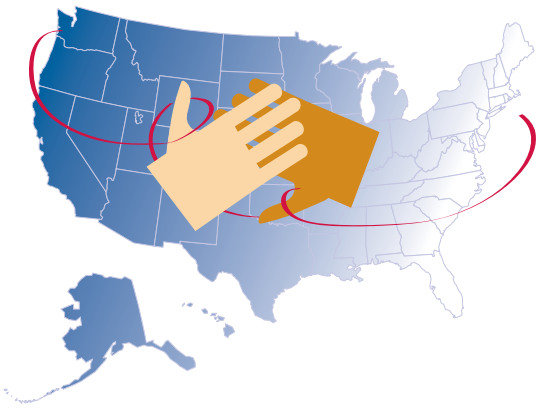

Implementing Exchanges

A series of briefs from Families USA on implementing health insurance exchanges

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State Responsibilities in a Partnership Exchange

Under the Affordable Care Act, every state must have a health insurance exchange where individuals and small businesses can obtain affordable coverage starting in 2014.[1] We are fast approaching the November 16 deadline[2] by which states must tell the U.S. Department of Health and Human Services (HHS) which type of health insurance exchange they will have for that year.[3] States have the following three options to choose from:

- A state-based exchange, where a state runs its own exchange directly.
- A federally facilitated exchange (FFE), where the federal government operates an exchange for the state.
- A partnership exchange, where the state operates some specific exchange functions within an FFE.

States that choose a partnership exchange may conduct plan management, in-person consumer assistance, or both functions within their FFE. If a state chooses to perform plan management, it is responsible for functions such as certifying that insurance plans meet the requirements to sell coverage in the exchange and are therefore qualified health plans (QHPs). If a state elects to run in-person consumer assistance, it will be responsible for overseeing the navigator program and for providing in-person assistance through other entities to consumers who need help with coverage.

This brief summarizes the functions that states must perform if they choose to implement a partnership exchange. The information that follows is based on the Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges,[4] from HHS. In addition, this piece describes the functions that the federal government performs in a partnership exchange and outlines key exchange deadlines.

State Functions in a Partnership Exchange

The following lists outline which functions states must perform in a plan management or consumer assistance partnership exchange. States that choose to operate both plan management and in-person consumer assistance must perform the functions that are listed in both sections. For each function, we provide the corresponding "Exchange Activity" number, as listed in HHS's *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges*.

State Functions in a Plan Management Partnership

- **Authority to certify QHPs (Activity 4.1):** The state must have statutory and/or regulatory authority to certify and oversee health insurance plans to ensure that they comply with QHP standards.
- **Process to certify QHPs (Activity 4.2):** The state must have a process to make sure that QHPs meet the following standards for both the individual and Small Business Health Options Program (SHOP) exchanges before annual open enrollment starts (for the 2014 plan year, enrollment starts on October 1, 2013):
  - QHP standards, including, but not limited to, standards relating to licensure, solvency, service area, network adequacy, essential community providers, marketing and discriminatory benefit design, accreditation, and consideration of rate increases
  - Actuarial value standards
  - Essential health benefits standards
  - Market reform standards

  This certification process must include a plan for integration between the exchange and the state's insurance department, where applicable.
- **Systems and processes to collect, analyze, and manage data on QHPs (Activity 4.3):** The state must have systems and processes to collect QHP information (such as premiums, covered benefits, and cost-sharing requirements) so that it can certify QHPs, provide plan information to consumers, share information with the exchange's federally run functions, and perform other critical functions that require plan data, such as determining which plan in the exchange is the second-lowest cost silver plan so that premium tax credits can be calculated.
- **Processes for monitoring ongoing compliance with QHP standards (Activity 4.4):** The state must have a process to ensure that QHPs maintain compliance with QHP standards, including monitoring QHP performance and collecting, analyzing, and resolving enrollee complaints in conjunction with any applicable state agencies.
- **Technical assistance for QHP insurers (Activity 4.5):** The state must provide technical assistance to participating insurance companies to ensure ongoing compliance with QHP standards.

- **Process for recertifying QHPs (Activity 4.6):** The state must have a process for recertifying QHPs for exchange participation, including a process for the annual collection and review of premium, benefit, and cost-sharing data.
- **Process for decertifying QHPs (Activity 4.6):** The state must have a process for decertifying QHPs that do not comply with QHP standards, including a process for transitioning enrollees into a different QHP and for allowing QHPs to appeal a decertification.
- **QHP accreditation timeline (Activity 4.7):** The state must have a timeline under which QHPs must be accredited, and it must have systems and procedures to ensure that insurance companies meet accreditation requirements as part of QHP certification.
- **QHP quality reporting (Activity 4.8):** The state must have systems and procedures to ensure that QHP insurance companies comply with required quality reporting to the exchange and to HHS.
- **Compliance with HHS information technology (IT) guidance; adequate IT infrastructure and bandwidth; and independent verification and validation, quality management, and test procedures (Activity 9.0):** The state technology and system functionality must comply with HHS guidance and be adequate to support all required exchange activities. The state must effectively implement quality and test procedures for business processes of the exchange and demonstrate that it has achieved HHS-defined functionality for each required activity.

Agreements and coordination with the FFE (Activity 13.1): The state must have agreements in place with the FFE that will ensure coordination with and data submission to the FFE.[5]

State Functions in a Consumer Assistance Partnership

- **Support, administration, and oversight for aspects of the navigator program established by the FFE (Activity 13.3a):** The state must have a plan to ensure that navigators—entities that receive grants from the exchange to provide unbiased information to consumers and small businesses about coverage options—are adhering to training, conflict of interest, and privacy and security standards established by the FFE.
- **Establishment of an in-person assister program (Activity 13.3b):** The state must establish an in-person assistance program that is distinct from the navigator program and that complies with FFE guidance, policies, and procedures.

Functions Required of All Partner States

The following are responsibilities of all partner states, whether they choose to operate plan management, consumer assistance, or both:

- **Capacity to interface with the FFE to ensure a seamless consumer experience (Activity 13.2):** The state must have the capacity to coordinate with the FFE on customer service, outreach, and education and to share data that are necessary for supporting eligibility processes.
- **Compliance with privacy and security standards (Activities 10.1 and 10.2):** Plan management partner states, and, if applicable,[6] consumer assistance partner states, must establish and implement written policies and procedures for the privacy and security standards outlined in the final exchange rule from HHS.[7] Plan management partner states must implement safeguards that ensure the protection of personally identifiable information as described in the final exchange rule,[8] and they must incorporate HHS IT requirements where applicable.
- **Oversight and monitoring (Activity 11.1-11.3):** Plan management partner states, and, if applicable,[9] consumer assistance partner states, must have a process to perform required oversight and monitoring of exchange activities that includes quality controls, the capacity to track and report performance and outcome metrics as specified by HHS, and procedures and policies to promote compliance with financial integrity requirements regarding accounting, reporting, auditing, cooperation with investigations, and the False Claims Act.
- **Contracting, outsourcing, and agreements (Activity 12.1):** Plan management partner states, and, if applicable,[10] consumer assistance partner states, must execute appropriate contractual, outsourcing, and partnership agreements with vendors and/or state and federal agencies as needed, including data and privacy agreements. Partner states must also comply with regulatory requirements regarding which entities are eligible exchange contractors.[11]
- **Transition of individuals enrolled in the Pre-Existing Condition Insurance Plan (PCIP) (Activity 3.14):** Where applicable, states must follow HHS procedures[12] related to the transition of PCIP enrollees into the exchange.

Additional Flexibility: Medicaid Eligibility and Reinsurance

All states, regardless of the exchange model they adopt, must implement Medicaid program modifications required under the Affordable Care Act.[13] However, regarding Medicaid eligibility determinations, partner states may elect to either 1) allow the FFE to determine Medicaid eligibility using consumers' modified adjusted gross income (MAGI), or 2) ask the FFE to transfer information for consumers who appear to be eligible for Medicaid based on

MAGI to the state's Medicaid agency for the final determination.[14] (In all exchanges, states are still responsible for performing eligibility determinations for individuals who may be eligible for Medicaid through other means, such as people with disabilities or long-term care needs.)

Additionally, partnership states have a choice to make regarding the temporary reinsurance program required by the Affordable Care Act through 2016, which will reimburse insurance companies that cover particularly high-risk, costly patients. All states, including those with partnership exchanges, can either opt in to the federally operated reinsurance program, or they can operate the program directly.[15]

Federal Responsibilities in a Partnership Exchange

In a partnership exchange, the FFE performs all functions other than plan management, in-person consumer assistance, or both, depending on which partnership model a state selects.[16] These include, but are not limited to, the following functions:

- Operation of a toll-free consumer call center for the exchange
- Design and operation of a public exchange website
- Design of the single application for coverage
- Selection and financing of navigators
- Eligibility determination for premium tax credits and cost-sharing reductions
- Enforcement of the individual responsibility requirement to maintain coverage and approval of exemptions from the requirement[17]

Conclusion

As exchanges will become the key vehicle for individuals and small businesses to obtain health insurance in 2014, it is critical that the entities responsible for plan management and in-person consumer assistance perform these functions well in all exchanges. A clear understanding of the roles and obligations a state will have in plan management and consumer assistance partnership exchanges is necessary to determine whether a state should pursue a partnership model. This piece, along with the HHS blueprint document[18] upon which it is based and Families USA's companion piece, *Health Insurance Exchange Implementation: To Partner or Not to Partner?* (availiable online at www.familiesusa2.org/assets/pdfs/health-reform/Partnerships-in-Exchange-Implementation.pdf), can serve as tools to help states and stakeholders determine which exchange model will best serve consumers and small businesses in 2014.

(See Key Exchange Deadlines on next page)

Key Exchange Deadlines

Deadlines for key exchange decisions and implementation milestones are fast approaching. The following are critical dates that states, consumer advocates, and other stakeholders must keep in mind when thinking through exchange options:

November 16, 2012

By November 16, 2012, any state seeking to operate a state-based or partnership exchange must submit a declaration letter to HHS indicating which type of exchange it intends to implement, along with a blueprint that outlines how the state will comply with all applicable exchange requirements and provide all necessary exchange functions for consumers and small businesses. HHS will establish federally facilitated exchanges in states that do not submit declaration letters by this deadline. All states, including those that will ultimately have federally facilitated exchanges, are urged to submit declaration letters as soon as possible (before November 16) so that coordination among the states and the federal government that is necessary for all types of exchanges can begin immediately. **If a state's declaration letter is received more than 20 business days prior to the submission of its blueprint, the state may request an exchange application consultation with HHS regarding its application for approval as a state-based or partnership exchange.**[19]

January 1, 2013

By January 1, 2013, HHS will indicate to each state that submitted a blueprint for a state-based or partnership exchange whether that state's blueprint has been approved or conditionally approved. Receiving conditional approval indicates that HHS anticipates that the state will be ready to operate a state-based or partnership exchange on time, but that the state must meet certain additional required benchmarks within a given timeframe in order to receive full approval.

October 1, 2013

October 1, 2013, is the date by which open enrollment for all exchanges must begin. By this date, all exchanges must have the capacity to allow consumers and small businesses to apply for and enroll in coverage.

January 1, 2014

January 1, 2014, is the date when exchange coverage goes into effect for individuals and small businesses.

Endnotes

[1] *Patient Protection and Affordable Care Act*, Public Law 111-148 (March 23, 2010), as modified by the *Health Care and Education Reconciliation Act of 2010*, Public law 111-152 (March 30, 2010), Title 1, Subtitle D, Section 1311.

[2] Center for Consumer Information and Insurance Oversight, *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges* (Washington: Department of Health and Human Services, August 14, 2012), available online at http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf. For a discussion of the November 16 deadline, see "Key Exchange Deadlines" on page 6 of this brief.

[3] States are permitted to change which exchange model serves consumers and small businesses in their state in any future year. For a discussion of the process for transitioning to a different exchange model, see Center for Consumer Information and Insurance Oversight, op. cit.

[4] Ibid.

[5] The use of the term FFE in the context of a partnership exchange refers to the components of the exchange that are operated by the federal government. When an exchange is fully federally operated, this term refers to all components of an exchange.

[6] HHS's *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges* indicates that this function is required for consumer assistance partner states "if applicable," but it provides no further information regarding when the requirement applies.

[7] 45CFR 155.260(a-g) in "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule," *Federal Register* 77, no. 59 (March 27, 2012).

[8] 45CFR 155.260(a)(4) in "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule," *Federal Register* 77, no. 59 (March 27, 2012).

[9] HHS's *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges* indicates that this function is required for consumer assistance partner states "if applicable," but it provides no further information regarding when the requirement applies.

[10] Ibid.

[11] 45CFR 155.110 in "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule," *Federal Register* 77, no. 59 (March 27, 2012).

[12] 45CFR 155.345(i) in "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule and Interim Final Rule," *Federal Register* 77, no. 59 (March 27, 2012); 45CFR 152.45 in "Pre-Existing Condition Insurance Plan Program," *Federal Register* 75, no. 146 (July 30, 2010).

[13] These modifications include, but are not limited to, procedures to simplify the application, eligibility determination, and renewal processes for the Medicaid program. For more information, see Families USA, *Enrollment Policy Provisions in the Patient Protection and Affordable Care Act* (Washington: Families USA, Updated December 2010), available online at http://www.familiesusa.org/assets/pdfs/health-reform/Enrollment-Policy-Provisions.pdf. For the latest federal guidance, including regulations, letters to states, and informational bulletins, see Medicaid.gov, *Federal Policy Guidance* (Washington: Department of Health and Human Services), available online at http://www.medicaid.gov/Federal-Policy-Guidance/Federal-Policy-Guidance.html.

[14] Center for Consumer Information and Insurance Oversight and Centers for Medicare and Medicaid Services, *General Guidance on Federally Facilitated Exchanges* (Washington: Department of Health and Human Services, May 16, 2012); Centers for Medicare and Medicaid Services, *Medicaid/CHIP Affordable Care Act Implementation Answers to Frequently Asked Questions: Coordination across Affordability Programs* (Washington: Department of Health and Human Services, May 22, 2012), available online at http://www.medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/Downloads/Coordination-FAQs.pdf.

[15] See Activity 5.2, Reinsurance Program, in Table I (Roadmap for Completing the Exchange Application) of Center for Consumer Information and Insurance Oversight, *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges,* op. cit. For more information, see Healthcare.gov, *Standards Related to Reinsurance, Risk Corridors,- and Risk Adjustment* (Washington: Department of Health and Human Services, March 16, 2012), available online at http://www.healthcare.gov/news/factsheets/2012/03/risk-adjustment03162012a.html.

[16] Refer to the section entitled "Additional Flexibility: Medicaid Eligibility and Reinsurance" on page 4 of this brief for two additional functions that may be performed by partner states.

[17] Center for Consumer Information and Insurance Oversight and Centers for Medicare and Medicaid Services, *General Guidance on Federally Facilitated Exchanges,* op. cit.

[18] Center for Consumer Information and Insurance Oversight, *Blueprint for Approval of Affordable State-Based and State Partnership Insurance Exchanges*, op. cit.

[19] Ibid.

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