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HEALTH CARE REFORM – SPECIAL EDITION

HHS Final Rule on Insurance Exchanges Gives States Flexibility

LEGISLATIVE BRIEF

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On March 12, 2012, Health and Human Services (HHS) published a 644-page final rule on Health Insurance Exchanges which is designed to give states flexibility in operating their Exchanges. An Exchange is a one-stop virtual marketplace where individual consumers and small businesses can select among various "qualified health plans" that meet minimum standards set forth in the Affordable Care Act (ACA). Exchanges are slated to become operational as of January 1, 2014.

The long-awaited final rule includes standards for Exchanges in determining:

- Establishment and operation of an Exchange
- Qualified Health Plans – the health insurance plans that can participate in an Exchange
- Applicants' eligibility to enroll in Exchange health plans and in insurance affordability programs
- Enrollment in health plans through Exchanges
- Employer eligibility for and participation in the Small Business Health Options Program (SHOP)

The final rule combines proposals from two Notices of Proposed Rulemaking (NPRMs) published last summer, and also makes changes in response to the 24,780 comments received on the NPRMs:

- Proposed framework to enable states to build Exchanges (July 15, 2011), and
- Proposed standards for eligibility for enrollment in and financial assistance with qualified health plans through the Exchange, e.g., premium tax credits (August 17, 2011).

Following is a summary of the final rule provisions on the five standards listed above.

Establishment of Exchanges

The final rule allows each state flexibility in designing its Exchange, such as:

1. Whether to structure the Exchange as a non-profit entity established by the state, as an independent public agency, or as part of an existing state agency.

2. Whether to operate the Exchange in partnership with other states through a regional Exchange; to operate multiple Exchanges that cover distinct areas within the state; or any combination of these options.

Exchanges are required to perform certain functions, but the final rule gives States flexibility in determining how Exchanges will perform many of these required functions:

- Certifying health plans as "qualified health plans" to be offered in the Exchange
- Operating a website to help consumers compare qualified health plans
- Operating a toll-free hotline for consumer support, providing grant funding to entities called "Navigators" for consumer assistance, and conducting outreach and education to consumers regarding Exchanges
- Determining eligibility of consumers for enrollment in qualified health plans and for insurance affordability programs (premium tax credits, Medicaid, CHIP and the Basic Health Plan)
- Facilitating enrollment of consumers in qualified health plans

Under the final rule, processing appeals is no longer a required Exchange function. The final rule allows states to determine a role for agents and brokers – including the use of on-line brokers. It also simplifies the process for approval and updating of states' Blueprints for Exchanges.

The final rule allows HHS to give conditional approval if a state has sufficiently advanced in its plans to operate an Exchange as of January 1, 2014 but cannot demonstrate complete readiness by January 1, 2013, the date originally required in the Affordable Care Act. States that are not ready to operate an Exchange as of 2014 can apply later to start operating it for 2015 or any subsequent year. The HHS Fact Sheet on the final rule notes that HHS will continue working with states to support their progress, including through new funding opportunities that will be available through the end of December 2014.

Qualified Health Plans

Health plans offered through the Exchange must be certified as "qualified health plans." To be certified by the Exchange, health plans must meet minimum standards that are primarily defined in the law. The final rule gives Exchanges flexibility to establish additional standards that health plans must meet to be offered in the Exchanges. For example:

- **Number and Type of Health Plan Choices:** Exchanges can allow *any* health plan meeting the standards to participate, or they can create a competitive process and only allow a limited number of health plans to offer coverage through the Exchange.
- S**tandards for Health Plans:** Exchanges, working with state insurance departments, can set specific standards for provider networks, carrier marketing to prevent discrimination against people with pre-existing conditions, and carrier accreditation for quality performance.

Eligibility

The Exchange final rule establishes a consumer-focused web-based eligibility determination process, under which an individual will use one application to apply for health coverage and will receive one determination specifying the individual's eligibility for Exchange policies and/or government programs (e.g., Medicaid, CHIP) as well as for insurance affordability programs (e.g., premium tax credits, cost-sharing reductions).

- **Eligibility Determinations:** Exchanges will use streamlined processes for initial eligibility determinations and for eligibility re-determinations. Consumers will be able to easily notify the Exchange of any changes that might affect their eligibility, such as marriage, divorce or a job change.

- **Simple Verification of Data:** Exchanges will rely on existing electronic sources of data to the maximum extent possible to verify relevant information, with high levels of privacy and security protection for consumers. An automated electronic data matching process should eliminate the need for paper documentation for most applicants.
- C**oordinating across Programs:** Exchanges will coordinate with Medicaid, CHIP, and the Basic Health Program, where applicable, to ensure a seamless eligibility and enrollment process regardless of where an individual submits an application.
- **New Options for States:** In response to comments, the final rule allows Exchanges to either conduct eligibility determinations for Medicaid and for advance payment of premium tax credits, or to make the *preliminary* eligibility assessment and turn it over to the state Medicaid agency for final determination (if applicable). Alternatively, a state Exchange could rely on HHS determination of an individual's eligibility for advance payments of the premium tax credit and cost-sharing reductions.

Enrollment

The enrollment process outlined in the final rule will be geared toward consumers and will use websites and toll-free call centers, among other tools, to help eligible individuals learn about the various coverage options available and to enroll in coverage. Exchanges can either design their own websites or use the website format the federal government will make available. The enrollment process must meet specific standards regarding the privacy and security of personal information.

The final rule also provides standards for Exchanges to use in awarding grants to at least two "Navigators" – entities who will reach out to employers and employees, consumers, and self-employed individuals. At least one of the Navigators must be a community or consumer-focused non-profit organization. Navigators will:

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

Small Business Health Options Program (SHOP)

Beginning in 2014, Exchanges will operate a Small Business Health Options Program (SHOP). Small employers can offer coverage to their employees through the SHOP and receive a single bill from the SHOP. The final rule allows minimum participation rules to be met through coverage in any SHOP plan, not a single one.

The final rule allows states flexibility to decide how a SHOP will be structured.

- **Size of small businesses that can participate in SHOP:** In 2014 and 2015, states can set the size of the small group market at either 1 to 50 or 1 to 100 employees. In 2016, states must allow employers with between 1 and 100 employees to participate in a SHOP. Starting in 2017, states have discretion to let businesses with more than 100 employees buy large group coverage through the SHOP.
- **Structure of choices for small businesses:** Exchanges can choose what and how many coverage options to give employers. They can allow employers to offer only a single plan, or can allow employers to choose the level of coverage they will offer, and offer employees choices of all qualified health plans within that level of coverage.

Starting in 2014, small employers purchasing coverage through SHOP may be eligible for a tax credit of up to 50% of their premium payments if they have 25 or fewer employees, pay employees an average annual wage of less than $50,000, offer all full time employees coverage, and pay at least 50% of the premium. Small employers who purchase coverage *outside* the Exchange will *not* be eligible for the small employer tax credit.

Additional Information about Exchanges

HHS has already awarded more than 700 million dollars in grants to help states plan and establish Exchanges. As of February 22, 2012, 49 states and the District of Columbia have received Exchange *Planning* grants, and 33 states and the District of Columbia have received Exchange *Establishment* grants. HHS continues to provide technical assistance to states.

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