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Newsroom

Affordable Insurance Exchanges: Choices, Competition and Clout for States

On March 12, 2012, the U.S. Department of Health and Human Services (HHS) published a final rule on Affordable Health Insurance Exchanges, which combines policies from two Notices of Proposed Rulemaking (NPRMs) published last summer. One rule, published on July 15, 2011, outlined a proposed framework to enable states to build Affordable Insurance Exchanges (Exchanges), which are new state-based competitive marketplaces created under the Affordable Care Act. A second NPRM, published on August 17, 2011, outlined proposed standards for eligibility for enrollment in qualified health plans through the Exchange and insurance affordability programs, including premium tax credits.

Starting in 2014, one-stop marketplaces called Exchanges will be operational, enabling consumers and small businesses to choose a quality, affordable private health insurance plan that fits their health needs. Exchanges will offer health insurance options that meet consumer-friendly standards; facilitate consumer assistance, shopping for and enrollment in a private health insurance plan; and coordinate eligibility for premium tax credits and other affordability programs that ensure health insurance is affordable for all Americans. Through Exchanges, the public will have the same kinds of insurance choices as members of Congress.

Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs.

The final rule released today offers a framework to assist states in setting up Affordable Insurance Exchanges. The framework preserves and, in some cases, expands the significant flexibility in the proposed rules that enables states to build an Exchange that works for their residents. For example, the final rule allows states to decide whether their Exchange should be operated by a non-profit organization or a public agency, how to select plans to participate, and whether to partner with HHS for some key functions. The final rule also offers significant additional flexibility regarding the eligibility determination process. It also makes it easier for small businesses to get coverage through the Small Business Health Options Program (SHOP), strengthens consumer protections, and keeps it simple for health plans interested in participating in Exchanges.

The final rule builds on over two years' work with states, small businesses, consumers and health insurance plans. The Administration examined models of Exchanges; held numerous meetings with stakeholders; and consulted closely with state leaders, consumer advocates, employers and insurers. Before the proposed and final rule was issued, HHS published a Request for Comment (the RFC) on August 3, 2010 on a number of policy issues addressed in the rules. In response to the proposed rules, HHS received approximately 24,780 comments from the public. The commenters represented a wide variety of stakeholders, including but not limited to states, tribes, tribal organizations, health plans, consumer groups, healthcare providers, industry experts, and members of the public. In the final rule, we have responded to comments submitted in response to the Exchange establishment and eligibility proposed rules and the RFC, where relevant. In addition to those comments received formally, HHS also

engaged in listening sessions with a wide range of stakeholders across the country after the proposed rules were released. This public input was also integral to the development of the final rule policy.

The Exchange final rule includes standards for:

- The establishment and operation of an Exchange
- Health insurance plans that participate in an Exchange
- Determinations of an individual's eligibility to enroll in Exchange health plans and in insurance affordability programs
- Enrollment in health plans through Exchanges
- Employer eligibility for and participation in the Small Business Health Options Program (SHOP)

This final rule is the latest in an ongoing series of steps to help states develop Exchanges. As of February 22, 2012, 49 states and the District of Columbia have received Exchange Planning grants, while 33 states and the District of Columbia have received Exchange Establishment grants. HHS is continuing to provide technical assistance to states, including technical consultations, monthly user groups, working groups on core functions, and conferences.

Public Comment

The comment period for the proposed rules ended October 31, 2011. HHS received approximately 24,780 comments on both proposed rules that informed the final rule policies. Several provisions in the final rule, which are being issued as interim final, are open to further public comment. This includes the new flexibility for the eligibility process.

Establishment of Exchanges

The final rule outlines the standards for a state to establish an Exchange while prioritizing state flexibility in numerous ways. For example, each state can structure its Exchange in its own way: as a non-profit entity established by the state, as an independent public agency, or as part of an existing state agency. In addition, a state can choose to operate its Exchange in partnership with other states through a regional Exchange or it can operate multiple Exchanges that cover distinct areas within the state. Any combination of these options can be approved. Exchanges that are run by independent agencies or non-profits must have governance principles, include consumer representation, and that ensure freedom from conflicts of interest and promote ethical and financial disclosure standards.

Exchanges will perform a variety of functions, including:

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

States have substantial flexibility in determining how to perform these functions. The final rule simplifies the process for states' Blueprints for Exchanges to be approved and updated; empowers states

to determine a role for agents and brokers – including the use of on-line brokers; and removes processing of appeals from minimum Exchange functions.

Affordable Care Act provides that a state's plan to operate an Exchange must be approved by HHS no later than January 1, 2013. However, the final rule allows for conditional approval if the state is advanced in its preparation but cannot demonstrate complete readiness by January 1, 2013. The final rule also allows states that are not ready for 2014 to apply to operate the Exchange for 2015 or any subsequent year. HHS will continue working with states to support their progress, including through new funding opportunities. New funding will be available for all Exchange models through a final award date no later than December 31, 2014. The budget and project period for Level One Exchange Establishment Grants is up to one year from the date of award and for Level Two Exchange Establishment Grants is up to three years from the date of award.

Qualified Health Plans

Health plans offered through the Exchange must be certified as "qualified health plans". Qualified health plans s will provide high-quality coverage like that of a typical employer plan. To be certified by the Exchange, health plans must meet minimum standards that are primarily defined in the law. The final rule gives Exchanges the flexibility to establish additional standards for health plans offered in their Exchanges. For example, Exchanges have flexibility on the:

- **Number and Type of Health Plan Choices:** The final rule allows Exchanges to work with health insurers on structuring qualified health plan choices that are in the best interest of their customers. This could mean that the Exchange allows any health plan meeting the standards to participate or that the Exchange creates a competitive process for health plans to gain access to customers on the Exchange.
- **Standards for Health Plans:** The final rule allows Exchanges, working with state insurance departments, to set specific standards to ensure that each qualified health plan gives consumers access to a variety of providers within a reasonable amount of time. Exchanges will also establish marketing standards to make sure that qualified health plans do not market plans in a way that discriminates against people with illnesses. It also gives Exchanges flexibility to set the timeframes in which health issuers need to become accredited for their quality performance (if they are not already), allowing consumers access to new and innovative health plans through the Exchange as they gain accreditation. And it amends the grace period policy to ensure that qualified health plans can provide seamless coverage without being left paying all the bills.

Eligibility

The Exchange final rule establishes a streamlined, coordinated, and web-based system through which an individual may apply for and receive a determination of eligibility for enrollment in a qualified health plan through the Exchange and for insurance affordability programs. This means that no matter how an application is submitted or which program receives the application, an individual will use the same application and receive a consistent eligibility determination, without the need to submit information to multiple programs. This consumer-focused approach will facilitate the enrollment of millions of Americans into affordable, high quality coverage while minimizing the administrative burden on states, individuals, and health plans.

- **Eligibility Determinations:** The final rule outlines standards and processes for Exchanges to consider whether consumers are eligible for all available programs using a single, streamlined application, meaning that consumers do not have to guess what programs they are eligible.

Consumers will be able to easily notify the Exchange of any changes that might affect their eligibility, including marriage, divorce or a job change. The final rule also ensures that Exchanges will make it easy for consumers to keep their coverage year to year through a simple eligibility redetermination process.

- **Simple Verification of Data:** To reduce paperwork and red tape for consumers, the final rule directs Exchanges to rely on existing electronic sources of data to the maximum extent possible to verify relevant information, with high levels of privacy and security protection for consumers. For the majority of applicants, an automated electronic data matching process should eliminate the need for paper documentation.
- **Coordinating across Programs:** The final rule ensures that Exchanges will coordinate with Medicaid, CHIP, and the Basic Health Program, where applicable, to ensure that an applicant experiences a seamless eligibility and enrollment process regardless of where he or she submits an application.
- **New Options for States:** In response to comments, the final rule provides two ways for Exchanges to interact with Medicaid agencies when making eligibility determinations: Exchanges, following state-established Medicaid rules, can conduct eligibility determinations for Medicaid and for advance payment of premium tax credits; or the Exchange will make the preliminary eligibility assessment and turn it over to the state Medicaid agency, if applicable, for final determination, within certain parameters. In addition, a state-based Exchange may determine eligibility for advance payments of the premium tax credit and cost-sharing reductions or it could be approved if HHS makes determinations for these functions. These approaches continue the commitment to facilitating enrollment in the appropriate insurance affordability program without delay.

Enrollment

Once determined eligible, the integrated enrollment system of the Exchange will use a streamlined, simple system to ensure that eligible Americans successfully enroll in the health coverage that best fits their needs. The enrollment process outlined in the final rule will be geared toward consumers and will use websites and toll-free call centers, among other tools, to help people enroll in coverage. Exchanges will enable consumers to learn about the varieties of coverage provided in the market so that they can make informed choices about the coverage available on the Exchange. Exchanges have options to improve the performance of this system through the design of their website. Exchanges may also decide whether to use the single application that will be made available or design one on their own that is comparable. Like the eligibility process, the final rule ensures that the enrollment process meets high standards regarding the privacy and security of personal information.

The final rule also provides standards for Exchanges to build partnerships with and award grants to entities known as “Navigators” who will reach out to employers and employees, consumers, and self-employed individuals to:

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

Exchanges will award grants to Navigators. The final rule directs states to choose at least two Navigator

organizations, one of which must be a community or consumer-focused non-profit organization.

Small Business Health Options Program (SHOP)

Beginning in 2014, Exchanges will operate a Small Business Health Options Program (SHOP). The SHOP will provide small employers with new ways to offer employee health coverage, better information, easier administration, and access to tax credits that make coverage more affordable.

As described in the final rule, the SHOP will allow employers to choose the level of coverage they will offer and offer the employees choices of all qualified health plans within that level of coverage. This allows employees a choice among plans and can select the one that best fits their needs and their budget. Employers can offer coverage from multiple insurers, just like larger companies and government employee plans, but get a single bill and write a single check. SHOP Exchanges can also allow employers to select a single plan to offer its employee, like is typically done today. And the final rule allows minimum participation rules to be met through coverage in any SHOP plan, not a single one.

Exchanges will decide how a SHOP is structured. Specifically, the final rule provides flexibility with regard to:

- **Size of small businesses that can participate in SHOP:** States can set the size of the small group market at either 1 to 50 or 1 to 100 employees until 2016. In 2016, employers with between 1 and 100 employees can participate in a SHOP. And, starting in 2017, states have the option to let businesses with more than 100 employees buy large group coverage through the SHOP.
- **Structure of choices for small businesses:** Exchanges can choose to offer employers additional ways to provide coverage, including allowing their employees to choose any plan in all levels of coverage or a traditional “employer choice” offer of a single plan.

Starting in 2014, small employers purchasing coverage through SHOP may be eligible for a tax credit of up to 50% of their premium payments if they have 25 or fewer employees, pay employees an average annual wage of less than $50,000, offer all full time employees coverage, and pay at least 50% of the premium.

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