State Health Reform Assistance Network
Charting the Road to Coverage

ISSUE BRIEF
August 2011

HHS Proposed Rules on Exchange Implementation Requirements

Prepared by Manatt Health Solutions -- Deborah Bachrach, Patricia Boozang, Melinda Dutton and Alice Lam

On July 11, 2011, the U.S. Department of Health and Human Services (HHS) issued proposed rules on the American Health Benefit Exchange (―Exchange") implementation: *Establishment of Exchanges and Qualified Health Plans (CMS-9989-P)*.

The regulations largely codify Affordable Care Act (ACA) requirements, with some notable exceptions. Embedded in the proposed regulations, and even more so in the accompanying commentary, are several significant policy shifts that will impact state planning and implementation of Exchanges. For example, the preamble introduces the new concept of a ―State partnership model" in which states may choose to combine state-designed and -operated business functions with federally designed and operated functions. Whereas Exchanges previously had been articulated by HHS as either distinctly state-run or federally run, the state partnership model offers a hybrid approach to establishing and operating Exchanges. Relative to the other substantive areas, the proposed rule provides significantly more detail on the Small Business Health Options Program (SHOP), enrollment periods and effective dates in the individual market, and the Exchange establishment process and criteria.

The purpose of this memo is to highlight the provisions of the regulations and accompanying commentary that clarify or amplify the ACA, or provide new insight into federal guidance or the collective thinking that has dominated the national discussion on Exchanges to date.

The regulations focus on a subset of crucial issues, but are not exhaustive. The preamble explicitly notes that the proposed rules do not address several key issues which are expected to be in future rule making, including:

- Individual eligibility standards for: Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, appeals of eligibility determinations and exemption from the individual responsibility requirement;
- Definitions of essential health benefits, actuarial value and other benefit design standards; and
- Quality reporting for Exchanges and Qualified Health Plan (QHP) issuers.

Guidance on these provisions—as well as on the Basic Health Plan, Medicaid eligibility and enrollment and Medicaid-Exchange interfacing—which are not addressed in the current issuance, are anticipated in the fall.

HHS will accept comments on the proposed rules within 75 days of publication in the Federal Register, on July 15. The proposed rules are available online at: http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf

EXCHANGE ESTABLISHMENT

- **Exchange Approval Process and Conditional Approvals.** *(Preamble: Sec. II.A.2.b; Regulatory Text: §155.105)* The proposed rule provides that states electing to establish an Exchange must (1) submit to HHS an ―Exchange Plan" describing how its Exchange meets federal standards and (2) demonstrate operational readiness through a readiness assessment conducted by HHS. The rule articulates a new concept of ―conditional approval," allowing HHS to presume a State Exchange will be operational by January 1, 2014 where it is able to demonstrate progress toward, but not complete readiness for Exchange operations by the statutory HHS approval deadline of January 1, 2013. The concept of conditional approval is a departure from the expectation set by HHS to date that states must demonstrate full implementation capacity for all Exchange functions by 2013 or risk HHS intervention to establish a federal exchange in the state. HHS would work with and monitor conditionally approved states until they are fully approved or their conditional approval is revoked. A state electing to operate an Exchange as of January 1, 2014 must have an approved or conditionally approved Exchange Plan by January 1, 2013. Without such approval HHS will implement a federally facilitated Exchange.

- **Changes to Exchange Plans** *(Preamble: Sec. II.A.2.b; Regulatory Text: §155.105)*. The rule requires that states notify HHS in writing of any substantial changes to Exchange Plans. Supporting commentary suggests that HHS is considering use of a State Plan Amendment (SPA) process similar to the process in place for Medicaid and CHIP as the vehicle for Exchange Plan changes. HHS seeks comment on the SPA approach.

- **Post-2014 Exchange Launch and Termination** *(Preamble: Sec. II.A.2.c; Regulatory Text: §155.106)*. The draft rule presents a more fluid picture of the timeline for state election to run Exchanges than that articulated in statute. Specifically, the rule would permit states to begin or cease Exchange operations after 2014. This does not however change the ACA requirements that: (i) a "federally facilitated" exchange will be established in states that do not elect to operate exchanges in 2014; and, (ii) Exchange establishment funding is not available after 2014. States electing to begin or terminate its Exchange after January 1, 2014 would be required to work with federal officials to transition from or to the federally facilitated Exchange, beginning at least 12 months in advance of the change.

- **State-Federal Partnerships** *(Preamble: Sec. II.A.2)*. Commentary supporting the proposed regulation articulates a new option for states to establish Exchange functionality through partnership with the federal government. Specifically, HHS contemplates partnership models through which states combine state-designed and operated business services with federally provided services. These models would reflect a hybrid of the two Exchange establishment options articulated in statute: State Exchange and Federal Exchange.

- **Governance** *(Preamble: Sec. II.A.2.d; Regulatory Text: §155.110)*. The proposed rule articulates new guidance to states with respect to Exchange Governance Board composition.
  - **Conflicts**. States are prohibited from establishing Exchange boards where a majority of representatives have conflicts of interest. The regulations define conflicted members to include representatives of insurance issuers, agents or brokers or other individuals licensed to sell health insurance. HHS expresses these limitations as a minimum federal standard and invites comment on whether additional categories of representatives with potential conflicts of interest should be further specified.
  - **By-Laws.** The proposed rules also require Exchanges that are operating as independent state agencies or not-for-profits entities to have a governing board; formal, publicly adopted operating charters or by-laws; regular public meetings announced in advance; and publicly available governance principles addressing ethics, transparency, accountability and conflicts standards.
  - **SHOP Governance.** While the proposed rules acknowledge the option to create a separate governance structure for the individual and SHOP Exchanges, the preamble expresses a preference for a single structure, and the proposed rules requires coordination between the two.

- **Existing Health Insurance Exchanges** *(Preamble: Sec. II.A,2.h; Regulatory Text: §155.150)*. The proposed rule codifies the ACA's compliance provisions with respect to existing State Exchanges. The ACA says that to be eligible for the presumption of compliance, existing Exchanges must "insure a percentage of the population not less than the percentage of the population projected to be covered nationally after the implementation of the ACA." The preamble indicates that HHS will apply the projected coverage level of the U.S. population in 2016. The CMS Office of the Actuary currently estimates this level to be 93.6 percent while the Congressional Budget Office estimates the coverage level to be 95 percent.

- **Financing** *(Preamble: Sec. II.A.2.i; Regulatory Text: §155.160)*. HHS proposes to require Exchanges to announce user fee assessments on issuers in advance of the plan year. HHS seeks comment on whether the final regulation should limit how and when user fees may be charged and whether such fees should be levied on an annual basis.

EXCHANGE FUNCTIONS

- **Navigator Program (***Preamble: Sec. II.A.3.c; Regulatory Text: §155.210).* The proposed rule codifies the categories of entities that may function as Navigators including community groups, professional associations, unions and licensed brokers and agents. The rule further requires that the Exchange include entities from at least two of the eight categories specified. The proposed rule codifies the prohibition on using federal Exchange establishment funds to support the Navigator program. Notably, in the preamble discussion, HHS articulates that States may draw down federal Medicaid and CHIP administrative matching funds for Navigator activities targeted to Medicaid and CHIP populations.

- **Website** ***(****Preamble, Sec. II.A.3.b; Regulatory Text: §155.205).* The proposed rule provides further details on the information and services to be offered on Exchange websites and requiring that such information be available in plain language and accessible to individuals with limited English proficiency and disabilities. In the preamble discussion, HHS contemplates requiring functionality for users to store and access information on the website and seeks comment on this proposal. This feature would include allowing applicants and enrollees to store, access and update personal account information and application assisters – such as case workers, Navigators, agents and brokers – to maintain records of individuals they have assisted in the application process.

- **Individual Premium Payments** ***(****Preamble, Sec. II.A.3. f; Regulatory Text: §155.240****).*** The proposed rule articulates parameters for individual premium payments through the Exchange, while maintaining flexibility for Exchanges with respect to this function. The discussion articulates the three options for individual premium collection by the Exchange: (1) take no part in payment of premiums (individual pays premium directly to the QHP issuer); (2) create an electronic "pass-through" without retaining any of the payments; or, (3) collect premiums from enrollees and pay an aggregated sum to the QHP issuer. In all cases, Exchanges must permit enrollees to pay premiums directly to QHP issuers.

- **Privacy & Security** *(Preamble, Sec. II.A.3. g; Regulatory Text: §155.260).* The rule offers a number of general provisions related to privacy and security in lieu of detailed privacy and security standards. Specifically, the proposed rule clarifies that HHS will not adopt uniform privacy standards, rather it would allow each Exchange to comply with existing ACA and HIPAA guidelines as applicable and to tailor privacy and security policies. HHS also suggests that each Exchange engage in a "fact intensive" analysis of operations and functions in order inform development of those policies.

INDIVIDUAL ENROLLMENT

- **Open Enrollment Periods and Coverage Effective Dates** *(Preamble, Sec. II.A.4.c; Regulatory Text: §155.410).* The proposed rule specifies timeframes and parameters for initial and annual open enrollment periods. HHS proposes an initial open enrollment period of October 1, 2013 through February 28, 2014, noting that it extends beyond the January 1, 2014 to allow for sufficient outreach and education. For coverage starting January 1, 2015, the proposed rule specifies an annual open enrollment period of October 15 through December 7. However, in the preamble, HHS also discusses an alternative timeframe of November 1 through December 15 and seeks comment on this alternative.

  The proposed rule also defines coverage effective dates. HHS limits coverage effective dates to the first of the month with specific exceptions for births and adoptions. This policy raises questions for maintaining continuity of coverage for individuals losing coverage at other times during the month.

- **Special Enrollment Periods** ***(****Preamble, Sec. II.A.4.d; Regulatory Text: §155.420*). ACA requires special enrollment periods for qualified individuals experiencing certain triggering events including loss of minimum essential coverage, change in citizenship or immigration status, change in eligibility for premium tax credits or cost sharing or other "exceptional circumstances." HHS imposes limitations on "loss of coverage" triggers for special enrollment periods and highlights two policies designed to mitigate against adverse selection. The preamble discussion notes that HHS has restricted its definition of loss of coverage to "minimum essential coverage" reasoning that those individuals enrolled in less than minimum

essential coverage could wait until experiencing a significant health care need to trigger the use of a special enrollment period to enroll. In addition, for individuals currently enrolled in a QHP seeking to change plans in a special enrollment period and who have not experienced a change in their premium tax credit or cost sharing reduction levels, HHS restricts their change in plans to QHPs within the same level.

- **Termination of Coverage** *(Preamble, Sec. II.A.4.e; Regulatory Text: §155.430).* The proposed rule outlines parameters on the termination of QHP coverage. HHS proposes to allow individuals to voluntarily terminate QHP coverage with adequate notice to the Exchange or the QHP. HHS also proposes conditions in which QHP coverage may be terminated for the individual, which include: ineligibility for QHP coverage; non-payment of premiums by the individual; and decertification or termination of the QHP. In the case of voluntary termination of coverage by the individual, effective date for the termination of coverage as a reasonable timeframe following notice of the individual. In the case of Exchange- or QHP-initiated termination of coverage, HHS proposes that the coverage end a month following notice of termination to the individual.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

- **SHOP Flexibility** *(Preamble, Sec. II.A.5.b; Regulatory Text: §155.705).* The proposed rule provides new flexibility with respect to employer choice requirements in the SHOP. As required by the ACA, the SHOP must allow an employer to select a level in which all QHPs are made available to employees. The proposed rule further provides that the SHOP may permit participating employers to select one or more QHPs to offer as coverage to their employees. HHS specifically seeks comment on this latter provision, which in statute appears to apply to large employers, but in the proposed rule has been extended to small employers.

- **Uniform Enrollment Timeline** *(Preamble, Sec. II.A.5.e; Regulatory Text: §155.720).* The proposed rule delegates responsibility to the SHOP to establish a uniform timeline relating to employer enrollment in the SHOP and employee enrollment in QHP coverage. These activities include: determination of employer eligibility to purchase coverage in SHOP; employer selection of level of coverage and QHPs; and determination of employee eligibility for enrollment in QHP coverage. HHS notes in the preamble discussion that due to the rolling enrollment process for employers, the timeline will be standardized to the plan year as opposed to the calendar year timeline applicable to individuals.

- **Employer Enrollment Periods** *(Preamble, Sec. II.A.5.f; Regulatory Text: §155.725).* The proposed rule specifies that the initial open enrollment period for SHOP commences October 1, 2013. However, HHS notes in the preamble discussion that this date represents a "starting point" for employers to begin participation in the SHOP. The proposed rule further requires the SHOP to establish a rolling enrollment process so that employers are able to enter a SHOP at any point during the year. The rolling enrollment process is intended to match the enrollment process for the small group market outside of the SHOP and HHS reasons that small employers are more likely to join the SHOP with the flexibility of a rolling open enrollment period rather than a single annual open enrollment period. The proposed rule specifies that the employer's plan year consists of the 12-month period beginning with the coverage effective date.

- **Employee Enrollment Periods** *(Preamble, Sec. II.A.5.f; Regulatory Text: §155.725*). The proposed rule requires the SHOP to establish annual open enrollment periods for employees which, due to the rolling enrollment process, standardized to the plan year. HHS further requires the SHOP to ensure that employees hired outside of the open enrollment period are provided with a specified timeframe to seek coverage when they start their employment.

- **Premium Aggregation** *(Preamble, Sec. II.A.5.b; Regulatory Text: §155.705).* In contrast to the flexibility offered in the individual Exchange, the proposed rule requires SHOP to perform premium payment administration duties. The statute is silent in this regard, but the discussion indicates that HHS reasons this policy to be an administrative simplification for employers.

- **Rate Setting** *(Preamble, Sec. II.A.5.b; Regulatory Text: §155.705).* The proposed rule specifies standards for rates and rate changes. HHS requires that the SHOP confine QHP issuer rate changes to a uniform timeframe that is either quarterly, monthly or annually, with rate changes occurring during the year applying only to new coverage and annual renewals. HHS invites comment on whether it should allow more or less restrictive timeframes.

- **Minimum Participation Standards** *(Preamble, Sec. II.A.5.b)*. In the preamble discussion, HHS contemplates issuers' minimum participation rules, a common tool used protect issuers against adverse selection. HHS invites comment on whether QHPs offered in the SHOP should be required to waive application of these rules on an issuer or plan basis or whether application of minimum participation rules should be permitted, how that rate should be calculated, and whether that should be codified in federal regulations.

ACCREDITATION AND CERTIFICATION STANDARDS FOR QHPS AND QHP ISSUERS

- **Distinction Between Plans And Issuers** *(Preamble, Sec. II.A.6.e; Regulatory Text: §155.20)*. The proposed rules make a distinction between a QHP that is certified to be offered through an Exchange and a QHP issuer which is an issuer that is subject to the requirements related to the offering of QHPs through the Exchange. In other words, a QHP is a product—an offering from an insurance issuer. This distinction is critical as discussed below with respect to the ACA's accreditation requirement.

- **QHP Accreditation** *(Preamble, Sec. II.A.6.e; Regulatory Text: §155.1045).* The preamble to the rules describes the accreditation requirement as a ―seal of approval," indicating that a QHP issuer meets minimum standards of quality and consumer protection. The proposed regulations interpret the ACA's accreditation requirement as applying to issuers, not QHPs, and specifically requires states to establish an accreditation timeline. Noting that the ACA does not set a deadline by which a QHP issuer must be accredited, the preamble encourages states to provide a sufficiently long grace period to accommodate issuers that may be seeking accreditation for the first time. This interpretation allows pure-play Medicaid managed care entities to secure certification of their QHPs even while they seek accreditation as a QHP issuer.

- **Certification Criteria** *(Preamble, Sec. II.A.6.a; Regulatory Text: §155.1000)*. The proposed rule provides minimum certification requirements to ensure that QHPs in all Exchanges meet minimum standards of quality and value, while allowing states to impose additional requirements tailored to local market conditions. Tracking the language of the ACA, the Exchange may only certify a QHP where it first determines that the QHP's participation in the Exchange is in the interest of consumers and small employers. The preamble suggests additional selection criteria a state might want to consider including: reasonableness of the QHP's cost; past performance of the issuer; quality improvement activities; enhancement of provider networks; service areas; and premium rate increases.

- **Recertification And Decertification** *(Preamble, Sec. II.A.6.i – II.A.6.j; Regulatory Text: §155.1075, §155.1080)*. An Exchange must establish a process for monitoring and recertifying QHPs and decertifying QHPs that no longer meet Exchange certification requirements. The preamble notes that the Exchange has the discretion to recertify QHPs annually or on a less frequent basis and seeks comments as to whether CMS should impose set time limits for recertification.

- **Multi-State Plans** *(Preamble, Sec. II.A.6.b; Regulatory Text: §155.1010)*. The ACA requires the Federal Office of Personnel Management to contract with health insurance issuers to offer at least two multi-state plans. HHS interprets the ACA's multi-state provisions to require Exchanges to accept these plans as QHPs without applying additional certification elements.

- **QHP Rate Increase Justification** *(Preamble, Sec. II.A.6.c; Regulatory Text: §155.1020*). QHP issuers must provide the Exchange with a justification for any rate increase for a QHP prior to implementing the increase and the Exchange must consider that justification in determining whether to certify or recertify a QHP. The preamble acknowledges that many state insurance agencies operate rate review programs and notes that such programs should be leveraged by the Exchange to avoid duplication and encourage collaboration.

- **Network Adequacy** *(Preamble, Sec. II.A.6.f; Regulatory Text: §155.1050).* The proposed rule compels QHPs to comply with network adequacy requirements established by the Exchange. The preamble notes that network adequacy requirements should be responsive to a states' particular geography, demographics and market conditions, and solicits comments as to whether additional federal quantitative or qualitative standards would be appropriate in evaluating QHP network sufficiency. Comment is also sought as to what additional standards might be imposed to ensure that enrollees in medically underserved areas have adequate access. Recognizing that primary care access may be a challenge, the preamble encourages states and Exchanges to consider broadly defining the types of providers that furnish primary care services.

- **Essential Community Providers (ECPS)** *(Preamble, Sec. II.B.2.f; Regulatory Text: §156.235)*. A QHP issuer must include within its network a sufficient number of essential community providers, where available, who serve predominantly low-income, medically underserved individuals. The word ―sufficient" does not appear in the ACA; the preamble discusses the rationale for the limitation and requests comment on how to define a sufficient number of ECPs. Comment is also sought as to the appropriateness of exempting staff model health plans from the ECP requirement.

- **Federally Qualified Health Centers (FQHC)** *(Preamble, Sec. II.B.2.f)*. The rules seek comment on potential approaches for reconciling: (i) the ECP provision that QHPs are not required to contract with ECPs who refuse to accept the generally applicable payment rates of the plans; with (ii) the ACA provision requiring QHPs to reimburse FQHCs at each facility's Medicaid prospective payment system (PPS) rate. PPS rates are paid on a per visit basis and are generally higher than generally applicable payment rates.

- **Quality Standards** *(Preamble, Sec. II.B.2.a; Regulatory Text: §156.200)*. The regulations require QHP issuers to implement and report on their QHP quality improvement strategies and enrollee satisfaction surveys. Specific quality standards, however, are deferred to a future regulation.

- **Marketing Standards** *(Preamble, Sec. II.B.2.d; Regulatory Text: §156.225)*. The ACA requires the Secretary to establish marketing requirements. The proposed rule requires QHP issuers to comply with state marketing rules and bars use of practices that discourage the enrollment of individuals with significant health needs. HHS seeks comment on the best means to monitor QHP issuers' marketing practices and whether a broad prohibition against unfair or deceptive marketing practices is warranted. Again, HHS urges that Exchanges work closely with state insurance departments to ensure that issuers in and out of the Exchange are subject to the same minimum marketing standards in order to create a level playing field with equal consumer protections.

- **QHP Rating** (*Preamble, Sec. II.B.2.i*; *Regulatory Text: §156.255*). The ACA limits variation in rating for QHPs to four factors: whether the coverage is individual or family, rating area, age and tobacco use. The ACA also requires QHP issuers to offer a QHP at the same premium rate whether the product is offered through or outside of the Exchange. The proposed rule codifies these requirements, and provides new guidance with regard to the family size rating factor. The rule states that QHP issuers must cover all families through some combination of: (i) individuals; (ii) two-adult families (iii) one adult families with a child or children; and, (iv) all other families. HHS seeks comments with respect to whether entire tax households should be articulated as an additional rating unit, as the taxable household will be the unit for determining premium tax credit eligibility.

ABOUT THE PROGRAM

State Health Reform Assistance Network, a program of the Robert Wood Johnson Foundation, provides in-depth technical support to states to maximize coverage gains as they implement key provisions of the Affordable Care Act. The program is managed by the Woodrow Wilson School of Public and International Affairs at Princeton University. For more information, visit www.rwjf.org/coverage.

ABOUT MANATT HEALTH SOLUTIONS

Manatt Health Solutions (MHS) is an interdisciplinary policy and business advisory division of Manatt, Phelps & Phillips, LLP, one of the nation's premier law and consulting firms. MHS helps clients develop and implement strategies to address their greatest challenges, improve performance and position themselves for long-term sustainability and growth.

ABOUT THE ROBERT WOOD JOHNSON FOUNDATION

The Robert Wood Johnson Foundation focuses on the pressing health and health care issues facing our country. As the nation's largest philanthropy devoted exclusively to health and health care, the Foundation works with a diverse group of organizations and individuals to identify solutions and achieve comprehensive, measureable and timely change. For nearly 40 years the Foundation has brought experience, commitment, and a rigorous, balanced approach to the problems that affect the health and health care of those it serves. When it comes to helping Americans lead healthier lives and get the care they need, the Foundation expects to make a difference in your lifetime. For more information, visit *www.rwjf.org*.

For more information, please contact Deborah Bachrach at DBachrach@Manatt.com or at (212) 790-4594.