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REFORM Update

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The Department of Health and Human Services (DHHS) recently published its final rules for Health Exchanges. In 2014, a number of health care reform requirements will drastically change the health insurance market:

- Employers will be required to "play or pay." This means they must offer a qualifying, affordable health plan to full-time employees, or pay a penalty for failing to offer coverage. In order to be considered "qualified," the employer plan will be required to offer at least a 60 percent benefit level that costs no more than 9.5 percent of an employee's household income for single coverage.
- Everyone will be required to "play or pay." This means people must buy and maintain health coverage or pay a penalty. The Supreme Court is currently reviewing this provision to ensure it is constitutional.
- States will be required to establish a new marketplace to buy insurance coverage. Carriers will no longer be able to medically underwrite applicants, nor will they be permitted to exclude or limit coverage for pre-existing conditions. This new market is being called the Affordable Insurance Exchange.

The Exchanges must meet a number of requirements for affordable, quality health coverage. The latest rules relate to the framework that states should use when they create their Affordable Insurance Exchanges. The rules establish:

- Minimum standards for establishing Exchanges
- Minimum Exchange functions
- Process for determining eligibility
- Enrollment periods
- Minimum Small Business Health Options Program (SHOP) functions
- Certification of health plans
- Requirements for health quality improvement standards

DHHS has taken a number of steps to help states establish operational Exchanges by 2014. As of February 2012, the District of Columbia and 49 states have received federal grants to help pay for establishing Exchanges. Beginning January 1, 2015, states will no longer be awarded federal money for these administration costs. States can generate funding through user fees on Exchange participating insurers.

The federal government will establish an Exchange for any state that chooses not to establish one. In addition, the federal government can step in if it does not believe a state will be capable of launching an operable Exchange by 2014.

This *Update* reviews the standards for establishing and operating Exchanges.

Establishment and Operation of the Exchange

States will have flexibility when they build their Exchanges. An Exchange can be a number of different entities, such as a non-profit entity, an independent public agency established to operate the Exchange, or a part of an existing state agency. A state can also partner with other states to offer a regional Exchange or establish multiple Exchanges to cover distinct areas within the state.

Exchanges run by a non-profit entity or an independent state agency must establish governing principles and create a governing board.

The governing principles include:

- Principles on ethics, conflicts of interest standards, accountability/transparency standards and disclosure of financial interests. This information must be made public.
- Procedures for board members to disclose financial interests.
- Continual consulting with key stakeholders, including qualifying health plan members, entities facilitating enrollment, businesses, advocates for hard-to-reach populations, Medicaid and Children's Health Insurance Plan (CHIP) agencies and public health experts.

The governing board must:

- Be administered under a formal, public charter or by-law.
- Hold regular public board meetings announced in advance.
- Include members that represent consumer interests:
    - At least one voting member must be a consumer representative.
    - The majority of voting members, such as health insurance issuers, agents, brokers or licensed insurance agents, cannot have conflicts of interest.
    - A majority of voting members must have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery, or public health.

Exchanges will perform a variety of functions, including:

- Certifying that health plans are "qualified health plans" (QHPs) and can be offered by the Exchange.
- Operating a website to help people compare QHPs.

- Determining eligibility for QHP enrollment and for insurance affordability programs such as Medicaid, CHIP and premium credits to subsidize the cost of coverage.
- Facilitating enrollment in QHPs.
- Operating a toll-free call center for consumer assistance.
- Providing grant money to Navigators to provide additional support, education and outreach regarding the Exchange.

The Exchange must also evaluate quality improvement strategies. These strategies include overseeing enrollee satisfaction surveys, assessing and rating health care quality and outcomes, and various disclosures and reporting requirements.

The Exchange website must meet the following form and function requirements:

- Provide standard information to help applicants compare QHPs, including, at a minimum:
  - Premium and cost-sharing information
  - The Summary of Benefits and Coverage (SBC)
  - An indication of whether the plan is bronze, silver, gold or platinum
  - Results of the satisfaction surveys that health care reform requires
  - Quality ratings that health care reform requires
  - Medical loss ratio information
  - Transparency of coverage measures that must be reported as part of the certification process
  - The provider network
- Publish specific financial data related to the Exchange, such as regulatory fees and administrative costs.
- Provide information on Navigators and other consumer assistance services.
- Perform eligibility determinations (as described in the next section).
- Allow people to select and enroll in QHPs.
- Include an electronic calculator to help people compare QHPs, after taking into account any premium tax credits and cost-sharing reductions available to them.

Many rules apply to designating Navigators. Navigators can be private or public entities, or qualified individuals licensed to assist with the Exchange. They receive financial grants for performing their services. The financial grants are intended to guard against conflicts of interest or financial incentives for steering applicants to specific QHPs. Navigators must also have specific training to ensure their expertise in the following:

- Needs of underserved and vulnerable populations
- Eligibility and enrollment rules and procedures

- Range of QHPs available and the insurance and affordability programs
- The privacy and security standards required of the Exchange

Navigators cannot be health insurance issuers or subsidiaries of an issuer. They also cannot be members of an association that lobbies on behalf of the insurance industry.

States can design the Exchange so that it will achieve the functions previously outlined. Before it approves each state's Exchange operational standards, DHHS will verify the following:

- Can the Exchange carry out the functions health care reform requires?
- Can the Exchange carry out the designated Internal Revenue Code information reporting requirements?
- Does the Exchange service area include the whole state? States may have multiple exchanges, but each part of the state must be covered.

The DHHS approval process requires states to:

- Submit an Exchange Blueprint that describes how the Exchange will meet the standards health care reform requires.
- Demonstrate the state is ready to implement the Exchange Blueprint using a DHHS readiness assessment.

Each state will be required to receive written or conditional approval by January 1, 2013, in order to be considered an approved Exchange. If a state chooses not to operate an Exchange, or does not have a written or conditionally approved blueprint by January 1, 2013, then DHHS will operate the Exchange for the state. DHHS can administer the Exchange directly or appoint a non-profit entity to run the Exchange. If a state subsequently decides to run its own Exchange, it must receive approval at least 12 months in advance. It also must develop a plan with DHHS to handle the transition from the federal Exchange.

States may permit agents and brokers to help clients evaluate Exchange coverage and enroll in Exchange options. Brokers will need to meet certain requirements to help with Exchange coverage.

Determination of Eligibility for Exchange Health Plans and Insurance Affordability Programs

The Exchange will develop a web-based, coordinated process that individuals can use to determine whether they are eligible for health plans and insurance affordability programs. Determining eligibility will be a complicated process behind the scenes. However, for consumers, it will be a single source entry point to Exchange products, Medicaid and premium assistance subsidies.

The process should include:

- An initial assessment to determine whether the applicant or any family member is eligible for Medicaid or the state's Children's Health Insurance Program (CHIP). The Exchange determines this eligibility based on the state's applicable income standards. It will also verify citizenship and immigration status as federal law requires. If an applicant is determined to be potentially eligible for Medicaid or CHIP, the Exchange will transfer all information provided during the application process to the state Medicaid or CHIP agency using a secure electronic interface. This data transfer must occur promptly.
- The Exchange must notify applicants not eligible for Medicaid or CHIP and allow them to:
    - Withdraw the application for Medicaid or CHIP.
    - Request a full determination of their eligibility for Medicaid or CHIP. If they make this request, the Exchange must transfer all information to the appropriate state agency. If the applicants request a full determination, the Exchange can consider them ineligible and proceed to the next step, determining whether they are eligible for premium credits. The full determination may take some time. The premium credit determination will allow these applicants to find more immediate coverage.
- Once applicants are determined to be ineligible for Medicaid or CHIP, the Exchange will evaluate the applicants' information to determine whether they are eligible for advance payments of premium credits or cost-sharing credits. The Exchange is allowed to make these determinations, provided:
    - These determinations are in accordance with DHHS standards.
    - The Exchange sends all the information received during the application process, mid-year updates and the renewal process to DHHS using a secure electronic interface. This data transfer must occur promptly. DHHS can then perform its own eligibility determination for premium credits and cost-sharing assistance.
    - The Exchange must agree to adhere to the DHHS eligibility determination for premium credits and cost-sharing assistance.
    - The Exchange and DHHS enter into an agreement outlining their respective responsibilities related to these processes.

The eligibility process for Medicaid, CHIP, premium assistance and coverage from QHPs will be streamlined by allowing the Exchange to assimilate the data for eligibility determinations. The expectation is that the eligibility determination will be coordinated across DHHS, the Exchange, state Medicaid and CHIP agencies.

The Exchange must determine the non-financial eligibility criteria for Medicaid or CHIP. They will also determine whether an applicant meets the non-financial eligibility criteria for premium assistance or cost-sharing credits. Remember, the financial requirement to qualify for premium assistance is that the household income cannot be expected to exceed 400 percent of the federal poverty level during the benefit year for which coverage is requested.

The Exchange must determine if the individuals are eligible to enroll in a QHP (outlined below). The Exchange must also confirm whether the applicant is ineligible for minimum essential coverage, including qualifying employer-sponsored coverage, Medicaid, Medicare and other governmental health plans. Any applicant who **is not eligible** to enroll in a QHP, or who **is eligible** for minimum essential coverage, **will not be eligible** for premium assistance or cost-sharing credits.

The Exchange must require enrollment in a QHP to pay premium credits. If the IRS notifies the Exchange that an applicant and spouse did not file a joint tax return for the year in which tax data is used to determine household income, then the applicant will not be eligible for advanced premium credits. Premium credits appear to be permitted at the time taxes are filed, as long as the married couple files jointly.

The Exchange will be required to notify applicants eligible for premium assistance or cost-sharing credits. If the applicant is employed, the Exchange must notify the employer that the employee has enrolled for Exchange coverage and is receiving subsidies. This is done so employers are aware of potential penalty situations.

The Exchange will evaluate whether the applicant meets the eligibility standards to enroll in a QHP. The applicant must meet the following requirements:

- Applicants must be citizens, nationals of the United States or non-citizens lawfully present in the United States and expect to be lawfully present for the entire period for which coverage is sought.
- Applicants must not be incarcerated. An exception is made pending the disposition of charges.
- Applicants must satisfy specific residency requirements, which generally means they must be residents of the QHP service area. Special rules will apply for tax households with members in multiple Exchange service areas.

The Exchange will need to establish a process to verify the information an applicant provides, specifically the information on eligibility for insurance affordability programs. This process will involve sending data to DHHS, which will verify information primarily with the IRS. Reasonable variations will be acceptable. However, if the process reveals significant discrepancies, then the Exchange will require the applicant to prove his or her reported information is correct.

The Exchange must also verify eligibility and enrollment in employer-sponsored health coverage. It should require applicants to state whether they are enrolled or eligible for coverage in such a plan. The Exchange can verify the information, but there are few details about how the Exchange will do this.

The Exchange must re-determine an enrollee's eligibility for a QHP and any insurance affordability programs every year before open enrollment. The enrollee will be required to provide updated information as part of the process. Once it confirms the enrollee is still eligible, the Exchange will notify both the enrollee and the enrollee's employer.

Enrollees will also be required to report any eligibility changes within 30 days. The Exchange must periodically check various data sources to identify a death or a potential eligibility issue for Medicare, Medicaid or CHIP. It will be required to report changes to DHHS.

The Exchange must also create an appeal process for adverse QHP eligibility determinations and insurance affordability program determinations.

Enrollment Process for Exchange Health Plans

Once eligibility is verified, applicants will have to enroll in a plan option. This may mean enrolling in Medicaid. It could also mean choosing an individual plan.

The Exchange will coordinate the enrollment process by:

- Notifying the insurer of the applicant's QHP selection.
- Transmitting to the QHP any data necessary to enroll the applicant.
- Establishing a process that allows the QHP to acknowledge it has received the applicant's information.
- Maintaining enrollment records of all the QHPs in the Exchange.
- Reconciling enrollment records with QHPs at least monthly.

The Exchanges will offer enrollment opportunities during specific times:

- **Initial Open Enrollment Period:** The initial enrollment period occurs when the Exchanges are launched. It will begin on October 1, 2013, and run through March 31, 2014.
- **Annual Open Enrollment Period:** For benefit years beginning on or after January 1, 2015, the annual open enrollment period will begin on October 15 and run through December 7. Open enrollment elections are effective as of January 1.
- **Special enrollment periods:** The Exchange must allow qualified individuals and enrollees to elect or change coverage mid-year if any of the following events occur:
    - Loss of minimum essential coverage (applies also to dependents).
    - Gaining a dependent or becoming a dependent through marriage, birth, adoption or placement for adoption.
    - Newly attained status as a U.S. citizen, national or lawfully present individual.
    - An Exchange error, misrepresentation or inaction of an Exchange party.

- Proof that the QHP substantially violated a material provision of its contract with the enrollee.
- Becoming newly eligible for an insurance affordability program, regardless of whether or not the individual is currently enrolled in a QHP.
- Gaining access to new QHPs because of a permanent move.
- Exceptional circumstances as defined by DHHS.

Finally, an American Indian who meets specific requirements may change enrollment or change QHPs once a month.

During the initial enrollment period, if a potential enrollee applies for coverage on or before December 15, 2013, coverage must be effective on January 1, 2014. If a potential enrollee applies between the 1st and the 15th of a subsequent month, the effective coverage date will be the first of the following month. If a potential enrollee applies between the 16th and the last day of a month, coverage becomes effective the first day of the month following the subsequent month. Exchanges can opt for earlier effective dates, but that would require the approval of all the QHPs in the Exchange.

Beginning in 2014, Exchanges will be required to send a written annual open enrollment notice to each QHP enrollee. The notice will state open enrollment rights, and must be sent between September 1 and September 30 of each year.

For special enrollment periods, the individual has 60 days from the date of the triggering event to change or enroll in a QHP. If the event is the loss of minimum essential health coverage, the loss of coverage cannot include terminations because of fraud or failure to pay premiums.

The rules also deal with premium payments. The Exchange must allow a qualified individual to pay any required premiums to a QHP directly. American Indian tribes must be permitted to pay premiums on behalf of qualified individuals. The Exchange is required to provide a three-month grace period for anyone receiving advance payments of premium credits. Coverage termination dates will depend on the situation:

- On the date requested, if the enrollee provides reasonable notice.
- Fourteen days after the termination request, if the enrollee **does not** provide reasonable notice.
- On the day before other coverage begins, if the enrollee is newly eligible for Medicaid, Medicare or CHIP. This is also true of coverage terminations related to changing plans during open enrollment.
- On the last day of the first month of the grace period, if payment is not received within the three-month grace period.

QHPs must track terminations and report them to DHHS.

Health Insurance Plans Requirements in the Exchange

The Exchange must certify any health plan it offers is a "qualified health plan." To be considered qualified, a plan must meet the following minimum standards:

- Be licensed and in good standing to offer coverage in each state where it is available.
- Ensure that it complies with required benefit standards.
- Meet any Exchange accreditation requirements.
- Comply with all the Exchange rules for eligibility processes and communication requirements.
- Implement and report on quality improvement strategies that health care reform recommends.
- Pay any applicable user fees for Exchange participation.
- Participate in the standards related to a risk adjustment program.
- Report specific information to DHHS on prescription drug coverage such as prescription utilization, rebates, discounts, price concessions and differences between what is paid to pharmacies and what is billed to the plan.

States can establish additional standards for health plans their Exchanges offer. They can work with health plans to structure benefits that are in the best interest of consumers and allow any qualifying plan to be offered through the Exchange. The Exchange could create a competitive process for health plans offering qualified coverage through the Exchange. It is expected that Exchanges will establish marketing rules for the plans they offer.

Insurers must offer at least one silver tier plan and one gold tier plan. In addition, they must provide rate and benefit information to the Exchange and justify any rate increases. The justification must be posted on the carrier's website.

The insurers will also have to provide a host of information to the Exchange, including:

- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment/disenrollment
- Data on number of claims denied
- Data on rating practices
- Information on cost-sharing and payments made to non-participating providers

The insurer must meet certain network adequacy standards if the plan has an associated provider network.

Privacy and Security Standards

These final rules include privacy and security standards that the Exchange and any associated entities must adopt. The standards are intended to protect "personally identifiable information," and are very similar to the protection HIPAA's Privacy and Security rules require. Only HIPAA-covered entities, like insurance carriers, are required to comply with the HIPAA rules. The Exchange itself, and any entities that may have a contract with the Exchange, are unlikely to be HIPAA-covered entities. Instead of extending the actual HIPAA rules to these organizations, the final rules apply similar requirements to organizations operating in the Exchange.

The following safeguards must be established:

- Ensure the confidentiality, integrity and availability of personally identifiable information the Exchange created, collected, used and/or disclosed.
- Ensure that personally identifiable information may be used or disclosed only by those authorized to receive or view it.
- Protect against any reasonably anticipated threats or hazards to the confidentiality, integrity and availability of such information.
- Protect against any reasonably anticipated use or disclosure of the information that is not permitted or required by law.
- Ensure personally identifiable information is securely destroyed or disposed of appropriately.
- Monitor and periodically assess system risks, and update security controls.
- Develop and use secure electronic interfaces when sharing personally identifiable information electronically.

The Exchange and any associated entities must monitor workforce compliance with security protocols. Security policies and procedures must be established in writing and disclosed to DHHS upon request.

Small Business Health Options Program (SHOP)

The SHOP Exchange can be run along with the individual coverage Exchange or as a separate Exchange. SHOP will be responsible for meeting all the Exchange requirements outlined in this *Update*.

In 2014, only "small businesses" can purchase coverage through a state's SHOP Exchange. A small business is one with between 1 and 100 employees, but states can reduce the limit to 50 employees. In 2017, states can also open their SHOP Exchanges to larger employers.

Employers choosing to obtain coverage through the SHOP Exchange can define their contribution for health plan coverage and designate the metal tier plan they offer their employees. For example, an employer may choose to offer "silver" level coverage. Employees of the company will be able to choose any silver plan option the Exchange offers.

The SHOP will have additional responsibilities regarding group health plan coverage:

- It must make at least one metal tier option available. However, states can permit employers to offer employees more than one metal tier.
- It must handle the enrollment of all employees into the QHP of their choice.
- It must perform a number of functions related to premium billing:
  - Provide each qualified employer with a monthly bill that identifies the employer contribution, the employee contribution and the total amount due to the QHPs.
  - Collect the total amount due and make payments to any QHPs covering the employees of that employer.
  - Maintain records of the premium billing and payments for at least ten years.
- It must require that QHPs change rates only at regular intervals (monthly, quarterly or annually) and prohibit QHPs from changing rates during an employer's plan year.
- It may authorize uniform group participation rules based on employees securing coverage through the SHOP. Participation rules cannot apply to selecting a particular QHP.
- It must offer a premium calculator to help compare QHP costs. This calculator will determine net employee cost after accounting for the employer subsidy.
- It must verify an employer is eligible to purchase SHOP coverage. It must also verify each eligible employee with the employer.
- It must handle an employer's withdrawal from the program and will be responsible for terminating all employees from their QHPs. It must also notify the employees of the coverage termination.
- It must maintain all records for at least ten years.
- It must report employer participation, employer contributions and employee enrollment information to the IRS.

Mid-year enrollment opportunities in the SHOP Exchange will be only slightly different from those in the individual Exchange. The SHOP does not have to offer a special enrollment period for anyone who becomes a U.S. citizen, national or is lawfully present or to anyone newly eligible for any insurance affordability program.

The SHOP must permit a qualified employer to purchase coverage at any time. The employer's plan year for SHOP purposes will be the 12-month period following the group coverage effective date. The SHOP must notify the employer of the annual election period and establish a standard open enrollment period for each employer. Employers must be given no fewer than 30 days before the open enrollment period to make annual changes, including those to employer contributions and the metal tier of coverage.

The SHOP will handle the enrollment of newly eligible employees during the plan year.

Once the SHOP Exchange is established, it will administer any small employer health plan tax credits.

Concluding Thoughts

The framework proposed in these final rules is complex. The federal government intends to create a streamlined, single-point enrollment stop for Medicaid, CHIP, Exchange coverage, premium assistance and cost-sharing subsidies. This single stop will require tremendous coordination among a number of governmental agencies and insurance carriers. Hopefully, many of the requirements will be successfully automated.

The scope of what needs to be accomplished in less than two years is overwhelming. Officially, Exchange development in many states is currently on hold, pending the Supreme Court's ruling on various provisions of the health care reform legislation. However, some states are moving forward behind the scenes and establishing plans to operate their Exchanges. States do not have much lead time to achieve the goals outlined in these latest rules.