

Report from the Study Panel on Health
Insurance Exchanges created under the
Patient Protection and Affordable Care Act

Federally-Facilitated Exchanges and the Continuum of State Options



*Deborah Bachrach
and
Patricia Boozang*

December 2011



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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 advises multiple foundations, state governments, health care providers and payers, and other health care stakeholder organizations on implementation of federal health reform.

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GLOSSARY OF ABBREVIATIONS

ACA	Patient Protection and Affordable Care Act
APTC	advance premium tax credits
BHP	Basic Health Program
CHIP	Child Health Insurance Program
CMS	Centers for Medicare and Medicaid Services
CSR	cost-sharing reduction
ECP	Essential Community Provider
FFE	Federally-facilitated Exchange
FOA	Funding Opportunity Announcement
HHS	Department of Health and Human Services
IAP	Insurance Affordability Program
MAGI	modified adjusted gross income
MEC	minimum essential coverage
MCO	managed care organization
NAIC	National Association of Insurance Commissioners
NGA	National Governors Association
NPRM	notice of proposed rulemaking
QHP	qualified health plan
SBE	State-based Exchange
SHOP	Small Business Health Options Program

Executive Summary

The Health Insurance Exchange (Exchange) is a central feature of the reforms advanced by the Patient Protection and Affordable Care Act (ACA), offering consumers and small businesses a transparent market in which they will be able to shop among affordable coverage options. The Exchange will also determine individuals' eligibility for Insurance Affordability Programs (IAPs) — Medicaid, the Child Health Insurance Program (CHIP), the Basic Health Program (BHP) (should a state decide to offer one) and advance premium tax credits and cost-sharing reductions (APTCs/CSRs). Since passage of the ACA on March 23, 2010, federal and state officials have devoted an extraordinary level of resources to planning and developing the systems, policies and protocols that will enable state Exchanges as well as the Federally-facilitated Exchange (FFE) to deliver on the promise of the ACA.

Some states will no doubt be positioned to stand up a State-based Exchange (SBE) on January 1, 2014, which requires at least conditional certification from the Department of Health and Human Services (HHS) on January 1, 2013. Others will not and will choose instead to rely on a Federally-facilitated Exchange or a Partnership Exchange wherein the state will assume some of the Exchange functions that would otherwise be performed by the Federally-facilitated Exchange. While we refer to three Exchange models (State-based, Federally-facilitated and Partnership), in fact, it is more accurate to think about Exchange operations along a continuum from entirely state-operated to entirely federally-operated, with several variations of shared operations in between. It is also important to note that a state may start out in 2014 with a Federally-facilitated or Partnership Exchange and over time assume more responsibility for Exchange functions, ultimately obtaining certification as a State-based Exchange. Finally, all Exchange models are grounded in either the State-based or Federally-facilitated Exchange that retains ultimate responsibility for Exchange operations and all must comply with ACA requirements, including the mandate for a simple and seamless eligibility and enrollment process.

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With the deadline for SBE certification barely a year away, states are taking a hard look at the three Exchange models – State-based , Federally-facilitated Exchange and Partnership Exchange – and considering which model works best for them in 2014 and beyond. To assist states and stakeholders in evaluating the different Exchange options, this report reviews how the core functions of an Exchange might be effectuated in the different Exchange models, and the implications for states selecting varying models as interim or permanent solutions.

The core responsibilities of an Exchange are the same regardless of model. They are: eligibility determinations for qualified health plans (QHPs) and Insurance Affordability Programs (Medicaid, CHIP, BHP and APTCs/CSRs); plan enrollment; plan management; consumer assistance; and, financial management. Where a State-based Exchange has flexibility in carrying out these functions, the federal government will exercise that flexibility (in consultation with the state) in a Federally-facilitated or Partnership Exchange model. Finally, in both the Federally-facilitated Exchange and the Partnership Exchange, the federal government retains responsibility for ensuring that the responsibilities of the Exchange are carried out in compliance with federal law and regulations. In a State-based Exchange, that responsibility is vested in the state.

States considering both the Federally-facilitated and Partnership Exchanges are wrestling with the degree of responsibility they want to assume, control they must cede to the federal government, and state fiscal implications with respect to the core functions of the Exchange – some of which implicate traditional state insurance and Medicaid responsibilities and others that represent entirely new functions for both the state and federal government. Ultimately, the challenge in the Partnership Exchange will be balancing the state role and desire for autonomy in certain Exchange functions against the degree to which a Federally-facilitated Exchange can respond to local market practices and still assure that consumers and small businesses have simple and streamlined access to affordable insurance coverage as mandated by the ACA.

ELIGIBILITY

Perhaps no core business function has received more attention in discussions of the Federally-facilitated and Partnership Exchanges than that of Exchange eligibility determinations. The ACA requires the Exchange to establish a consumer-centric eligibility determination process that will seamlessly determine an individual's eligibility to enroll in QHPs and Insurance Affordability Programs through a streamlined process that rivals best in class internet commerce experiences.¹ By law and implementing regulation, the consumer eligibility determination experience must be standardized, web-based, and technology-supported.

The ACA and implementing guidance also impose clear and reciprocal obligations on Exchanges and state Medicaid/CHIP programs to ensure that consumers are screened for and enrolled, without delay, in the Insurance Affordability Programs for which they are eligible. The ACA mandates that Exchanges not only inform consumers of Medicaid and CHIP eligibility requirements, but also determine consumers eligible for and enroll them in those programs if through “screening of the application by the Exchange, the Exchange

1 Centers for Medicare and Medicaid Services, “Guidance for Exchange and Medicaid Information Technology (IT) Systems” Version 2.0, May 2011.

determines that such individuals are eligible for any such program.”² Likewise, the law requires state Medicaid programs to ensure that individuals who apply for but are determined to be ineligible for Medicaid or CHIP are screened for eligibility for enrollment in QHPs offered through the Exchange and APTCs/CSRs and, if eligible, enrolled in such a plan without having to submit additional information or a separate application.³

HHS initially proposed that the Federally-facilitated Exchange carry out the eligibility function in both the Federally-facilitated and Partnership Exchange models. However, after states expressed concern about ceding to an Exchange (whether State-based, Federally-facilitated or Partnership) Medicaid eligibility determinations, HHS released new guidance in the form of Questions and Answers (Q&A) on November 29, 2011, providing additional options for effectuating eligibility functionality. The report explores the three models for effectuating eligibility determinations suggested in the HHS guidance to date. The foundation for each of these models is the ACA requirement for a simple and seamless eligibility process for all Insurance Affordability Programs – Medicaid, CHIP, BHP (if offered) and APTCs/CSRs.

Model #1. Federally-facilitated Exchange Retains Responsibility for Eligibility Determination Function for All Insurance Affordability Programs. This model reflects HHS’s initial proposal that the FFE retain the eligibility determination function – including responsibility for QHP and Insurance Affordability Program eligibility determinations (including Medicaid). State Medicaid policies would apply with respect to Medicaid eligibility determinations and there would be close collaboration between the Federally-facilitated Exchange and the state Medicaid agency to enable, among other things, the secure exchange of information and data. Two significant benefits to states of this model are federal assumption of the cost of Medicaid and CHIP (and presumably BHP) eligibility determinations and the transfer of litigation and audit risk to the federal government.

Model #2. Federally-facilitated Exchange Screens All Insurance Affordability Program Applications; State Medicaid/CHIP Agency Makes Final Medicaid/CHIP Eligibility Determinations. In this model, proposed by HHS in new guidance, the FFE would screen all IAP applications, do initial Medicaid/CHIP assessments, make APTCs/CSRs determinations, while state Medicaid/CHIP agencies make final Medicaid/CHIP determinations. While there is no detail regarding how this model would be implemented, presumably the FFE would transmit data to the state Medicaid agency with respect to those consumers who

2 ACA §1311 (d)(4)(F).

3 ACA §1943 (1)(C).

appear Medicaid eligible. For some consumers, no additional eligibility information would be required and the state Medicaid agency would directly enroll them into coverage; for others, the state Medicaid agency would complete the eligibility review and thereafter effectuate coverage. This model requires states to have in place ACA compliant Medicaid/CHIP eligibility systems that are capable of interfacing with the FFE. While the FFE would appear to have ultimate legal responsibility for IAP determinations, states would share oversight, audit and appeal risk for assuming operational responsibility for these decisions. In addition, the state would bear much of the cost of the eligibility determination. Notably, this model comes with significant challenges for states and the FFE in terms of coordinating their respective roles in such a manner as to support the ACA requirement for a simple, uniform and streamlined eligibility process for all IAPs.

Model #3. State-based Exchange Uses Federally-managed Services to Make Determinations for APTCs/CSRs and Exemptions from Individual

Responsibility. In this model, a third option proposed in the November Q&A guidance, the state has a certified SBE, but it “contracts” with the federal government to use “federally-managed services” to determine eligibility for APTCs/CSRs and exemptions from the individual responsibility requirement.⁴ Again, there is no additional guidance as to how this model would work and it is unclear what it means for the federal government to make APTCs/CSRs determinations once a State-based Exchange has completed a modified adjusted gross income (MAGI) determination as part of the Medicaid eligibility screen. It is also unclear whether states would be required to pay for the federally-managed services.

The three models require varying levels of coordination between the Exchange and the state Medicaid/CHIP agency to ensure that the consumer has access to a web-based and seamless eligibility determination process.

ENROLLMENT

Once an individual is determined eligible for participation in the Exchange or to access Insurance Affordability Programs, he or she is able to enroll in coverage. Consumers will leverage the tools available through the Exchange website to shop among QHP products, calculate their premium with the applicable tax credit for which they are eligible, and use decision support tools to compare and select a QHP in which to enroll. Once a consumer selects the plan, the Exchange will transmit enrollment information to the carrier to

4 The November 29th guidance also indicates that HHS is exploring how the federal government could provide services for verification of employer-sponsored minimum coverage.

effectuate the enrollment. HHS has indicated that the enrollment functionality will remain with the Federally-facilitated Exchange in the Partnership Exchange model.

PLAN MANAGEMENT

The ACA establishes key requirements for issuers of QHPs to ensure that all issuers meet minimum consumer protection standards and that the products they offer are “in the interests” of consumers.⁵ The Exchange is responsible for certifying and monitoring ongoing compliance with minimum standards and such additional requirements as the Exchange determines are in the interests of consumers and small employers. Exchanges also recertify and decertify plans; collect and review rate information; maintain operational data and assign plan quality ratings; and, manage an open enrollment process.

The ACA adds critical transparency requirements and imposes new standards, such as quality improvement, on health insurers participating in Exchanges, enhancing what state insurance regulators do today with respect to licensing, monitoring and enforcing market rules and managing the processes for insurers to compete for and participate in state Medicaid, CHIP, employee or other state-sponsored health insurance programs. At the same time, the ACA does not displace the traditional role of state insurance regulation.

Plan management is one area where the Exchange – regardless of model – and state insurance departments will need to coordinate, delineating their respective roles and responsibilities and when and how hand-offs will be effectuated. With respect to the Federally-facilitated Exchange, HHS, in the November 29, 2011 guidance, noted that “[t]o the greatest extent possible, HHS intends to work with State to preserve traditional responsibilities of State insurance departments when establishing a Federally-facilitated Exchange.” HHS has also suggested that plan management is a functionality that states may want to assume in a Partnership Exchange, thereby retaining (but expanding) their traditional role as primary regulators of insurance companies. The high degree of state flexibility in setting QHP standards and establishing procurement purchasing strategies is yet another reason a state may wish to assume plan management under a Partnership Exchange model. Whether the Federally-facilitated Exchange will be an active or passive purchaser in some or all Federally-facilitated Exchange states are open questions that are

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⁵ ACA §1311 (e)(1)(B).

unlikely to be answered until much more is known about which states opt for the Federally-facilitated Exchange and how the Federally-facilitated Exchange is operationalized.

CONSUMER ASSISTANCE

The effectiveness of any Exchange will be in large measure determined by its consumer assistance services including outreach and education, website, call center, Navigator program, consumer correspondence and complaint resolution capacity. These are required functions of the Exchange.

Like plan management, some consumer assistance functions including outreach and education, the Navigator Program, and in-person consumer assistance, fall into traditional areas of state oversight and regulation, and HHS has proposed that these functions be maintained by the states in a Partnership Exchange. The Federally-facilitated Exchange would operate other consumer assistance functions, such as the website, call center, and eligibility-related customer service.

States have expressed some concern about HHS retaining responsibility for the Exchange website, call center and consumer correspondence related to eligibility and enrollment in the Partnership Exchange. As with other Partnership Exchange functions, states and the federal government will need to explore a middle ground without compromising simple and seamless enrollment.

FINANCIAL MANAGEMENT

HHS has proposed that it would be responsible for financial management in a Federally-facilitated or Partnership Exchange. Among other things, this includes the ACA's three risk sharing programs, two of which – risk adjustment and reinsurance – apply both to plans in the Exchange as well as plans sold outside the Exchange. Additional financial functions performed by HHS, regardless of Exchange function, include premium processing for the Small Business Health Options Program (SHOP), data collection for payment processing and payment reconciliations and APTCs/CSRs.

Financing the Exchange will play out differently in the Federally-facilitated Exchange and the Partnership Exchange. HHS has been clear that the Federally-facilitated and Partnership Exchanges will charge user fees to underwrite operating costs. The federal government will assume full responsibility for the costs of the FFE and for the functions it retains in the Partnership Exchange; it will share with states the costs of the interfaces necessary to exchange information and data between the FFE and state Medicaid/CHIP and insurance agencies. States may use federal grant dollars to fund the costs of establishing a SBE and also the costs of the functions it will assume in the Partnership Exchange.



This report opens with a brief discussion of the legal authority for Federally-facilitated and Partnership Exchanges and then explores the issues with which states will have to grapple in selecting among the range of options available to collaborate with the federal government. Our review focuses on the individual Exchange, rather than the Small Business Health Options Program Exchange. Many of the same issues arise with respect to the SHOP Exchange and the differences tend to reflect the idiosyncrasies of state small employer markets.

Introduction

The ACA holds the promise of near universal coverage in the United States. Central to the success of the ACA's coverage goal is the Health Insurance Exchange (Exchange), a competitive market place through which individuals and small businesses will be able to access affordable health insurance. The Exchange has two overarching responsibilities: (1) to provide a seamless, user friendly system that determines consumer eligibility for Qualified Health Plans and Insurance Affordability Programs, including Medicaid, CHIP, the Basic Health Program (where available) and advance premium tax credits and cost-sharing reductions; and, (2) to establish a transparent marketplace where consumers will shop and select among health plans based on price, benefits and cost-sharing, and quality. Ultimately, an Exchange can be a powerful force to drive quality improvement and value in a state's health care delivery system.

In 2014, 12 million Americans – most with federal subsidies – will access coverage through Exchanges. By 2019, it is estimated that 28 million Americans will secure coverage through this new marketplace; premium revenues in Exchanges nationally could reach \$200 billion.⁶ If these estimates prove correct, Exchanges will have market leverage similar to or even greater than that of large employers and can use their clout to drive better pricing, choices and quality for individuals and small businesses that have little or no leverage in today's market.

The ACA mandates five core functions of Exchanges:

- **Eligibility.** Establishing a seamless process for determining eligibility for QHPs and all Insurance Affordability Programs; handling eligibility appeals; processing redeterminations of eligibility.
- **Enrollment.** Enrolling consumers into QHPs and connecting Medicaid and CHIP eligible consumers with the appropriate state agency to effectuate enrollment (or at

⁶ Congressional Budget Office, "March 2011 Baseline: Health Insurance Exchanges," March 18, 2011 and PwC Health Research Institute, "Change the channel: Health insurance exchanges expand choice and competition," July 2011.

the state option, directly effectuating the enrollment into Medicaid/CHIP plans); transmitting enrollment information to plans; transmitting to the federal government information necessary to initiate APTCs and CSRs.

- **Plan Management.** Determining plan standards beyond federal minimums; certification, selection and oversight of plans; collection, review and analysis of plan rates, benefits and quality information; issuer outreach, training and oversight and the exchange of issuer and plan data with the state department of insurance and with the Centers for Medicare and Medicaid Services (CMS).
- **Consumer Assistance.** Providing assistance, education and outreach to consumers; Navigator management; call center operations; website management; and general support of the Exchange’s eligibility and enrollment functionality.
- **Financial Management.** Developing a sustainable business model; collecting user fees; handling transfer payments related to tax credits and CSRs; assuring financial integrity; and applying risk adjustment, reinsurance and risk corridor programs.

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Pursuant to the ACA, states have the option of establishing state-based Exchanges, and the Secretary is charged with certifying those State Exchanges by January 1, 2013.⁷ In States failing to seek or achieve certification by 2013 a Federally-facilitated Exchange will be implemented. In its July 11, 2011 proposed rules on Exchange implementation, HHS offered states an additional option, a “Partnership Exchange” that combines state-operated functions with federally-operated functions.⁸ HHS has since expanded on its proposed Exchange implementation models, articulating a continuum of state-federal partnership options for Exchange implementation, across State-based Exchanges, Partnership Exchanges and the FFE. This latest guidance is consistent with previous federal decisions to transition from the initial binary “State vs. Federal Exchange” approach to a more fluid

partnership concept that states may tailor to their unique needs. This evolving HHS vision is reflected in a continuum of federal-state partnership models for Exchange implementation. While many details remain to be worked out between HHS and the states, it is clear that there will be a range of Exchange functions that could be assumed by the federal government in the context of a State-based Exchange or conversely, by the states in the context of a Federally-facilitated Exchange.

⁷ ACA §1321 (c).

⁸ CMS-9989-P, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans,” 76 FR 41866 (hereinafter “July 11, 2011 Exchange NPRM”).

Regardless of the implementation model — State-based, Partnership or Federally-facilitated — Exchanges must ensure that core Exchange functions are carried out in compliance with the ACA. And no matter the division of labor between the federal and state governments, coordination of policy, rules and requirements; transition protocols; and systems interfaces among the Exchange, state insurance departments and Medicaid agencies will be key to effective Exchange operations, a first-class consumer experience, and harmonizing rules inside and outside the Exchange. Proposed Exchange regulations provide states with considerable flexibility in implementing these functions. The federal government will exercise (indeed already is exercising) that flexibility in consultation with states in states that opt for a Federally-facilitated or Partnership model.

Partnership Exchanges provide a pathway enabling continued movement toward a State-based Exchange. However, as the National Governors Association (NGA) pointed out in a November 2, 2011 letter to Secretary Sebelius, later certification requires continued availability of start-up funding under Section 1311 of the law in order for states to have a viable path from a Partnership Exchange to a State Exchange after 2013.⁹ Responding to states' concerns, on November 29, 2011, HHS released new guidance on the implementation of Exchanges, in the form of a questions and answers document and an amended Funding Opportunity Announcement (FOA) for Exchange Establishment cooperative agreements. This guidance clarifies that Exchange establishment funding authorized under Section 1311 of the ACA is available to states not only for establishing a State-based Exchange, but also for building functions that a state elects to operate under a Partnership Exchange, and to support State activities to build interfaces with a FFE. The Q&A further indicates that 1311 funding may be awarded until December 31, 2014 for approved establishment activities after that date, including for activities related to improving and enhancing key Exchange functions.

This continued funding for states selecting the Partnership or FFE model is also critical to consolidating and building on the significant federal and state resources that have already been committed to Exchange planning. (Unfortunately, the media focus on the partisan battles over state Exchange legislation has missed this more important story.) Forty-nine states and the District of Columbia have received Exchange planning grants¹⁰, seven states or consortia of states have received Early Innovator grants¹¹, and 29 states have received Exchange establishment grants to move from planning to implementation of Exchanges. To date, states have received funding totaling over \$620 million to fund Exchanges. State officials at every level of government and in almost every state are

9 Letter from the National Governors Association to U.S. Department of Health and Human Services Secretary Kathleen Sebelius, November 2, 2011.

10 Florida returned its planning grant to HHS.

11 Two of these states, Kansas and Oklahoma, returned their Early Innovator grants to HHS.

working to implement the ACA consistent with local markets and culture. At the same time, a few Governors have announced their intent not to pursue a State-based Exchange, preferring to rely instead on a Federally-facilitated-facilitated or Partnership Exchange.

There are many complex and delicate nuances related to the implementation of the Federally-facilitated and Partnership Exchanges, many of which are addressed in the following sections of this report.

Authority for a Federally-Facilitated Exchange

The ACA directs the Secretary to issue regulations setting Exchange standards with respect to: the establishment and operations of Exchanges (including SHOP Exchanges); the offering of QHPs through such Exchanges; the establishment of reinsurance and risk adjustment programs; and, such other requirements as the Secretary determines appropriate.¹² Where a state elects not to establish an Exchange or is unable to have a State Exchange operational by January 1, 2014:

“... the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange in the State and the Secretary shall take such actions as are necessary to implement such other requirements.”¹³

In effect, the ACA requires HHS to operate a State Exchange in states unable or unwilling to establish and operate a State Exchange. Proposed Exchange regulations codify the statutory requirements of the ACA with respect to the Federally-facilitated Exchange providing:

“If a State is not an electing State ... or an electing State does not have an approved or conditionally approved Exchange by January 1, 2013, HHS must ... establish and operate such Exchange within the State....”¹⁴

The proposed regulation further notes that the Federally-facilitated Exchange is subject to the requirements of the following sections of the regulations: stakeholder consultation; general functions of an Exchange; Exchange functions in the individual market: QHP

12 ACA §1321 (a).

13 ACA §1321 (c).

14 July 11, 2011 Exchange NPRM Subpart B §155.105(f).

enrollment; Exchange functions for SHOPs; and, Exchange functions: Certification of QHPs.¹⁵ In addition, in the November 29, 2011 Q&A, HHS noted that the ACA and the proposed regulations are clear that individuals enrolling through a Federally-facilitated or Partnership Exchange have access to advanced payments of premium tax credits.

Where the federal government is operating an Exchange in a state, it has the same authority, flexibility and responsibilities as an Exchange operated by the state.

Federal officials have noted the impracticality of the federal government standing up multiple, unique Exchanges and thus anticipate a core Federally-facilitated Exchange model operating in non-electing states, with some adaptations to local market conditions and state interests. These adaptations will not be unlimited since the federal government cannot realistically act as a vendor subject to the different policies and priorities of each state in which it operates a Federally-facilitated Exchange. Thus, by relying on a Federally-facilitated Exchange, a state is, to some extent, ceding certain traditional state public and private insurance functions to the federal government.

Federal officials have noted the impracticality of the federal government standing up multiple, unique Exchanges and thus anticipate a core Federally-facilitated Exchange model operating in non-electing states

The concept of a Partnership Exchange, implemented through part federal functions and part state functions, was first proposed by HHS in the Exchange Notice of Proposed Rulemaking (NPRM) issued on July 11, 2011:

“Some States have expressed a preference for a flexible State partnership model combining State designed and operated business functions with Federally-designed and operated business functions. Examples of such shared business functions might include eligibility and enrollment, financial management and health plan management systems and services. ... HHS is exploring different partnership models.”¹⁶

The federal government elaborated further on the Partnership Exchange in a State Exchange Grantee meeting on September 19-20, 2011 in Arlington, Virginia. HHS indicated that the authority for the Partnership Exchange is grounded in its authority to operate a Federally-facilitated Exchange and as such, the federal government would remain responsible and accountable for ensuring that a Partnership Exchange meets all Exchange standards and requirements. In sum, as articulated by HHS, the Partnership

15 July 11, 2011 Exchange NPRM Subpart B §150.130, Subpart C, Subpart E, Subpart H and Subpart K.

16 July 11, 2011 Exchange NPRM Preamble.

Exchange is legally and practically a variation of the Federally-facilitated Exchange and as such, the federal government bears ultimate responsibility for its operation.

The federal government, through CMS, is moving forward to establish a Federally-facilitated Exchange consistent with the requirements of the ACA. CMS has developed and is implementing a comprehensive work plan to stand up the Federally-facilitated Exchange in states that choose not or are unable to operate state-run Exchanges. On September 30, 2011, HHS announced that: CGI Federally-facilitated, Inc. had been awarded a \$55 million base contract (up to \$93.7 million over five years) for building and supporting the information technology systems of the Federally-facilitated Exchange; Booz Allen Hamilton had been awarded a contract to develop the eligibility and enrollment operating procedures, provide support for implementation of a Navigator program for the Federally-facilitated Exchange and technical support to Navigator grantees, and develop the Federally-facilitated Exchange eligibility appeals process. A separate contract was awarded for the Data Services Hub to provide data verification services to support the eligibility process for all Exchanges (whether operated as state-run or Federally-facilitated Exchange) as well as for state Medicaid and CHIP programs.

Core Functions of an Exchange

ELIGIBILITY

ACA Requirements and Implementing Guidance

The ACA establishes a consumer-centric eligibility determination process that will enable individuals seeking health coverage in 2014 to (i) purchase QHP coverage through the Exchange and (ii) determine Insurance Affordability Program¹⁷ eligibility through a streamlined process that rivals best in class internet commerce experiences.¹⁸ According to the ACA, the features of this process will be supported by both information technology and operational features including:

- A single, streamlined application;
- Online, mail, phone and in-person application pathways;

17 Exchange eligibility functionality extends to both (i) eligibility of individual consumers to participate in and purchase coverage in the Exchange and (ii) consumer eligibility for Insurance Affordability Programs. For the purposes of this report, we assume that the Federally-facilitated Exchange or Federally-facilitated Exchange partnership will retain responsibility for determining consumers eligible to purchase QHPs.

18 Centers for Medicare and Medicaid Services, "Guidance for Exchange and Medicaid Information Technology (IT) Systems" Version 2.0, May 2011.

- Secure data interfaces that permit data exchange among the Exchange, the federal government and state agencies for the purposes of eligibility determination; and
- Electronic verification of eligibility information through interfaces with third party data sources.¹⁹

Implementing guidance expands on the requirements for electronic verification, requiring such data matches to take place “in real time” and reiterates the centrality of eligibility systems capable of supporting secure eligibility data exchange in the new paradigm of eligibility.²⁰

The ACA and implementing guidance also impose clear and reciprocal obligations on Exchanges and state Medicaid/CHIP programs to ensure that consumers are enrolled, without delay, in the Insurance Affordability Programs for which they are eligible. For example, Exchanges are required not only to inform consumers of Medicaid and CHIP eligibility requirements but also to determine consumers eligible and enroll them in those programs if through “screening of the application by the Exchange, the Exchange determines that such individuals are eligible for any such program.”²¹

The ACA extends this same vision and requirements to state Medicaid and CHIP programs. In order to continue to receive federal matching funds after January 1, 2014, states must: (i) comply with all ACA technology and process requirements related to streamlining eligibility and enrollment; (ii) enroll, without further determination, consumers who have been determined Medicaid eligible by the Exchange; and, (iii) ensure that individuals who apply for but are determined to be ineligible for Medicaid or CHIP are screened for eligibility for enrollment in QHPs offered through the Exchange and APTCs/ CSRs and, if eligible, enrolled in such a plan without having to submit an additional or separate application.²²

State Medicaid agencies and Exchanges are required by the ACA and implementing regulation – and indeed by the practical imperatives of the law – to closely coordinate their activities. Draft regulations compel Exchanges and Medicaid/CHIP agencies to enter into agreements to coordinate eligibility and enrollment processes for Insurance Affordability Programs. Commentary to the proposed Medicaid eligibility regulations suggests three broad ways in which States may design these agreements:

19 ACA §1413.

20 CMS-9974-P, “Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers,” 76 FR 51202.

21 ACA §1311 (d)(4)(F).

22 ACA §1943.

- One or more of the entities (the Exchange, Medicaid or CHIP agencies) could enter into an agreement whereby some or all of the responsibilities of each entity are performed by one or more of the others;
- A State could develop a fully integrated system whereby the responsibilities of all entities are performed by a single integrated entity; or,
- Each entity could fulfill its responsibilities and establish strong connections to ensure the seamless exchange of information and data.²³

Draft guidance expands on these coordination models by discussing the option for the Exchange to delegate to the state Medicaid agency responsibility to determine eligibility for QHPs, APTCs and CSRs. The guidance also contemplates an option for Medicaid agencies to delegate to Exchanges responsibility for all Medicaid, including non-MAGI, eligibility determinations. Further, guidance references a model in which Medicaid agencies delegate responsibility for enrolling MAGI eligible consumers into Medicaid managed care plans to Exchanges.²⁴

Medicaid guidance is also clear that state Medicaid agencies must certify criteria necessary for their Exchanges to perform delegated Medicaid functions – including the applicable Medicaid MAGI standards and immigration/citizenship rules. In doing so, the regulations clarify that while Exchanges will generate Medicaid eligibility determinations that require no further action by the Medicaid agency or consumer in order to effectuate enrollment, they do so based on the eligibility rules and requirements designed and certified by the state Medicaid agency (which must be consistent with federal law and regulation).²⁵

The November 29, 2011 HHS guidance in the form of an Exchange Q&A document offers significant new options for states, whether they are electing to implement a State-based Exchange, a Partnership Exchange or the FFE, with regard to implementation of the Exchange eligibility functionality.

For those states opting for the Federally-facilitated Exchange, the Q&A indicates that the federal government could be responsible for eligibility determinations for the full range of Insurance Affordability Programs, including Medicaid/CHIP determinations pursuant to

23 *CMS-2349-P*, “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010,” 76 FR 51148, Preamble.

24 *CMS-2349-P*, “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010,” 76 FR 51148, Preamble, §431.10(c)-(d), §435.1200(c)(2).

25 *CMS-2349-P*, “Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010,” 76 FR 51148, Preamble.

state rules. The guidance further clarifies that State Medicaid and CHIP programs will not be required to contribute to the costs associated with the FFE making Medicaid/CHIP determinations. Finally, the new guidance provides an alternative eligibility model which would allow for the Federally-facilitated Exchange to make an **initial** Medicaid/CHIP eligibility assessment, with the state Medicaid/CHIP agency responsible for the **final** eligibility determination.

For those states electing to implement a State-based Exchange, the Q&A also provides a new coordination or “shared responsibility” option for states, where the state and federal governments will partner to execute the eligibility functionality in a State-based Exchange. According to the Q&A, State-based Exchanges may elect to rely on “federally managed services” to make eligibility determinations for APTCs/CSRs and exemptions from the individual responsibility requirement. Notably, the Q&A reiterates that regardless of the eligibility functionality model elected by a state, ACA requirements for a streamlined, seamless and real-time eligibility determination process prevail.

Operationalizing the ACA Eligibility Requirements

The HHS vision with respect to eligibility determination functionality in the State-based, Federally-facilitated, and Partnership Exchanges has evolved over the last several months in response to a dialogue with states. HHS provided initial details on the FFE and Partnership Exchange models at a September meeting of State Exchange Grantees, in which federal officials indicated that the Federally-facilitated Exchange would expect to retain the Exchange eligibility determination function – including responsibility for QHP and Insurance Affordability Program eligibility determinations:

“(The) Federally-facilitated Exchange will determine eligibility for qualified health plans, tax credits, CSRs, and Medicaid and CHIP eligibility based on modified adjusted gross income...(The) Federally-facilitated Exchange will provide eligibility information to the applicable State agency to enroll those individuals in coverage.”²⁶

The State response to this approach was immediate. In addition to the significant state concerns expressed at the State Grantee Meeting, a letter from the NGA to Secretary Sebelius stated that;

“Under the proposed partnership models, states would be required to cede many operations that have traditionally been handled at the state level, including Medicaid eligibility...States have invested taxpayer resources in state based

26 “Exchanges: A Proposed New Federally-facilitated-State Partnership,” HHS, CMCS, CCIIO PowerPoint Presentation at State Grantee Meeting, September 19-20, 2011, Arlington, VA.

eligibility systems since the Medicaid program began and want to avoid duplication of effort.”²⁷

The more recent Q&A guidance from HHS reiterates this model, but characterizes it as one of two alternatives for eligibility functionality in a state that opts for the FFE. In addition to the “FFE does it all” eligibility model, HHS articulates a “shared responsibility” model in which state Medicaid/CHIP agencies retain responsibility for determinations in those programs. New guidance also clarifies that in states that opt for the FFE, the State Medicaid/CHIP programs will not be required to contribute to the costs associated with the FFE making Medicaid/CHIP determinations. Finally, states that opt for a State-based Exchange may use federally-managed services to make determinations of APTC/CSR eligibility.

Regardless of whether a state elects the Federally-facilitated, a Partnership Exchange or a State-based Exchange, the Exchange is responsible for ensuring consumer access to a fully coordinated eligibility determination function that provides automated and administratively simple eligibility determinations for QHP coverage and Insurance Affordability Programs in 2014.

The operational and coordination issues and implications for states and the federal government in achieving this seamless and coordinated eligibility process are discussed below. “Model #1” reflects the HHS proposal that the federal government retain responsibility for all eligibility determination functionality, whether in a Federally-facilitated or Partnership Exchange. “Model #2” reflects the HHS option for state agencies to make final Medicaid/CHIP determinations after an initial screening by the FFE, and Model #3 reflects the option for a State-based Exchange to contract with the federal

government for determinations of APTC/CSR eligibility. Two common themes across these models are: (i) the statutory requirement that the Exchange is responsible for effectuating eligibility determinations for consumers that apply for Insurance Affordability Programs through the Exchange; and, (ii) the need for close, consistent collaboration between the federal government and states to effectuate the eligibility vision, process, and functionality required by the ACA. In short, regardless of model, the eligibility determination must be seamless and streamlined so that consumers are enrolled, without delay, in the Insurance Affordability Program for which they are eligible. Additionally, while not discussed below, all models assume that in states opting for the Federally-facilitated Exchange, the FFE will have the responsibility of determining

Regardless of model, the eligibility determination must be seamless and streamlined so that consumers are enrolled, without delay, in the Insurance Affordability Program for which they are eligible.

²⁷ Letter from the National Governors Association to U.S. Department of Health and Human Services Secretary Kathleen Sebelius, November 2, 2011.

consumer eligibility to purchase QHP coverage through the Exchange, including whether an individual has access to affordable employer-sponsored insurance that provides minimum essential coverage (MEC); the QHP eligibility determination will rest with the state in a State-based Exchange. HHS indicates that it is exploring the feasibility of the FFE assuming the employer sponsored MEC responsibility as a federally managed service.

MODEL #1. FEDERALLY-FACILITATED EXCHANGE RETAINS RESPONSIBILITY FOR ELIGIBILITY DETERMINATION FUNCTION FOR ALL INSURANCE AFFORDABILITY PROGRAMS.

This approach to eligibility determination in a Federally-facilitated Exchange is consistent with ACA statutory and regulatory requirements that the Exchange determine eligibility for consumers applying for Insurance Affordability Programs through the Exchange, and the vision of a single, streamlined eligibility process for those programs. Indeed, the most consumer friendly construct that can be envisioned with respect to seamless, end-to-end eligibility determination is that of a single business and IT process that determines eligibility for all Insurance Affordability Programs. Such a cohesive process would appear best achieved in a Federally-facilitated Exchange (or State-based Exchange) that performs all eligibility determinations.

However, even this model is not without operational challenges. The FFE and states will need to collaborate closely to effectuate the IT system interfaces and operational processes to ensure secure data sharing and “hand-offs” between the FFE and state Medicaid and CHIP agencies. (This same level of collaboration will be required between a State-based Exchange and state Medicaid and CHIP agencies.) Such collaboration in policy, process and system interfaces will be essential to the following hand-offs, among others:

- Transmitting MAGI Medicaid and CHIP eligibility determinations from the FFE to the state Medicaid agency to effectuate seamless and immediate enrollment of consumers into the government program for which they are eligible;
- Transmitting data from state Medicaid and CHIP agencies to the FFE for consumers who seek coverage through state Medicaid or CHIP agencies and are eligible for APTCs/CSRs;
- Referring consumers from the FFE to state Medicaid for evaluation of non-MAGI based Medicaid eligibility and coordination of that determination with consumers’ APTC/CSR eligibility; and
- Transmitting non-MAGI Medicaid eligibility determinations from state Medicaid to the FFE to trigger termination of APTCs and QHP disenrollment.

Given new guidance indicating that state Medicaid and CHIP agencies will not be required to contribute to the costs associated with the FFE making Medicaid/CHIP determinations, there is a significant fiscal benefit to states of relying on the FFE to

provide full eligibility determination functionality including Medicaid and CHIP. By electing this option, states could avoid financial obligation for transaction costs related to FFE eligibility determination for state funded health insurance programs. Additionally, HHS has committed to implementing Medicaid/CHIP determinations in the FFE using “state eligibility rules and standards.”

Another underlying (and not to be underestimated) benefit of the Federally-facilitated Exchange assuming responsibility for all or some Medicaid eligibility determinations is that in doing so the Federally-facilitated Exchange would appear to assume the audit scrutiny and oversight responsibility for these determinations. Eligibility oversight and audit is a cumbersome and costly process for states and there may be significant appeal to states in having a federal entity process eligibility determinations under state rules, and by doing so assuming the post-determination oversight, audit and appeal responsibility. Ultimately, HHS will need to address how appeals would be handled in this model. As noted above, the ACA mandates that states provide the same consumer centric, simple eligibility process to consumers that seek coverage directly through the Medicaid/CHIP agencies. As such, states that opt for an FFE or Partnership Exchange in 2014 may want to consider contracting with the Federally-facilitated Exchange in order to access FFE eligibility systems with respect to Medicaid eligibility determinations for healthy non-elderly adults and children (i.e. the MAGI populations). This would avoid duplicative federal and state investment in eligibility system upgrades to meet ACA requirements.²⁸ In addition, for non-disabled, non-elderly Medicaid-eligible adults, the federal government is underwriting all or virtually all of their medical costs. Accordingly, having the federal government assume the eligibility function may be less problematic from a state’s perspective.

MODEL #2. FEDERALLY-FACILITATED EXCHANGE SCREENS ALL INSURANCE AFFORDABILITY PROGRAM APPLICATIONS; STATE MEDICAID AGENCY MAKES FINAL MEDICAID ELIGIBILITY DETERMINATIONS.

HHS has proposed an alternative model for implementing eligibility determination functionality in States that opt for the Federally-facilitated or Partnership Exchange. In this model, the Federally-facilitated Exchange would screen all Insurance Affordability Program applications, make **initial** Medicaid/CHIP assessments, make APTC/CSR determinations, while state Medicaid/CHIP agencies make **final** Medicaid/CHIP determinations. While there is no detail regarding how this model would be operationalized, presumably the FFE screen would be based on: (i) electronic verification of eligibility information accessed through the federal hub and, to the extent available, real-time state based

28 On the other hand, states selecting this approach on more than an interim basis will still need to address system upgrades for their non-MAGI populations and in all cases will need to construct seamless and secure interfaces between the Exchange and the Medicaid agencies.

eligibility data; and, (ii) consumer attestation. The FFE would effectuate APTC/CSR eligibility determinations for those applicants who appear Medicaid/CHIP **ineligible** based on state rules. For those consumers who appear eligible for Medicaid, the FFE would transmit data to the state Medicaid agency for completion and effectuation of the Medicaid eligibility determination. The final determinations may need to be transmitted back to the FFE as it would appear that the Exchange retains legal responsibility and oversight of eligibility determinations for consumers who apply for Insurance Affordability Programs through the Exchange.

This model satisfies the ACA requirement that consumers are screened for Medicaid eligibility before being determined eligible for an APTC/CSR and would enable the federal government to accommodate states who wish to retain ultimate responsibility for Medicaid eligibility determinations. It also appears consistent with the ACA allowance for state Medicaid agencies to assume contractual responsibility for Insurance Affordability Program eligibility determinations. But this model brings the significantly greater coordination and IT challenges for states than Model #1. In this model, the FFE (presumably) would enter into a contractual agreement with the state Medicaid agency whereby the state would agree to make Medicaid/CHIP eligibility determinations for their residents who seek access to Insurance Affordability Programs through the FFE. The state would not only have to upgrade their current Medicaid/CHIP eligibility systems to meet ACA requirements with regard to seamless, secure and real-time determinations, but also develop the requisite system and process interfaces with the FFE to ensure coordinated and seamless eligibility and enrollment for Medicaid/CHIP eligible consumers.

While the Federally-facilitated Exchange would have ultimate legal responsibility for Insurance Affordability Program determinations, states would share oversight, audit and appeal risk for assuming responsibility for these decisions – and the inevitable liability of eligibility related lawsuits.

Finally, it is worth noting that for some consumers, perhaps many, the screen by the FFE should be sufficient to determine Medicaid eligibility, and the role of the Medicaid agency should simply be to effectuate Medicaid enrollment based on the Exchange screen.²⁹ Indeed it appears clear in the law that Medicaid agencies are compelled to effectuate “without further determination,” Medicaid eligibility for consumers who screen eligible for Medicaid in the Exchange. For at least some consumers it will be possible, and legally mandated, that their enrollment is effectuated without redundant or additional requirements. Federally-facilitated Q&A guidance begins to address this issue by

29 Section 1943(b)(4) of the ACA requires states to develop procedures whereby individuals who are determined Medicaid eligible by the Exchange are enrolled without any further determination and through a linked Medicaid website linked with the Exchange website.

indicating that states electing this option would “agree to make these determinations consistent with general guidelines and the terms of an agreement established between the State and the Federally-facilitated Exchange to ensure that applicants are not required to submit redundant documentation and that timeliness standards are met.”

MODEL #3. STATE-BASED EXCHANGE USES FEDERALLY-MANAGED SERVICES TO MAKE DETERMINATIONS FOR APTCs/CSRs AND EXEMPTIONS FROM INDIVIDUAL RESPONSIBILITY.

In this model, a certified SBE would be able to contract with the federal government to use federally-managed services to determine eligibility for APTCs/CSRs and exemptions from the individual responsibility requirement. The November 29th guidance also indicates that HHS is exploring how the Federal government could manage service for verification of employer-sponsored minimum coverage.

There is little detail regarding how this new shared eligibility responsibility would work. However, one could envision the State-based Exchange screening all applicants for Medicaid/CHIP eligibility, making Medicaid/CHIP eligibility determinations (directly or through coordination with the State Medicaid agency), and transmitting data for Medicaid/CHIP ineligible applicants to the federal government for APTC/CSR determination. These consumers, including those determined eligible for APTCs/CSRs by the federal government, would shop and enroll for coverage in the State-based Exchange. Ultimately, it is not clear what additional “determination” activities the FFE would be required (or allowed) to perform beyond the Medicaid agency eligibility determination screen that meets ACA requirements. This division of labor might amount to no more than “optics” and ultimate audit/appeal liability.

While not contemplated in Q&A guidance, it might also be possible for some State-based Exchanges to rely on federally managed eligibility services for all eligibility determinations, including MAGI Medicaid/CHIP determinations, for several reasons. Given that states are hard-pressed to upgrade or replace current Medicaid/CHIP eligibility systems to meet ACA mandates by 2014, they may need to rely on federally managed eligibility services for a transition period until their new systems are operational.

Models #2 and #3 – the new, flexible eligibility options articulated by HHS, in which an Exchange (whether Federally-facilitated or State-based) is “sharing” with a state Medicaid agency responsibility for Insurance Affordability Program eligibility functionality, are complex as compared to the notion of a single, cohesive and streamlined eligibility system managed by either a State-based or Federally-facilitated Exchange, or federally managed services provided to a State-based Exchange. These models will require intensive collaboration, scrutiny and oversight to ensure that they consistently meet the ACA’s requirement for a simple and seamless eligibility determination process. At the

outset, to effectuate these models, both the Medicaid agency and the Federal Exchange will have to operate ACA compliant eligibility systems. In addition, it would appear that the same “reasonably compatible”³⁰ standards and business requirements (for verification of eligibility) would have to apply across Insurance Affordability Programs for all states that opt for the Federally-facilitated and Partnership Exchange as the federal government is unlikely to be able to craft, program and implement unique reasonable compatibility standards for each state in which it operates. Further, such arrangements must be operationalized to produce efficient and timely eligibility determinations and enable the prompt enrollment of consumers into the Insurance Affordability Programs for which they are eligible. In many respects, it seems impractical to disaggregate the Medicaid/CHIP eligibility from the APTC/CSR eligibility determination process in the manner described in these models. One can envision a worst case scenario in which consumers end up in a revolving door of referrals to the “other program” for which they may be eligible. These models would likely also require development and financing of redundant eligibility systems, an inefficient use of scarce federal and state resources in both the short and long-term. In short, even if these models can be constructed on paper to comply with the letter of the law, they will be difficult to operationalize so as to assure timely and seamless coverage determinations as required by the ACA.

One can envision a worst case scenario in which consumers end up in a revolving door of referrals to the “other program” for which they may be eligible.

ENROLLMENT

Once an individual is determined eligible for participation in the Exchange or to access Insurance Affordability Programs, he or she is able to enroll in coverage. Consumers will leverage the tools available through the Exchange website to shop among QHP products, calculate their premium with the applicable tax credit for which they are eligible, and use decision support tools to compare and select a QHP in which to enroll. Once a consumer selects the plan, the Exchange will transmit enrollment information to the carrier to effectuate the enrollment.

For those consumers deemed Medicaid or CHIP eligible, the Exchange will either transmit their eligibility to the Medicaid agency to effectuate immediate enrollment, or, in states where Medicaid/CHIP eligible families enroll in health plans, enable consumers to shop for and enroll in a Medicaid managed care or CHIP health plan through the Exchange

30 Both the Exchange and Medicaid NPRMs incorporate a “reasonably compatible standard” to determine when the Exchange or the Medicaid agency must or may examine additional electronic data sources or seek additional information directly from the consumer in order to verify eligibility for Insurance Eligibility Programs.

website. HHS has indicated that while the law does not compel shopping and enrollment for Medicaid/CHIP through the Exchange, such a model would be desirable to promote a seamless and uniform process for accessing coverage.

In the Federally-facilitated and Partnership Exchange models, shopping and enrollment would take place through the Federally-facilitated Exchange supported Exchange website. HHS has indicated to states that website management is among the functions that will remain part of Federally-facilitated Exchange responsibility in the Partnership model, supporting end to end seamlessness and quality of the consumer eligibility and enrollment Exchange experience. As a result, QHP carriers in states that elect the Federally-facilitated Exchange option will be required to establish data sharing capacity with the FFE as a condition of Exchange participation.

Ideally, state Medicaid agencies interested and seeking to extend the Exchange shopping and enrollment experience to their Medicaid programs, would collaborate with the Federally-facilitated Exchange to share data necessary to put Medicaid managed care plans “on the Exchange shelf” and facilitate transmission to Medicaid managed care plans of enrollments effectuated through the Federally-facilitated Exchange.

PLAN MANAGEMENT

The ACA establishes key requirements for issuers of QHPs to ensure that all issuers meet minimum consumer protection standards and that the products they offer are “in the interests” of consumers.³¹ The Exchange is responsible for certifying compliance with these minimum standards and such additional requirements as the Exchange determines are in the interests of consumers and small employers. Exchanges also monitor ongoing compliance with the Exchange standards; recertify and decertify plans; collect and review rate information; maintain operational data and assign plan quality ratings; and, manage an open enrollment process.

Exchange responsibilities with respect to issuers build on what state insurance departments do in regulating insurance companies, agents, and others involved in the business of insurance. Insurance departments have regulatory expertise and essential data on health plan issuers doing business in their states and this is certainly the starting point for the plan management function in the Exchange. Among the areas where Exchanges, regardless of model, can benefit from coordination and information-sharing with state insurance departments are the following:

- Company licensing, which ensures that companies meet solvency standards, have experienced and competent management, and have policies and procedures to achieve compliance with state and federal laws.

³¹ ACA §1311 (e)(1)(B).

- Agent licensing, which ensures that agents meet educational standards and do not have a history of market conduct violations.
- Rate and form reviews, which generate information on insurer product offerings and rating practices. Many states are using ACA grants to implement or enhance their rate review processes for health insurers.
- Financial and market conduct exams, which measure how effective insurer compliance programs are in the field. This kind of ongoing oversight, which often focuses on new laws and regulations, will provide critical information as guaranteed issue, limitations on age rating, and other reforms are implemented in the individual market in 2014.
- Consumer assistance, which includes tracking and resolving consumer complaints, often an early warning signal of problems with particular insurers.

The ACA adds significant new disclosure, transparency and oversight requirements and new standards, such as quality improvement, that enhance current state requirements of health insurers and more complaint-oriented enforcement. Overall the ACA requirements for Exchanges start with, but go beyond, what states do today in licensing insurers, monitoring and enforcing market rules and in managing the processes for insurers to compete for and participate in state Medicaid, CHIP, employee or other state-sponsored health insurance programs.

Moreover, the ACA does not displace the traditional role of state insurance regulation.³² Health insurance regulation has been and will continue to be the responsibility of state government. In fact, the ACA imposes new requirements on state regulators, such as implementation of disclosure and transparency requirements and significant new private insurance reforms (e.g. guaranteed issue and elimination of underwriting), that will be critical to the success of Exchanges. However, after 2014, state insurance departments will share that authority with Exchanges and coordination between the Exchange and state insurance departments will be critical to the effective operations of both. Indeed, as suggested by the proposed Exchange regulations, plan management is one area where the Exchange – regardless of model – and the state’s insurance department will need to delineate their respective roles and responsibilities, and when and how hand-offs are to be effectuated, considering, among other things, tight annual enrollment cycles. These hand-offs will implicate all of the areas of state insurance regulation mentioned above, from company and agent licensing information to rate and form review data to financial

32 The ACA does not preempt any state law “that does not prevent the application of the provisions” of the ACA. ACA §1321 (d).

and market conduct trends to consumer complaints to any compliance problems in the implementation of guaranteed issue and other market reforms.

In order to preserve the traditional responsibilities of state insurance agencies, HHS has indicated its intent to work closely with these agencies in states opting for a Federally-facilitated Exchange to harmonize Exchange policy with existing state programs and law to the greatest extent possible.³³ As with eligibility determination processes, the federal-state coordination must be effectuated in such a way as to assure compliance with the ACA's overarching standards.

Whatever the model adopted in a particular state, there will be a compelling need for coordinated regulation between the Exchange market and the state market outside the Exchange.

The Partnership Exchange may be an attractive middle ground for states that cannot achieve certification as a State Exchange in 2013 but want to preserve their traditional role as primary regulators of insurance companies. In addition, by assuming responsibility for plan management, states will be better positioned to address and drive state public health and delivery system priorities in their respective state. Whatever the model adopted in a particular state, there will be a compelling need for coordinated regulation between the Exchange market and the state market outside the Exchange.

QHP Certification Criteria

The ACA requires the Secretary to establish minimum requirements for issuers offering QHPs in the Exchange. These minimum certification standards are described in the July 11, 2011 proposed regulations and include the following:

- **Accreditation.**³⁴ QHP issuers must be accredited by an accrediting entity recognized by HHS and the accreditation survey must be released to the Exchange and HHS. The Exchange is given flexibility to determine timeframes for accreditation, so that the needs of new market entrants can be considered in states that may want to encourage Medicaid managed care organizations (MCOs) or others to expand into the commercial market.
- **Network Adequacy.**³⁵ The Exchange has considerable discretion in determining network adequacy based on local conditions but must ensure that a QHP provider network "offers a sufficient choice of providers for enrollees."

33 November 29, 2011 State Exchange Implementation Question and Answers, Answer 6.

34 July 11, 2011 Exchange NPRM Subpart C §§156.275 and 155.1045.

35 July 11, 2011 Exchange NPRM Subpart C §156.230 and Subpart K §1155.1050.

- **Essential Community Providers.**³⁶ A QHP issuer must include within its provider network a “sufficient” number of essential community providers (ECPs), where available, that serve predominantly low-income, medically-underserved individuals.
- **Marketing Practices.**³⁷ QHPs and their agents must not engage in “unfair and deceptive” marketing practices; the regulations leave enforcement to state marketing laws and regulations.
- **Quality.**³⁸ QHPs must implement and report on quality improvement strategies, disclose information on health care quality and implement enrollee satisfaction surveys. In the November 29th guidance, HHS indicated that it will be taking a phased approach to the quality rating provisions with quality ratings in 2014 predicated on generally available metrics and measures.
- **Rate Justifications.**³⁹ QHP issuers must submit a justification for any rate increase to the Exchange prior to implementing such increase and the Exchange must take into consideration such justifications in determining whether to certify or recertify the QHP. In addition, the Exchange must consider findings of the state insurance agency under the ACA with respect to the unreasonable rate review provision.⁴⁰
- **Transparency.**⁴¹ QHP issuers must provide detailed information on financial status, claims practices, and other performance measures that go beyond what most states require today.

With respect to each of these standards, the proposed regulation provides an overarching standard, with some level of detail and a commensurate level of discretion left to the Exchange. At the State Exchange Grantee meeting on September 19-20, 2011, CMS provided the following information with respect to the flexibility vested in a State Exchange:

36 July 11, 2011 Exchange NPRM Subpart C §156.235.

37 July 11, 2011 Exchange NPRM Subpart C §156.225 and Preamble.

38 July 11, 2011 Exchange NPRM Subpart C §156.200(b)(5).

39 July 11, 2011 Exchange NPRM Subpart C §156.210 and Subpart K §155.1020.

40 ACA §2794.

41 July 11, 2011 Exchange NPRM Subpart C §156.220.

Exchange NPRM	State Exchange Flexibility	State Exchange Flexibility With Federally-facilitated Floor
QHP Selection Process	X	
Network Adequacy Standards	X	
Marketing Standards	X	
Agent and Broker Role	X	
Accountability/Governance		X
QHP Offerings		X
QHP Accreditation		X
Essential Community Providers		X

Given the high degree of state flexibility in the QHP standards, states that opt for either a State Exchange or a Partnership Exchange will have latitude to adapt their Exchange to local market conditions. And, even in the FFE, HHS will rely on state rules to the maximum extent possible. For example, HHS has indicated that it will rely on state standards for network adequacy and will consult with states in applying these standards. Where states have not adopted such standards, HHS would look to a commonly recognized standard such as the National Association of Insurance Commissioners (NAIC) Network Adequacy Model Act.⁴² A similar approach would be used with respect to marketing standards.

Implementation of the rate justification provisions of the ACA is another example of an area where a Federally-facilitated Exchange must work closely with state officials. The rate justification provision requires an Exchange to consider: (1) the plan's justification for a rate increase; (2) recommendations provided to the Exchange from the state pursuant to its review of unreasonable rate increases under section 2794 of the ACA; and (3) any excess of rate growth outside the Exchange as compared to inside the Exchange.⁴³ The balancing of these factors in the plan certification process is left to the Exchange. However, the Exchange must interface with the state insurance department with respect to its finding under the unreasonable rate review provisions of the ACA and may accept the justification provided to the state insurance department (or from HHS, if applicable) in lieu of requiring plans to separately submit to it. The regulations specifically contemplate

42 November 29, 2011 State Implementation Questions and Answers, Answer 6.

43 July 11, 2011 Exchange NPRM Subpart K §155.1020.

a close working relationship between the Exchange – again no matter the model – and the state insurance department with respect to rate review:

“We seek to avoid duplicating the State rate review process [under the ACA]. We recognize that many States already operate an effective rate review program, collect information from issuers in the rate filing process and make a determination if the rate complies with State law. This process, when available, should be leveraged by the Exchange to avoid duplication. For example... Establishing consistency between the rate justification described in Section 154.215 [state or HHS rate review programs] and the justification required from QHP issuers by Section 156.210 would reduce duplication of effort for issuers and Exchanges and promote greater transparency.”⁴⁴

In the November 29, 2011 guidance, HHS specifically notes that it is working to determine how best to incorporate state reviews of rates and benefit packages into the certification of QHPs by the FFE. In addition, HHS will endeavor to harmonize the federal and state workflows to enable timely certification of QHPs.

Another certification requirement which deserves mention is the determination of QHP service areas. Exchanges may pre-determine these areas, permit plans to propose them, or negotiate with issuers over them. The proposed regulations again provide some minimum constraints; namely that the service area of a QHP cover at least the geographic area of a county or group of counties (unless a smaller area is in the interests of consumers and employers) and that the service area of a QHP be established on a non-discriminatory basis.⁴⁵ The implications of these choices can be critical for local plans that may only serve limited geographic regions and must be informed by local market conditions. A decision to require QHPs to serve overly broad regions may prevent certain plans (e.g. Medicaid MCOs) from participating in an Exchange.

In putting forth these standards, CMS sought to ensure that QHPs in all Exchanges meet consistent minimum standards, while providing Exchanges flexibility to set standards – either through refinements of the basic standards or by adding supplemental standards – tailored to local market conditions. HHS has also taken pains to note where coordination with or delegation to state insurance agencies is desirable or required. In short, Exchanges, regardless of model, have discretion in applying even federal minimum criteria and in determining whether or how to supplement federal minimums. In all cases, Exchanges are expected to coordinate with state insurance agencies in establishing and

⁴⁴ July 11, 2011 Exchange NPRM Preamble.

⁴⁵ July 11, 2011 Exchange NPRM Subpart K §155.1055.

implementing these criteria and where the Exchange is operated by the federal government, such coordination is imperative.

QHP Contracting Strategies

HHS has been clear since its initial Exchange guidance in November 2010 that an Exchange has very broad latitude in exercising its statutory responsibility to determine whether a health plan's participation in the Exchange is "in the interests of" consumers and small employers.⁴⁶ Exchanges must ensure that participating plans meet federal minimum certification standards, but they can be "open marketplaces" or "passive purchasers," meaning the Exchange can determine that it is in the interest of the consumers and small employers that all plans that meet minimum standards should participate in the Exchange. Alternatively, the Exchange can be an "active purchaser," meaning that it can impose additional requirements on plans or use a competitive procurement to drive higher value insurance design and seek to advance quality and efficiency in the state's health care delivery system.

The role of the Exchange in a state's health insurance market is where the ACA's goals to expand health insurance coverage and catalyze higher quality, more cost effective health care come together, providing a pathway to reform both.

The role of the Exchange in a state's health insurance market and the extent to which the Exchange will be an active purchaser on behalf of consumers and small businesses are issues with which every state is grappling. In some sense, here is where the ACA's goals to expand health insurance coverage and catalyze higher quality, more cost effective health care come together, providing a pathway to reform both. While some states see maximizing choice through an open marketplace as the best way to serve consumers, other states see imposing additional certification criteria on health plans or implementing more selective contracting strategies as the most promising way to assure greater value for consumers shopping for coverage through the Exchange. Such additional activities could include standardizing benefit design, recruiting new issuers into the market, negotiating price discounts and encouraging or requiring plans to adopt new provider reimbursement strategies or care

models. In addition, by aggregating the purchasing power of individuals and small groups and aligning with other large purchasers, the Exchange could potentially drive quality improvement and delivery reform system wide.⁴⁷ Whether the Federally-facilitated Exchange purchasing model will be applied uniformly in states remains an open question.

46 U.S. Department of Health and Human Services, "Initial Guidance to States on Exchanges," November 18, 2010.

47 S. Corlette and J. Volk, "Active Purchasing for Health Insurance Exchanges," Georgetown University Health Policy Institute/National Academy of Social Insurance, June 2011.

In evaluating the role of a Federally-facilitated Exchange and its relationship to state activities, states may want to consider decisions within the purview of the Exchange:

- Will the Federally-facilitated Exchange impose additional criteria beyond ACA minimums on plans or use purchasing strategies to provide consumers higher quality products with more affordable premiums?
- How, if at all, might a Federally-facilitated Exchange align with other large purchasers, such as the state's Medicaid or state employee benefits agency, to advance payment and delivery reform?
- Will the Federally-facilitated Exchange use its market presence in multiple states, potentially including some of the nation's largest markets, to bring more plans into states where there is considerable market concentration? In other words, might the Federally-facilitated Exchange condition participation of national plans in the FFE in one state on their participation in the FFE in another state? Of course, this assumes the national plan could, among other things, put together an adequate provider network in the state.

Each of these questions speak to strategies whereby the Exchange, by taking a more active role on behalf of consumers and small business, could potentially improve plan quality and price for purchasers within the Exchange and influence the insurance and health markets outside the Exchange. It bears emphasis, of course, that just like State Exchanges can be emboldened or constrained by local market conditions, so will the Federally-facilitated Exchange in a particular state have to be informed by the dynamics of the local insurance market. What is possible in a large state with multiple national and local carriers may not be viable in a small state with one dominant insurer. And, in all cases, what is possible inside the Exchange will depend to some degree on what is going on outside the Exchange in that state.

Avoiding Adverse Risk Selection

Regardless of the Exchange model, to ensure a level playing field and to avoid adverse risk selection, uniform rules should be imposed inside and outside the Exchange. Coordination between the Federally-facilitated Exchange and the state insurance department is essential to achieving this level playing field. States will want to apply the same standards that HHS sets for QHPs to plans offered in the individual and small group market outside the Exchange. For example, states could prohibit plans offered outside the Exchange from using marketing and benefit design to avoid enrolling costly enrollees, require them to include ECPs in their networks, and report on quality measures as QHPs do. (In some instances, this will require states to adopt new insurance laws or regulations.) Likewise, where the Exchange has discretion in defining minimum QHP standards, it is has indicated that a Federally-facilitated Exchange would follow state insurance rules. In short,

aligning the standards of QHPs and plans in the external market is critical no matter the Exchange model. And for that reason, in a Federally-facilitated Exchange model, HHS will have to be especially sensitive to rules and activity outside the Exchange and use the tools at its disposal to deter risk selection adverse to the Exchange and ensure a level playing field in and out of the Exchange. Ultimately, the most powerful tools available to HHS may be its authority to set conditions for issuer participation in the Exchange and the application of risk adjustment to plans in and out of the Exchange.

Monitoring and Oversight of Plans

State Insurance departments will need to coordinate plan monitoring and oversight with the Federally-facilitated Exchange. The Exchange is required to monitor QHP compliance and recertify and decertify plans that no longer meet Exchange certification criteria.⁴⁸ At the same time, plan monitoring is a core function of state insurance departments. How these respective monitoring obligations are coordinated or delegated should be discussed and agreed upon by the Federally-facilitated Exchange and the state insurance department to avoid redundancies or, worse yet, conflicting positions.

Consistency will be especially important with respect to the implementation of guaranteed issue, elimination of health underwriting, and the other market reforms that go into effect both inside and outside the Exchange in 2014. The reforms are arguably as important as the coverage expansion mechanisms in the ACA since they do more than any other reform to bring health security to all Americans. They must be implemented consistently across all markets to provide health security to all consumers, and to ensure that they work effectively and are not undermined by uneven application.

CONSUMER ASSISTANCE

Consumer assistance is an essential and core functionality of an Exchange. The value of an Exchange to consumers will in large measure rise and fall with the quality of its consumer assistance services including outreach and education, a website, a call center, a Navigator program, consumer correspondence and complaint resolution capacity. These services are required of Exchanges by the ACA and implementing guidance, and are central to the ability of Exchanges to attract, engage and retain consumers as customers. To do so, these functions must be competitive with the private market, meeting best in class consumer service standards.

These consumer assistance functions, like plan management, are traditional areas of state regulation, and HHS has proposed that some of these consumer assistance functions be

⁴⁸ July 11, 2011 Exchange NPRM Subpart K §§155.1075 and 155.1080.

maintained by the states in a Partnership Exchange, while HHS would operate other consumer assistance functions, such as the website, call center, and eligibility-related customer service. The functions vested with states in the Partnership Exchange, including outreach and education, the Exchange Navigator Program, and in-person consumer assistance, require on the ground, human resources to successfully execute and would seem well suited for state implementation in the Partnership Exchange. States will be able to rely on and leverage existing community-based resources and their broker/agent distribution system to support these functions. States electing to assume responsibility for these consumer assistance functions will need to support a robust outreach program, including:

- Analyzing the uninsured and underinsured target market for the Exchange to develop appropriate Navigator and consumer assistance capacity;
- Establishing the mechanism for the Exchange to compensate Navigators;
- Developing communication and referral protocols between the Exchange and state Navigators and brokers/agents;
- Ensuring that outreach and education materials are current and reflect the most up to date information regarding the Federally-facilitated Exchange; and
- Ensuring that Exchange information technology is supportive to Navigator, broker and other consumer assistance programs.

States have been less enthusiastic about HHS retaining responsibility for the Exchange website, call center and consumer correspondence related to eligibility and enrollment in the Partnership Exchange. While the rationale is sensible – a simple and seamless consumer experience is easiest when one party controls all the eligibility and enrollment functions – there also are valid state claims on these traditional state functions.

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As in other Partnership Exchange functions, there may be middle ground to be found here. For example, there are clear practical benefits for building and maintaining an Exchange website for deployment in multiple states, especially with the work being done through the Enroll UX 2014 project, a public-private partnership between eight national and state health care foundations, the federal government, and 11 participating states, to build a consumer friendly, interactive site to enhance consumer decision-making. However, there is nothing to prevent those projects from being deployed in State-based Exchanges as well as Federally-facilitated Exchanges, and therefore no compelling reason why it has to be on the federal side of the ledger in a Partnership Exchange. There may also be a rationale for states that assume responsibility for plan management to deploy and maintain the website in that the consumer assistance and plan management

functions of an Exchange should be closely linked to enable rapid and accurate updating of product and plan information. More broadly, there may be ways to let states own and brand websites without compromising simple and seamless enrollment, just as states may be able to have some say over call centers without compromising multi-state efficiencies.

FINANCIAL MANAGEMENT

The final core function of the Exchange relates to financial management. As with all of the functions discussed above, cooperation and coordination with state officials will be key. Among other things, the Federally-facilitated Exchange will be responsible for the ACA's three risk spreading programs: risk adjustment, reinsurance and risk corridors. The chart below describes each program, whether it applies to the insurance market outside the Exchange and the entity responsible for administration in the context of a state-based Exchange and a Federally-facilitated Exchange.

Program Applicability by Market and Administration

ACA Provision	Sold within Exchange		Sold Outside Exchange			Who Administers	
	Individual	Small Group	Individual	Small Group	Grand-fathered	State-based Exchange	Federally-facilitated Exchange
Risk Adjustment	Yes	Yes	Yes	Yes	No	State or HHS ¹	HHS
Reinsurance	Yes	No	Yes	No	No	State	State or HHS
Risk Corridor	Yes	Yes	No	No	No	HHS	HHS

¹ State can decide to administer or allow HHS to administer. If HHS administers, all parameters will be federal.

Source: Wakely Consulting Group, *Analysis of HHS Proposed Rules on Reinsurance, Risk Corridors and Risk Adjustment*, RWJF State Health Reform Assistance Network, August 2011

With the possible exception of the reinsurance function, HHS has indicated that the Federally-facilitated Exchange will be responsible for the financial management of both the Federally-facilitated and Partnership Exchange models. In addition to administration of the risk spreading functions, this includes premium processing for the SHOP and data collection for payment processing and payment reconciliation. HHS/CMS will make issuer payment transfers including APTCs and CSRs regardless of Exchange model.

Financing of Exchange operations also plays out differently in each of the Exchange models and also for building the Exchange and for operating the Exchange in 2014 and

beyond. The November 29, 2011 Q&A amended the FOA for Exchange Establishment Cooperative Agreements to provide new guidance addressing state concerns related to availability of federal funding to states that elect the FFE or Partnership Exchange models. Specifically, the Q&A clarifies that Exchange establishment funding authorized under Section 1311 of the ACA is available to states not only for establishing a State-based Exchange, but also for building functions that a State elects to operate under a Partnership Exchange, and to support State activities to build interfaces with a FFE.

The Q&A further indicates that 1311 funding may be awarded until December 31, 2014 for approved establishment activities after that date, including for activities related to improving and enhancing key Exchange functions. This reflects a significant extension of federal funding availability to states.

In 2014, the federal government will underwrite 100 percent of the administrative costs of a State-based Exchange. Federal funds will also be available to states to underwrite the costs of the Exchange functions the state assumes in the Partnership model in 2014. Federal funding will not be available to underwrite the cost of operating a BHP. In 2015 and beyond, Exchanges must be self-sustaining and may fund ongoing operations in a variety of ways including by charging assessments or user fees on participating issuers or, as some states are considering, on all issuers in the individual and small group markets inside and outside of the Exchange. Medicaid will be responsible for underwriting Medicaid related functions of the State-based Exchange, both with respect to administration and the underlying eligibility and enrollment system. Under Medicaid rules, states receive a 75 percent federal match for ACA-compliant eligibility systems and a 50 percent federal match for administrative costs. Medicaid and state Exchanges will need to agree upon a cost allocation methodology to ensure that appropriate costs are charged to Medicaid. It would also seem that to the extent that a state insurance agency assumes tasks that would otherwise be the responsibility of the Exchange, it would be appropriate for the Exchange to reimburse the insurance agency for the related costs. HHS has indicated that it does not anticipate charging states for use of the federal data services hub.

According to the November 29, 2011 Q&A, HHS will not charge states for operating a Federally-facilitated Exchange nor for the functions the FFE retains in the Partnership Exchange, including the costs associated with Medicaid/CHIP eligibility determinations. HHS will share with states the cost of the interface between the FFE and state Medicaid and CHIP agencies. To fund its costs, the Federally-facilitated Exchange will charge user fees to underwrite the cost of operations of the Federally-facilitated Exchange, noting as much at the September 19-20 grantee meeting and also in a letter to the Montana Legislature where it wrote:

“.... Sec. 1311(d)(5)(A) of the Affordable Care Act allows States to collect a user fee to fund the Exchange. CMS anticipates assessing a user fee to fund its costs of

operating a Federally-facilitate Exchange. Although Sec. 1311(d)(5)(A) does not expressly provide the Federally-facilitated government authority to collect user fees when it operates a Federally-facilitated Exchange on behalf of a state, the Federally-facilitated government has general user fee authority (31 USC Sec. 9701) that could be utilized.”⁴⁹

Whether the authority to charge user fees on issuers flows from the ACA or from the federal government’s general user fee authority, the Federally-facilitated Exchange can and in fact must charge such fees in order to sustain the Exchange. While the Federally-facilitated Exchange has the authority to charge fees on issuers participating in the Exchange, it would seem that only the state could decide to extend these fees to issuers outside the Exchange.

Conclusion

Over the next 12 months, the federal government will continue to invest in and build a Federally-facilitated Exchange to operate in states that elect not to operate a State Exchange, or are unable to meet the certification and implementation schedule to stand up their Exchanges in 2014. At the same time, state governments will be evaluating their Exchange implementation options – State-based, Federally-facilitated and Partnership Exchange models – to determine how best to launch an Exchange consistent with the letter and spirit of the ACA and the attributes of their local insurance markets. These models will be further refined and better understood in the coming months, as states and the federal government negotiate common ground with respect to shared responsibility for Exchange functions and funding. Once a state and the federal government agree in principle on the responsibilities each will assume, an equally difficult task follows: namely, turning the agreement into operating protocols and business process flows that delineate when and how information is shared and decision-making transferred between the Exchange and state Medicaid and insurance agencies. Regardless of the model, the goals, requirements and imperatives of Health Insurance Exchanges remain the same: to provide access to affordable health insurance coverage to all Americans through a consumer oriented, best in class commerce experience. And whether state run, federally provided or some combination of both, this vision can only be achieved through intensive collaboration around a common goal.

49 Letter from Joel Ario, Director, Office of Insurance Exchanges, Center for Consumer Information and Insurance Oversight to Economic Affairs Interim Committee of Montana Legislature, dated August 18, 2011.

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