

Initial Guidance to States on Exchanges

This guidance document is the first in a series of documents that the Department of Health and Human Services (HHS) intends to publish over the next three years to provide information to States and the Territories seeking to establish a Health Insurance Exchange (Exchange) under Section 1311(b) of the Affordable Care Act. The Secretary intends to issue regulations for public comment under Section 1321(a) in 2011, but is providing this guidance earlier to assist States and Territories with their overall planning, including legislative plans for 2011.

The first Notice of Proposed Rulemaking (NPRM), which will address many of the basic federal requirements outlined below, is scheduled for publication in the spring of 2011. Additional regulations are scheduled for publication later in 2011 and in 2012. These regulations will be subject to public comment.

Following a brief overview, this guidance focuses on four main categories:

- Principles and priorities
- Outline of statutory requirements
- Clarifications and policy guidance
- Federal support for the establishment of State-based Exchanges

What is an Exchange?

An Exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, Exchanges create more efficient and competitive markets for individuals and small employers.

Historically, the individual and small group health insurance markets have suffered from adverse selection and high administrative costs, resulting in low value for consumers. Exchanges will allow individuals and small businesses to benefit from the pooling of risk, market leverage, and economies of scale that large businesses currently enjoy.

Beginning with an open enrollment period in 2013, Exchanges will help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices. Exchanges will assist eligible individuals to receive premium tax credits or

coverage through other Federal or State health care programs. By providing one-stop shopping, Exchanges will make purchasing health insurance easier and more understandable.

Principles and Priorities

The following principles and priorities will inform federal funding and technical support for State establishment of Exchanges:

- **Establishing a State-based Exchange.** Establishment of an Exchange is a critical step that States must take to be on track for achieving certification of an Exchange by January 1, 2013 under Section 1321. Establishment of an Exchange requires a planning process leading to State action, by legislation or other means, to create an Exchange entity with the authority necessary to meet all the Exchange requirements of the Affordable Care Act. In States that choose, now or at a later point in the process, not to establish an Exchange, HHS will work with the State to establish an Exchange.
- **Promoting Efficiency.** Exchanges must be mindful of costs for consumers, employers, and the federal government. Exchanges should have the flexibility to respond to local market conditions and take actions to facilitate competition among plans on price and quality. Successful Exchanges will adapt to changes in the market by redesigning and modifying business plans as opportunities develop, and will have the flexibility to deal with insurers, agents, and other business partners in a manner that serves the Exchange's interest in maximizing value for consumers.
- **Avoiding Adverse Selection.** Successful Exchanges will avoid adverse selection by ensuring that those who buy through the Exchange are a broad mix of the healthy and the less healthy. The tax credits, which can only be accessed through the Exchanges, and insurance reforms required by the Affordable Care Act will reduce the potential for adverse selection against the Exchange, but will not eliminate it. States have flexibility to provide consistent regulation inside and outside the Exchange, and to take additional action to prevent adverse selection under section 1311(e)(1)(B). The federal government will work with States to maximize State flexibility in this area.
- **Streamlined Access and Continuity of Care.** Section 1311(d)(4)(F) requires Exchanges to evaluate and determine eligibility for applicants in Medicaid, the Children's Health Insurance Program (CHIP), and other health programs. Exchanges must also comply with all applicable federal statutes relating to nondiscrimination. The federal government will provide critical building blocks and financial support for achieving an efficient enrollment process including verification of eligibility for tax credits. Successful Exchanges will use those building

blocks to streamline access for consumers, while also promoting seamless access for applicants eligible for other health programs beyond the Exchange coverage options. Successful Exchanges will upgrade information technology (IT) systems and other business operations, and improve continuity of care across health programs.

- **Public Outreach and Stakeholder Involvement.** Section 1311(d)(6) requires Exchanges to consult with a broad range of stakeholders in carrying out their activities. Successful Exchanges will undertake aggressive and multi-faceted outreach to inform the public of their services and coverage options. Successful Exchanges will work closely with consumer advocates, national insurers, and community-based insurers, including potential new market entrants, to create a competitive climate that will offer purchasers a range of product offerings.
- **Public Accountability and Transparency.** Accountability requires transparency. Section 1311(d)(7) requires public reports on Exchange activities, and Section 1311(e)(3) requires additional reporting, which should include standardized data reporting on price, quality, benefits, consumer choice and other factors that will help measure and evaluate performance. Successful Exchanges must ensure public accountability in areas such as objective information on the performance of plans; availability of automated comparison functions to inform consumer choice; fair and impartial treatment of consumers, plans and other partners; and prohibitions on conflict of interest.
- **Financial Accountability.** Section 1313 provides for the efficient and non-discriminatory administration of Exchanges, and seeks to prevent fraud and abuse. Successful Exchanges will streamline enrollment and minimize acquisition expenses; implement policies to prevent waste, fraud and abuse; and promote financial integrity.

Statutory Requirements

The Affordable Care Act includes two basic types of federal requirements for Exchanges, most of which are found in Section 1311. These include: 1) minimum functions Exchanges must undertake directly or, in some cases, by contract; and 2) oversight responsibilities the Exchanges must exercise in certifying and monitoring the performance of Qualified Health Plans (hereafter referred to as “plans”), as defined in Section 1301. Plans participating in the Exchanges must also comply with State insurance laws and federal requirements in the Public Health Service Act.

In defining the authority and duties of an Exchange, States in authorizing legislation or other governing documents should incorporate, by reference or explicit provisions, the federally-required Exchange functions and oversight responsibilities.

a. Exchange Functions

Section 1311(d)(4) specifies core functions that an Exchange must meet:

- Certification, recertification and decertification of plans
- Operation of a toll-free hotline
- Maintenance of a website for providing information on plans to current and prospective enrollees
- Assignment of a price and quality rating to plans
- Presentation of plan benefit options in a standardized format
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs
- Provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions
- Certification of individuals exempt from the individual responsibility requirement
- Provision of information on certain individuals identified in Section 1311 (d)(4)(I) to the Treasury Department and to employers
- Establishment of a Navigator program that provides grants to entities assisting consumers as described in Section 1311(i)

Additional Exchange functions include:

- Presentation of enrollee satisfaction survey results under Section 1311(c)(4)
- Provision for open enrollment periods under Section 1311(c)(6)
- Consultation with stakeholders, including tribes, under Section 1311(d)(6)
- Publication of data on the Exchange's administrative costs under Section 1311(d)(7)

b. Oversight Responsibilities

Section 1311(c) requires the Secretary to develop regulatory standards in five areas that insurers must meet in order to be certified as qualified health plans by an Exchange:

- Marketing
- Network adequacy
- Accreditation for performance measures
- Quality improvement and reporting
- Uniform enrollment procedures

Additional areas where Exchanges must ensure plan compliance with regulatory standards established by the Secretary include:

- Information on the availability of in-network and out-of-network providers as identified in Section 1311(c)(1)(B) and (C), including provider directories and availability of essential community providers
- Consideration of plan patterns and practices with respect to past premium increases and submission of plan justifications for current premium increases under Section 1311(e)(2)
- Public disclosure of plan data identified in Section 1311(e)(3)(A), including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by the Secretary
- Timely information for consumers requesting their amount of cost sharing for specific services from specified providers as described in Section 1311(e)(3)(C)
- Information for participants in group health plans as described in Section 1311(e)(3)(D)
- Information on plan quality improvement activities as specified in Section 1311(g)

Clarifications and Policy Guidance

States should consider the following issues in establishing an Exchange.

- **Organizational Form.** Section 1311(d) gives States the option to establish the Exchange as a governmental agency or nonprofit entity. Within the governmental agency category, the Exchange could be housed within an existing State office, as it is in Utah, or it could be an independent public authority, as it is in Massachusetts. Regardless of its organizational form,

the Exchange must be publicly accountable, transparent, and have technically competent leadership, with the capacity and authority to take all actions necessary to meet federal standards, including the discretion to determine whether health plans offered through the Exchange are “in the interests of qualified individuals and qualified employers” as Section 1311(e)(1) requires. The Exchange also must have security procedures that meet the data and privacy standards necessary to receive tax data and other sensitive information needed for enrollment. The type of organization may affect the federal tax treatment of an Exchange, including potential income taxation (depending upon whether a nonprofit organization qualifies as a tax-exempt organization), annual filing requirements, the availability of tax-exempt bond financing, and FICA liability for employees.

- **Operating Model.** States have a range of options for how the Exchange operates from an “active purchaser” model, in which the Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an “open marketplace” model, in which the Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings. In both cases, consumers will end up with options, and States should provide comparison shopping tools that promote choice based on price and quality and enable consumers to narrow plan options based on their preferences.
- **Small Business (SHOP) Exchanges.** Small business customers offer unique challenges but also powerful opportunities for Exchanges. Successful Exchanges will streamline the process for small businesses. Federal rules will provide a framework for SHOP Exchanges, including options for how employers can provide contributions toward employee coverage that meet standards for small business tax credits.
- **Risk Adjustment.** Federal rules in 2011 will outline risk adjustment methods and require all health plans to report demographic, diagnostic, and prescription drug data. Further guidance addressing risk adjustment rules and formulas will be provided in subsequent regulations. As specified by the law, federal rules will apply risk adjustment consistently to all plans in the individual and small group markets, both inside and outside of Exchanges. Federal rules on reinsurance payments will apply to all plans in the individual market, and rules on risk corridors will apply to all qualified health plans in the individual and small group market, as specified in the law.
- **Performance Measures.** Standardized public data reporting will be needed to evaluate Exchange performance and assure transparency. Federal rules will require accurate and timely public disclosure of coverage data and other key performance measures to facilitate

research, analysis, and evaluation. Given that Exchanges are likely to pursue diverse strategies on several issues, analysis of performance metrics will be critical to identifying best practices that can be shared and used to improve the performance of all Exchanges.

- **State Choices.** Federal rules will clarify that the following policy areas, among others, are State decisions, although HHS may offer recommendations and technical assistance to States as they make these decisions:
 - Whether to form the Exchange as a governmental agency or a non-profit entity
 - Whether to form regional exchanges or establish interstate coordination for certain functions
 - Whether to elect the option under the Affordable Care Act to use 50 employees as the cutoff for small group market plans until 2016, which would limit access to exchange coverage to employer groups of 50 or less
 - Whether to require additional benefits in the Exchange beyond the essential health benefits
 - Whether to establish a competitive bidding process for plans
 - Whether to extend some or all Exchange-specific regulations to the outside insurance market (beyond what is required in the Affordable Care Act)
- **State Authority.** The federal government will work with the Governor of the State as the chief executive officer unless authority to operate the Exchange has been delegated to a specific authority through state law.

Federal Support

Forty-eight States and the District of Columbia were awarded their first Exchange grants under Section 1311 in September 2010. Those grants were for planning purposes and the next round of grants will be for the purpose of establishing an Exchange. The opportunity to apply for grants will be announced in February 2011 and will become available on a rolling basis throughout the next three years. States will have to meet certain milestones in order to be awarded grants in 2011, and the size of State awards may be related to the number of milestones met. States that are not able to meet required milestones by spring 2011 may apply for grants later in the year. Necessary Exchange costs will be fully funded by HHS until 2015. After January 1, 2015, Exchanges must be self funded.