the Medicaid and CHIP agencies support the eligibility process by executing some or all functions under an agreement with the Exchange. Certification as an Exchange would also require that procedures and systems are in place to ensure a simplified, seamless consumer experience. In addition, for States that are interested in determining eligibility for all programs under the Affordable Care Act, we are exploring how the Federal government could manage services for verification of employer-sponsored minimum essential coverage.

Under these flexible options, to ensure a strong consumer experience to applicants and enrollees and to minimize administrative burden and costs, it will be critical for States and the Federal government to work closely together.

IRS elements to which States will have access

Q8: What data will IRS provide to support the eligibility verification process?

A8: Section 6103(l)(21) of the Internal Revenue Code, as added by section 1414(a)(1) of the Affordable Care Act, permits the Secretary of the Treasury to disclose the following taxpayer information – with taxpayer consent – to support eligibility determinations for insurance affordability programs: “(i) taxpayer identity information with respect to such taxpayer, (ii) the filing status of such taxpayer, (iii) the number of individuals for whom a deduction is allowed under section 151 with respect to the taxpayer (including the taxpayer and the taxpayer’s spouse), (iv) the modified adjusted gross income (as defined in section 36B) of such taxpayer and each of the other individuals included under clause (iii) who are required to file a return of tax imposed by chapter 1 for the taxable year, (v) such other information as prescribed by the Secretary by regulation to indicate whether the taxpayer is eligible for such credit or reduction (and the amount thereof), and (vi) the taxable year with respect to which the preceding information relates or, if applicable, the fact that such information is not available.”

The IRS will provide modified adjusted gross income (MAGI) for the parents or other head of household and for certain dependents who had enough income to have been required to file a tax return. Modified adjusted gross income is the adjusted gross income shown on the Form 1040 with additional amounts added: any tax-exempt interest on State or local bonds, social security benefits that are excluded from gross income, and any amounts earned abroad that are otherwise excluded from adjusted gross income. This information will be taken from the return that was last due to be filed. For example, during open enrollment in the last quarter of 2013, income information will be provided from 2012 income tax returns.

The IRS will also provide information about the size of the household shown on the returns that were filed and coding to help the Exchange understand the information being provided and instances in which information may not be available. Where there has been a change in circumstance, the applicant will work with the Exchange to establish what changes should be reflected in household income. Similarly, where there is no prior year tax return data on file, for example in the case of individuals with very low or no income who had not previously been required to file, the applicant will work with the Exchange to establish household income through alternate means.

Multi-State Plans

Q9: To what extent should multi-State plans contracting with the Office of Personnel Management (OPM) adhere to State-based standards, including State insurance standards (e.g., solvency, prompt payment, market conduct) as well as Exchange-specific qualified health plan certification standards in a State (e.g., network adequacy standards)?

A9: While the proposed rule on Establishment of Exchange and Qualified Health Plans deems OPM-approved multi-State plans as certified by an Exchange, we recognize States’

concerns about the need to apply State insurance requirements and State-specific certification standards to multi-State plans. We also note that Section 1324 requires a level playing field in connection with certain State and Federal legal requirements for health plans.

We seek to ensure that implementation of section 1324 does not disrupt existing markets both inside and outside the Exchanges in the States. HHS and OPM will work with the National Association of Insurance Commissioners to address these questions. We will explore this issue by further identifying existing State standards as well as specific issues of greatest concern for multi-State plans and States including reduction of adverse risk selection, the risks to multi-State plans and States, and potential alternatives.

Risk Adjustment Data Collection

Q10: Could HHS collect encounter data and let States perform risk adjustment?

A10: The Affordable Care Act calls for a risk adjustment program to reduce incentives for health insurance plans to avoid covering people with pre-existing conditions or those in poor health. Risk adjustment ensures that health insurance plans have a financial incentive to provide services to the people who need them most by adjusting premiums to provide more funds to plans enrolling a higher proportion of people with high health costs. This mechanism ensures that insurance plans compete on the basis of quality and service, and not on the basis of avoiding sick, high-cost people.

HHS issued a proposed rule on Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (published on July 15, 2011). HHS did not propose and will not implement any proposal that calls for States or the Federal government to collect personal data such as name, social security number or address for the risk adjustment program. Protecting the privacy and confidentiality of an individual's personal health information continues to be among HHS's highest priorities. HHS will not require States to collect medical record or information that identifies an individual's doctor; nor would the Federal government collect this information.

Quality Certification Requirements

Q11: What quality activities must States engage in to meet Exchange approval and certification requirements?

A11: The Exchange establishment grant funding opportunity announcement indicates that State-based Exchanges must develop and report a quality rating for QHPs; however, the current expectation is that further guidance will be released before Exchanges are required to implement the quality rating system. At this time, States should focus on developing and establishing other Exchange operational capacities. When focusing on quality, States should consider their strategy for using quality information to certify QHPs, including when to require issuer accreditation and how to assess the quality of plans seeking to participate in Exchanges. States will also need to determine what quality information or

metrics the Exchange will display to consumers and build capacity in the development of Exchange systems to accept this quality data and report it on the website. States should also consider how the Exchange will monitor QHP quality during the plan year, including performance monitoring of complaints, appeals and network adequacy. HHS intends to propose a phased approach to the quality rating provisions in which quality ratings in 2014 would be predicated on generally available and collected metrics and measures, transitioning to a QHP-specific rating in 2016.

Advance Payments of the Premium Tax Credit in the Federally-facilitated Exchange

Q12: Will individuals who are enrolled in coverage through a Federally-facilitated Exchange have access to premium tax credits, as well as the advance payments of tax credits that will be authorized by Exchanges?

A12: Yes. The proposed regulations issued by the Treasury Department, and the related proposed regulations issued by the Department of Health and Human Services, are clear on this point and supported by the statute. Individuals enrolled in coverage through either a State-based Exchange or a Federally-facilitated Exchange may be eligible for tax credits, including advance payments. Additionally, neither the Congressional Budget Office score nor the Joint Committee on Taxation technical explanation discussed limiting the credit to those enrolled through a State-based Exchange.

Program Integrity

Q13: How will HHS ensure that States that adopt procedures, consistent with Federal policy and rulemaking, to streamline Medicaid and CHIP eligibility and perform real-time determinations, will not be penalized as a result of subsequent audits or error-reduction programs?

A13: In 2010, CMS issued new regulations establishing the principle that in applying the Payment Error Rate Measurement (PERM) program to Medicaid and CHIP, PERM reviews should measure the extent to which State policies and procedures are consistent with Federal policy and regulations. As long as Federally-approved State procedures are followed, PERM classifies the case as an accurate determination. For example, where States rely on self-attestation to establish certain facts regarding eligibility, PERM audits also rely on those self-attestations to establish those facts. If Federally-approved State policies require additional verifications and data collection, auditors will review cases against those standards.

We will review and analyze all of our error rate measurement programs to ensure consistent application of this principle. While we are still evaluating how we will apply the Improper Payments Elimination and Recovery Act in the case of eligibility determinations involving advance payments of the premium tax credit, our intention is to follow the same general principle.