

STATE HEALTH POLICY

STATE HEALTH POLICY BRIEFING PROVIDES AN OVERVIEW AND ANALYSIS OF EMERGING ISSUES AND DEVELOPMENTS IN STATE HEALTH POLICY.

State health insurance exchanges are a key feature of the Affordable Care Act. This *State Health Policy Briefing* sets forth the major requirements for exchanges as described in the federal law. These requirements fall into four categories: administration and governance, insurance plan oversight, interactions with consumers, and information transfer and availability.

The Affordable Care Act requires the Secretary of the Department of Health and Human Services to issue regulations in several critical areas relevant to the exchange. States should anticipate future guidance and regulation by the federal government and be prepared to take these regulations into account in their planning.

This *State Health Policy Briefing* is a product of the State Consortium on Health Care Reform Implementation—a collaboration among the National Governors Association, the National Academy for State Health Policy, the National Association of Insurance Commissioners, and the National Association of Medicaid Directors. This product has been reviewed by the Consortium and found to be consistent with its mission to provide useful information to state policymakers and stakeholders in health reform implementation. Responsibility for the contents of this brief rests with the National Academy for State Health Policy.

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Briefing

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Health Insurance Exchange Basics

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State-based health insurance exchanges play a central role in implementation of the Patient Protection and Affordable Care Act. Exchanges are intended to simplify and structure health insurance choices for individuals, families, and small businesses, while they will be the exclusive mechanism for people to apply their federal premium assistance tax credits toward the cost of insurance coverage.

The purpose of this brief is to set forth the major requirements for exchanges as described in the federal law. These requirements provide states with sufficient guidance to define the overall parameters of their exchanges, recognizing that states will likely revisit or refine these decisions as the federal law is clarified through federal regulations.

Some states will debate legislation creating health insurance exchanges in their 2011 legislative sessions. Other states will defer legislative action to later years, relying upon existing legal authority to begin developing the exchange. States will vary in how much detail they include in their exchange statutes; in some states new statutory authority may not even be needed. States may wish to consult the model exchange statutes developed by the National Association of Insurance Commissioners¹ and the National Academy of Social Insurance.²

A threshold question for states is whether or not to develop an exchange. If states fail to do so, choose not to do so, or are determined by the Secretary of the U.S. Department of Health and Human Services no later than January 1, 2013, not to be sufficiently far along in exchange implementation to be ready to perform all exchange functions on January 1, 2014, the federal government will administer the exchange in that state.

Another threshold question is whether or not to separate the exchange functions for individuals and families from those for small businesses. The law devotes most of its attention to the American Health Benefit Exchanges, which are designed to serve individuals and families, and are what most people mean when they refer to an exchange. But the law also requires the creation of the Small Business Health Options Exchange, or SHOP Exchange. States may combine the functioning of the two (whether or not they combine the risk pools), in which case all of the exchange functions described below need only be created once. States that separate the exchanges will need to assure that the standards described below are met in both exchanges. Because we anticipate that most states will combine at least the major administrative functions of the two exchanges, when we refer to the “exchange” in this brief we are referring to the American Health Benefit Exchange, which we presume will operate the SHOP Exchange as well.

In order to qualify for certification by the Secretary, an exchange must meet certain statutory requirements. For ease of presentation, we divide these requirements into four categories: administration and governance, insurance plan oversight, interactions with consumers, and information transfer and availability.

ADMINISTRATION AND GOVERNANCE

Administration and governance includes design, oversight, and financial sustainability and integrity.

States may establish one statewide exchange, subsidiary exchanges that serve geographically distinct areas within the state, or join a regional exchange serving multiple states.

States are required to consult with stakeholders relevant to the activities of an insurance exchange during its development and operation. Enumerated stakeholders include educated health care consumers who are enrollees in qualified health plans, individuals and entities with experience in

facilitating enrollment in qualified health plans, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates for enrolling hard to reach populations.³

Exchanges must be operated by a governmental agency or non-profit entity established by the state. States can contract with an eligible entity to carry out one or more duties of the exchange. An eligible entity is defined as the state Medicaid agency or an entity that has demonstrated experience on a state or regional basis in the individual and small group health insurance markets and in benefits coverage and that is not a health insurance issuer.⁴

Under federal law SHOP Exchanges are restricted to small employers (100 or fewer employees) until 2017, although states may restrict SHOP Exchanges to employers of 50 or fewer employees until 2016.⁵ In 2017 states may elect to open up their SHOP Exchanges to larger employers.⁶ States may merge the exchange and the SHOP exchange, so long as the combined exchange has adequate resources to assist both individuals and employers.

Federal grants are available to assist states in planning and establishing their exchanges, but the exchanges must be financially self-sustaining by January 1, 2015. Exchanges are allowed to charge assessments or user fees to participating health insurance issuers.

Exchanges are subject to various spending restrictions including prohibitions against certain uses of funds considered wasteful. Exchanges are required to keep an accurate accounting of all activities, and are subject to annual audit by the Secretary.⁷

INSURANCE PLAN OVERSIGHT

Exchanges are required to certify, recertify, and decertify plans as being “Qualified Health Plans,” and must oversee the insurance products and practices of carriers offering coverage through the exchange.

Qualified Health Plans must cover the Essential Health Benefits and provide an actuarial value (pay a share of the cost of covered services) at one of four defined levels: bronze (60%), silver (70%), gold (80%), or platinum (90%). Participating health insurance issuers must offer at least one plan at the gold and silver levels before they will be allowed to offer other plans in the exchange.

Qualified Health Plans must implement a quality improvement strategy which includes improving health outcomes through care coordination and case management, preventing hospital readmissions, improving patient safety, implementation of wellness and health promotion activities, and reducing health care disparities.⁸ Qualified Health Plans must also be accredited with regard to quality measures during a standardized time period that is defined by the exchange.⁹

Qualified Health Plans are required to meet standards for marketing, including not employing marketing practices that discourage the application of individuals with significant health needs; ensure a sufficient choice of providers, including community providers in plan networks that serve predominantly low-income and medically-underserved individuals (where available); and have a standardized plan presentation and uniform enrollment form.¹⁰

An exchange may only offer a Qualified Health Plan when it is “in the interests of qualified individuals and qualified employers.” Exchanges may not exclude a plan solely because it pays providers fee-for-service, or for providing “treatments necessary to prevent patients’ deaths in circumstances the exchange determines are inappropriate or too costly.”¹¹ States may choose to require additional benefits beyond the essential health benefits, but are responsible for covering the cost of the additional benefits, either through payments to individual enrollees or on behalf of the individual directly to the plan. States must allow limited scope dental benefit plans to be offered through the exchange as well, either separately or in conjunction with a qualified health plan.

Exchanges have premium oversight responsibilities for Qualified Health Plans offered in the exchange that extends beyond the oversight of the state insurance regulator. Exchanges must require participating health plans to submit a justification for any premium increase prior to implementation of the increase. In addition, the exchange must take patterns of excessive or unjustified premium increases into consideration when determining whether to make a health plan available through the exchange. The exchange must also take into account excess premium growth outside the exchange as compared to the rate of growth inside the exchange.¹²

Exchanges must require health plans to submit to the exchange, Secretary, and state insurance commissioner, and disclose to the public in plain language, accurate and timely information on claims payment policy and procedures, data on enrollment and disenrollment, and other information as deemed appropriate by the Secretary. Exchanges must

require health plans to provide cost-sharing information for out-of-network coverage.

INTERACTIONS WITH CONSUMERS

Exchanges must help consumers determine their eligibility for enrollment in health plans through the exchange or other public health programs, their qualification for advance federal premium assistance tax credits, and help them select the health plan that best meets their needs.

Exchanges must establish initial, annual, and special enrollment periods.

The Secretary has indicated that successful exchanges will promote “seamless access for applicants eligible for other health programs beyond the Exchange coverage options” and upgrade IT systems to support seamless eligibility and continuity of care across programs.¹³ By law, exchanges are required to inform applicants of eligibility standards, screen consumers for eligibility for Medicaid, CHIP, or any applicable state or local public programs, and enroll eligible consumers. Exchanges must employ a single application developed by the Secretary to facilitate enrollment, or a similar form created by the state and deemed equivalent by the Secretary.¹⁴ This form must be accepted online, in person, by mail, or by telephone, and may be filed with the exchange or other state health subsidy programs.¹⁵ The precise allocation of responsibility for eligibility determination across the exchange, various federal agencies, and the state Medicaid agency is not clear from the statute, and additional guidance is expected. Even without that guidance it is apparent that the exchange must be prepared to play a significant role in the eligibility determination process and should be designed with this role in mind.

Exchanges must present standardized information regarding participating health plans with a focus on relative quality and price of each plan. Thus, exchanges are required to present plan options in a standardized format, including the benefit tier of the plan, and a uniform outline of coverage with content requirements that will be developed by the Secretary. Coverage summaries cannot be longer than four pages and must use culturally and linguistically appropriate language. Exchanges are also required to assign a rating to each qualified health plan in accordance with criteria determined by the Secretary that compares plans on the basis of quality and price for each benefit level.¹⁶ As noted above, the exchange must also provide consumers with plain language descrip-

tions of plan performance in areas such as claims payment and consumer enrollment and disenrollment.

Exchanges are required to create and maintain an Internet website through which enrollees can obtain information on participating plans. The website must include standardized information about and ratings of qualified health plans, information on premium tax credits or cost-sharing reductions for individuals, and information about the small business tax credit for small employers. The exchange must also operate a toll-free telephone line to provide consumer assistance.

Exchanges must accept applications from individuals and families for federal advance payable premium assistance tax credits. Exchanges must establish and make available a calculator that will determine the actual cost of coverage after accounting for any premium tax credits or cost sharing reductions. Qualified health plans must also make it clear what the costs are at time of service by providing information on cost sharing (e.g., deductibles and copayments.)

Exchanges must also determine whether an individual qualifies for an exemption from the individual mandate, either because no affordable plan is available through the exchange or the individual's employer, or if the individual meets any other requirements for an exemption. There are a variety of exemptions provided in the statute, including exemptions for those who are members of a health sharing ministry and a financial hardship exemption. Exchanges are required to grant a certification attesting the exemption.

Exchanges are required to set up a Navigator program, in which exchanges will give grants to eligible entities to conduct public education campaigns, distribute information about and facilitate enrollment in qualified health plans, and provide referrals to other assistance entities.¹⁷

The SHOP Exchange must be able to assist small employers in enrolling their employees for coverage. The statute is somewhat ambiguous regarding the degree of plan choice by employees of employers offering coverage through the SHOP Exchange, as well as regarding the role of SHOP exchanges in enrolling employees and collecting premiums. While additional regulatory guidance may clarify this issue, based on a plain reading of the statute, states should expect that their SHOP Exchanges will be required to interact with employers and the enrolling firms' individual employees and that the SHOP Exchange must be designed to support both employer and employee choice. That is, despite some ambiguity in the

statute, it appears that employers may choose to designate a single plan for their employees, designate a single benefit tier from which employees can choose their own plan, or contribute toward their employees' premiums leaving choice of plan and benefit tier to the employee.

INFORMATION TRANSFER AND AVAILABILITY

The exchange has a substantial responsibility for the collection and reporting of data to outside parties.

To assure transparency in its operations, initial guidance establishes a requirement for "accurate and timely public disclosure of coverage data and other key performance measures to facilitate research, analysis, and evaluation."¹⁸ In addition, the exchange is required to publish on a website for consumer education the average cost of licensing, regulatory fees, and any other payments required by the exchange, administrative costs, and money lost to fraud, waste or abuse.

Exchanges are responsible for transferring information regarding exemption from the individual mandate, qualification for tax credits, and information about employees who cannot afford their employer sponsored coverage. The exchange must transfer to the Secretary of the Treasury: a list (name and taxpayer identification number) of individuals issued a certification of exemption; a list of individuals who were deemed eligible for the premium tax credit because the employer sponsored insurance was unaffordable, or does not offer the minimum essential benefits; and a list of individuals who have notified the exchange they have changed employers and each individual who ceases coverage under a qualified health plan during the plan year.¹⁹ Exchanges must also provide employers with a list of employees who are eligible for a premium tax credit that cease coverage under a plan during the plan year, and the cessation date.

All information related to individuals' eligibility for the federal premium assistance tax credit collected in the exchange must be given to the Secretary for verification, and the Secretary may choose to delegate information verification to other parties, including the exchange. If the information cannot be verified, the exchange must make a "reasonable effort" to identify the cause of error by contacting the applicant to confirm the accuracy of the information, and through additional actions the Secretary may identify through regulation or other guidance. If this does not resolve the inconsistency, exchanges are required to notify the applicant of the error

and provide an opportunity for the applicant to submit satisfactory documentary evidence or otherwise resolve the inconsistency.²⁰

In addition, exchanges must be able to process appeals by employers notified that they may be liable for a tax with respect to an employee because the employer does not provide minimum essential benefits through an employer-sponsored plan.²¹

ADDITIONAL FEDERAL GUIDANCE

The Patient Protection and Affordable Care Act requires the Secretary to issue regulations in several critical areas relevant to the exchanges. The Secretary is required to promulgate regulations setting standards for meeting the exchange requirements in the statute, including (a) the establishment and operation of exchanges (including SHOP exchanges); (b) the offering of qualified health plans; (c) reinsurance and risk adjustment programs; and (d) other requirements as the Secretary determines appropriate.²² The Secretary has broad regulatory authority in areas that extend beyond exchange operations, but will be critical to the exchange; most prominent among these is defining the Essential Health Benefits.

Federal regulations must be promulgated in accordance with the Administrative Procedures Act, which requires notice and the opportunity for public comment. Courts give a high level of deference to administrative agency interpretation of federal statute. Under a legal precedent known as *Chevron*, courts first determine whether the statute addresses the precise question at issue. If congressional intent is unambiguous, the agency must follow Congress's intent.

However, if the statute remains silent or is ambiguous, a reviewing court looks to see whether the agency's interpretation is reasonable. As long as it is deemed reasonable, the agency's interpretation will stand.²³ The reasonableness standard means that courts rarely invalidate properly promulgated regulations.

HHS may also use sub-regulatory guidance to issue policy directives. Sub-regulatory guidance includes letters, memoranda, determinations, agreements, findings, and other types of directives. When sub-regulatory guidance is reviewed by a court, an agency must prove three things: (1) that its interpretation is thorough, logical, and in line with expert views; (2) that its interpretation follows from the agency's earlier interpretations of the statute; and (3) that other factors support the interpretation.²⁴ Again, these standards are quite deferential to agency interpretation.

CONCLUSION

States will have a keen interest in the federal regulations promulgated and other forms of guidance issued under the Act. The content of these regulations and guidance, and the federal government's own plans for how it will operate an exchange in a state where the state elects not to operate its own, will have a significant effect on states' desires to establish their own exchanges. Despite significant uncertainty regarding the content of future regulations, states can discern a great deal from the plain language of the statute. The statutory language provides critical information for states as they consider insurance exchange legislation or begin developing plans for an exchange within their existing legal authority.

ENDNOTES

1 National Association of Insurance Commissioners; "American Health Benefit Exchange Model Act"; Nov. 22, 2010; http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf.

2 National Academy of Social Insurance; "Designing an Exchange: A Toolkit for State Policymakers"; Jan 2011; http://www.nasi.org/sites/default/files/research/Designing%20an%20Exchange_A%20Toolkit%20for%20State%20Policymakers.pdf

3 The Patient Protection and Affordable Care Act §1311 (d)(6).

4 PPACA §1311 (f)(3).

5 PPACA §1304(b).

6 PPACA §1312(f)(2).

7 PPACA §1311 (d)(5).

8 PPACA §1311 (g).

9 PPACA §1311 (c).

10 PPACA §1311 (c).

11 PPACA §1311 (e)(1)(B).

12 PPACA §1311 (e)(2).

13 Center for Consumer Information and Insurance Oversight "Initial Guidance to States on Exchanges"; Retrieved Feb 3, 2011; http://www.hhs.gov/ccio/regulations/guidance_to_states_on_exchanges.html.

14 PPACA §1311 (d)(4).

- 15 PPACA §1413.
- 16 PPACA §1311 (d)(4).
- 17 PPACA §1311 (i).
- 18 Center for Consumer Information and Insurance Oversight “Initial Guidance to States on Exchanges.”
- 19 PPACA §1311 (d)(4)(l).
- 20 PPACA §1411 (e)(4).
- 21 PPACA §1411 (f)(2).
- 22 PPACA §1321 (a)(1)(A)-(D).
- 23 Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc., 467 U.S. 837 (1984).
- 24 Skidmore et al. v. Swift & Co., 323 U.S. 134 (1944); United States v. Mead, 533 U.S. 218 (2001).

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