Working Together to Implement Exchanges

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Consumer Information and Insurance Oversight

Health Insurance Exchange System-Wide Meeting

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Background

- The Affordable Care Act provides for the establishment in each State of an Affordable Insurance Exchange to help qualified individuals and qualified small employers to purchase health insurance coverage offered by qualified health plans. Each State may elect to establish an Exchange or rely on the Secretary of Health and Human Services to establish an Exchange for that State
- **Exchanges will increase access to coverage** by providing a single point of access for consumers to receive eligibility determinations for enrollment in the Exchange and for insurance affordability programs
- **Exchanges will increase competition among issuers** by permitting consumers and employers to easily compare qualified health plans that meet minimum quality and other standards
- Coverage through the Exchange will begin in every State on January 1, 2014

Exchange Landscape

- Exchange are State-based competitive marketplaces where individuals and small businesses can:
  - Find information and compare health plans
  - Receive determinations of eligibility for tax credits for private insurance or health programs like Medicaid and the Children's Health Insurance Program (CHIP)
  - Easily enroll in a health insurance plan that meets their needs
- Exchanges are integral to the operation of a reformed insurance market:
  - Guaranteed issue, providing access for people with pre-existing conditions
  - Rating rules (e.g., 3:1 age rating limits)
  - Premium stabilization programs that operate both inside and outside an Exchange
- Regulations provide many areas of flexibility for States in setting up an Exchange; Coordination between HHS and States is important regardless of a State's approach

Minimum Exchange Functions

- As set forth in the final rule, Exchanges must:
  - Provide consumer support for coverage decisions,
  - Facilitate eligibility determinations for individuals,
  - Provide for enrollment in qualified health plans in the Exchange,
  - Certify health plans as qualified health plans (QHPs), and
  - Operate a Small Business Health Options Program (SHOP).

- Contracting ability: Exchanges can contract with certain entities to carry out these minimum functions.

Federal Support to Exchanges

Exchange functions require collaboration between Exchanges and the Federal government

- **Data hub**
  - IT infrastructure for supporting business services
  - Provides connection points to other Federal agencies
- **Advance payments of the premium tax credits (APTC) and cost sharing reductions (CSR)**
  - State Exchanges have the option to use Federal eligibility determinations
  - State Exchange completes enrollment and reports APTC and CSR data to HHS
  - Federal government issues payments directly to issuers

Premium Stabilization Programs

- The Affordable Care Act establishes State-based reinsurance and risk adjustment programs, and a Federal risk corridors program.
- The overall goal of these programs is to provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets as market reforms and Exchange begin in 2014.
- The Reinsurance, Risk Corridor and Risk Adjustment final rule* establishes standards to ensure effective program implementation while providing significant State flexibility and imposing minimal burden on States and issuers.

*77 Fed. Reg. 17220 (Mar. 23, 2012)

Premium Stabilization Programs

Program:	Reinsurance	Risk Corridors	Risk Adjustment
What:	Provides funding to issuers that incur high claims costs for enrollees	Limits issuer losses (and gains)	Transfers funds from lower risk plans to higher risk plans
Who Participates:	All issuers and third party administrators on behalf of group health plans contribute funding; non-grandfathered individual market plans (inside and outside the Exchange) are eligible for payments	Qualified health plans	Non-grandfathered individual and small group market plans, inside and outside the Exchange
When:	Throughout the year	After reinsurance and risk adjustment	Before June 30 of the calendar year following the benefit year
Time Frame:	3 years (2014-2016)	3 years (2014-2016)	Permanent

Transitional Reinsurance Program

- States have the option to establish a reinsurance program, regardless of whether they establish an Exchange. If State elects not to establish a reinsurance program, HHS will establish program and will perform all reinsurance functions for that State.
- HHS will collect reinsurance contributions from the self-insured market, even if a State runs its own reinsurance program.
- States that establish a reinsurance program have the option to collect contributions from issuers in fully insured market or have HHS collect contributions from the fully insured market on behalf of the State.
- States operating their own reinsurance program must contract with a not-for-profit reinsurance entity to run its program

Risk Adjustment Program

- States that operate a State-based Exchange may elect to operate a risk adjustment program:
  - States operating a risk adjustment program may have an entity other than the Exchange perform this function
  - HHS will operate a risk adjustment program for each State that does not operate risk adjustment
- HHS will develop, publish, take comment, and finalize a risk adjustment methodology for use when operating risk adjustment on behalf of a State
- A State operating risk adjustment may use the Federal methodology or propose alternate risk adjustment methodologies for certification by HHS
  - Any federally certified risk adjustment methodology can be used by a State operating risk adjustment

Exchange Establishment

All States have the option to establish a State-based Exchange. In States where a State-based Exchange is not operating, HHS will operate a Federally-facilitated Exchange (FFE) or in a State Partnership.

State submits an Exchange Blueprint to HHS and demonstrates **operational readiness**.

January 1, 2013
HHS approves or conditionally approves Exchange Blueprints.

States with approved or conditionally approved State-based Exchanges move towards **full operation by initial open enrollment period, October 1, 2013**.

State does not elect to operate an Exchange.

States without approved Blueprints will have a **Federally-facilitated Exchange** in 2014, but can seek approval in subsequent years.
States can **partner** with HHS to operate some functions and **seek approval to operate a State-based Exchange in subsequent years.**

Exchange Models and Additional Flexibility

State-based Exchange
State operates all Exchange activities; however, State may use Federal government services for the following activities:

- Premium tax credit and cost sharing reduction determination
- Exemptions
- Risk adjustment program
- Reinsurance program

State Partnership Exchange
State operates activities for:

- Plan Management
- Consumer assistance
- Both

State may elect to perform or can use Federal government services for the following activities:

- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination*

Federally-facilitated Exchange
HHS operates; however, State may elect to perform or can use Federal government services for:

- Reinsurance program
- Medicaid and CHIP eligibility: assessment or determination*

*Coordinate with Medicaid and CHIP Services (CMCS) on decisions and protocols

Guidance on Federally-facilitated Exchanges

Guidance released May 16 outlines HHS' intended approach to implementing a FFE in any State where a State-based Exchange is not operating.

Addresses:

1. **How States can partner with HHS to implement selected functions in an FFE**
2. **Key policies organized by Exchange function**
3. **How HHS will consult with stakeholders to implement an FFE**

Subsequent guidance documents will include policy and operational details intended to inform State decision-making and preparation for Exchange participation, roles and responsibilities, and potential areas of collaboration.

Guiding Principles for an FFE

- **Commitment to Consumers.** Our goal is to ensure that consumers in all States have access to high-quality, affordable health coverage options through an Exchange.
- **Market Parity**. HHS will work to harmonize State market requirements inside and outside of an FFE, to:
  - Promote the competitiveness of each FFE
  - Minimize administrative burden for issuers
  - Ensure consumer protections
- **Leveraging traditional State Roles**. HHS will seek to capitalize on existing State policies, capabilities, expertise, and infrastructure.
- **Engagement with States and stakeholders.** HHS will seek input from a variety of stakeholders to support and inform decision-making, and will communicate our progress regularly.

State Partnership Options

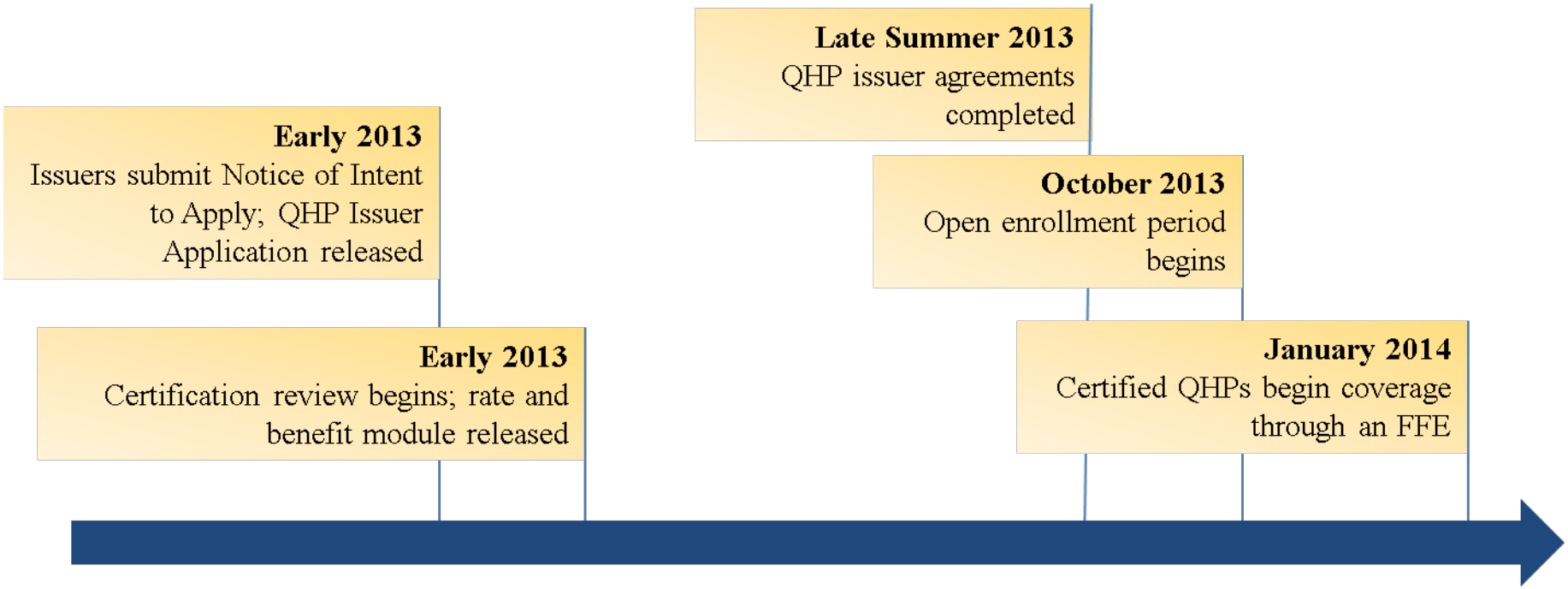
- Subject to applicable law, States can choose to administer selected functions in partnership with an FFE. States can choose one or both options:
  - In a **State Partnership in plan management**, the State Partner will be responsible for plan management activities, such as certification, recertification, and decertification of QHPs; data collection and transmission; and issuer oversight and management, subject to Federal law and oversight.
  - In a **State Partnership in consumer assistance**, the State Partner will provide in-person assistance to individuals, including filling out and submitting an application, comparing and selecting a QHP, and enrolling in coverage. HHS will operate the call center and website.

State Partnership Administration

State Partnership options will increase State control over key business areas.

- State Partners may vary design processes or activities.
- In addition, the Partnership options will allow States to serve as first-line resources to issuers and consumers.
- State Partners will be approved to carry out plan management or consumer assistance functions, and will perform plan management or consumer assistance functions for both the individual and small group markets.
- HHS will approve inherently governmental decisions on an ongoing basis.

QHP Certification Timeline for an FFE



Accreditation and Quality Reporting*

Accreditation requirements in FFEs, including where a State Partnership is operating, will be phased in through 2016

- In the interim, FFEs will display selected CAHPS* results from existing accreditation survey data.
- In the first year of certification, QHP issuers without this existing accreditation must schedule this accreditation and be accredited on QHP policies and procedures by the second year of certification.
- By the fourth year of certification, all QHP issuers must be accredited on the QHP product type.

Quality reporting will also be phased in

- In the interim, FFEs will display selected CAHPS** results from existing accreditation survey data

*HHS intends to propose policies as described on this slide as part of future rulemaking; **CAHPS = Consumer Assessment of Healthcare Providers and Systems

Options for Performing Medicaid and CHIP Eligibility Determinations

- **States will have two options related to Medicaid and CHIP eligibility determinations.**
- Option 1: FFE performs Medicaid and CHIP Eligibility Determinations
  - The FFE will determine Medicaid and CHIP eligibility based on MAGI and other State policies and electronically transmit all information for any eligible applicants to the State Medicaid and CHIP agency. The Medicaid and CHIP agency will accept the FFE's determination and provide Medicaid or CHIP enrollment and coverage.
- Option 2: FFE performs Medicaid and CHIP Eligibility Assessments
  - The FFE will conduct assessments of Medicaid and CHIP eligibility based on MAGI and other State policies as part of the determination of eligibility for APTC and CSR. The FFE will electronically transmit all information for any potentially eligible applicants to the State Medicaid and CHIP agency, which will make final determinations and notify the Exchange if the State Medicaid or CHIP agency finds that the applicant is ineligible.

Agents and Brokers

- HHS will leverage both traditional agents/brokers and web-based brokers to draw consumers to FFEs and FF-SHOPs
- HHS will build capabilities to assist agents and brokers in supporting their clients
  - **Traditional Agents and Brokers:** Each FFE will offer an agent and broker portal, which would allow an agent or broker to assist individuals in enrolling in QHPs using the FFE website
  - **Web-Based Brokers:** HHS will develop an Application Programming Interface (API) to allow a web-based broker to assist individuals in comparing and selecting QHPs using the broker's website
- Agents and brokers will be required to meet certain consumer protection standards (for example, web-brokers must allow clients to view all available QHPs)

FF-SHOP

FF-SHOPs will simplify the process for employers

- FF-SHOPs will use the upper threshold (50 or 100 employees) used in the State to define a small employer for purposes of SHOP participation requirements
- Each employer will choose from among Exchange-approved coverage options and select a contribution scheme
- The employer decides whether employees pay individualized or composite rates
- The FF-SHOP Web site will allow employers to model different coverage scenarios (for example, by changing the employer contribution percentage) before making a choice
- An FF-SHOP will provide each employer with a single monthly bill, and collect a single, aggregated payment

Stakeholder Engagement

HHS will conduct extensive outreach and education on FFE policy and operations.

- HHS will continue to provide technical assistance to stakeholders
- HHS will provide a transparent process for stakeholders to provide input on FFE implementation in their States
  - We will work with the NAIC to explore options for gathering consumer input in every State
- In some areas, HHS will work with stakeholders to develop policy on particular topics
  - For example, HHS will implement an outreach and communication strategy to work with State agencies, employer groups, issuers, and brokers on the successful implementation of FF-SHOPs