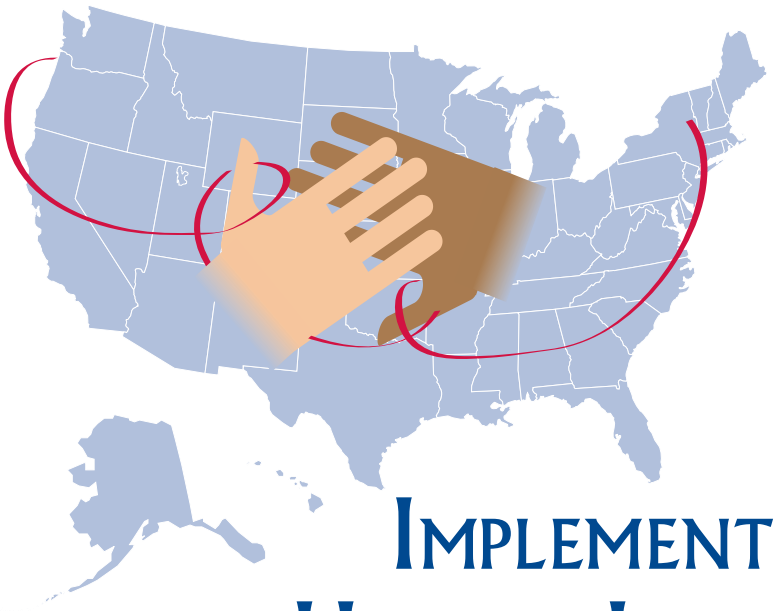

Implementing Health Insurance Exchanges:

A Guide to State Activities and Choices

This guide describes the requirements in the Affordable Care Act that all the new exchanges must meet. It then outlines activities and choices that states face as they begin to design their new health insurance exchanges, along with various issues that consumer advocates should consider as their states address them.

Families USA

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Implementing Health Insurance Exchanges: A Guide to State Activities and Choices

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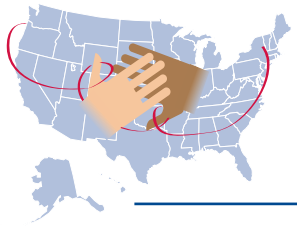

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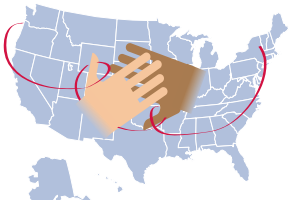
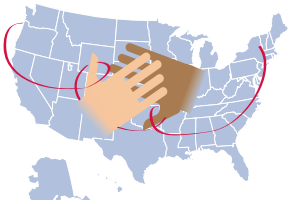


Introduction

One of the central features of the Patient Protection and Affordable Care Act (or Affordable Care Act) is the development of new insurance marketplaces, called "exchanges," in every state in time to enroll people by 2014. Exchanges are designed to serve as a place where individuals and businesses can shop for coverage with the help of easy-to-understand information on all their options. Plans sold through exchanges will have to meet certain standards so that consumers get good value for their money. The exchanges will serve an important purpose for people who are middle- or low-income: They will be the place where people can purchase insurance with the tax credits that the Affordable Care Act provides to make coverage affordable for all Americans. In addition, when individuals who are eligible for Medicaid or other public coverage programs enter the exchange, they will quickly and smoothly be directed to the correct program.

However, all of this is possible only if implementation of the exchanges is successful in each state. The Affordable Care Act envisions that states will develop and run their own exchanges (or, if any states fail to do that, a federally operated exchange will serve residents of those states). The law contains many provisions to make sure that state implementation goes smoothly and that the exchanges work for consumers (see next page). Although these provisions establish a critical baseline of protections to help exchanges work well, states still have many tasks to complete and choices to make regarding the development and operation of exchanges. With the right choices, states can make sure that exchanges function as intended: as marketplaces for high-value coverage that are user-friendly, transparent, and stable.



Exchange Requirements in the Affordable Care Act

The Affordable Care Act requires every state to have an exchange up and running by January 1, 2014. Some flexibility is permitted in how states set up their exchanges, but at a minimum, all exchanges must meet the following requirements (Section 1311 of the Affordable Care Act):

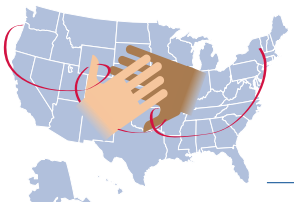
- **Consumer usability and enrollment requirements: Exchanges must be able to enroll individuals and small businesses (with up to 100 workers) into coverage in a user-friendly way. Specifically, they must:**
  - Implement a web portal where consumers and businesses can view coverage options, with benefits and costs presented in a standardized format;[1]
  - Operate a toll-free hotline for consumer assistance;
  - Make an online calculator available so that people can see the actual costs of their coverage after accounting for the premium tax credits they may receive;
  - Be able to screen eligibility for, and enroll people in, Medicaid, the Children's Health Insurance Program (CHIP), and other public programs;
  - Use a standardized enrollment form for coverage;
  - Provide for an initial enrollment period as well as annual and special enrollment periods;
  - Establish "navigators"—individuals or entities that help consumers and employers learn about, and enroll in, coverage options;
  - Inform consumers of plan quality and enrollee satisfaction ratings; and
  - Have the capability to identify, and inform the U.S. Treasury, about consumers who are exempt from the law's individual responsibility requirements.
- **Plan certification requirements: An exchange must be able to certify that plans sold in the exchange meet a number of standards outlined in the Affordable Care Act, including the following:**
  - Coverage for a federally determined essential benefits package (as well as any other benefits the state requires) in a plan that has the required out-of-pocket caps;

- The offering of only specified tiers of coverage: bronze, silver, gold, and platinum. A bronze plan covers 60 percent of medical costs for covered services (excluding premiums) for an average enrollee population; silver covers 70 percent; gold covers 80 percent; and platinum covers 90 percent.[2] Any insurer participating in the exchange must offer at least one plan at the silver level and one plan at the gold level. Insurers may also offer "catastrophic" plans for people under 30 and people who are exempt from the individual responsibility requirements (see Section 1302 of the Affordable Care Act).
- Availability of an adequate number of providers in the plan's network, including providers that serve predominantly low-income, medically underserved individuals (where applicable);
- Marketing standards;
- Specified quality, quality improvement, and accreditation standards;
- Transparency standards, such as disclosure of information on claims denials, plan finances, cost-sharing information, and enrollee rights in plain language; and
- Prior justification of any premium increases (which will be made public, and which exchanges are asked to consider when determining whether to allow an insurer to participate).

- **Other requirements: Additionally, exchanges must meet the following requirements:**
  - **Consumer and public input**: Exchanges must consult with stakeholders, including educated health care consumers, enrollment experts, small business representatives and self-employed individuals, and advocates with experience enrolling hard-to-reach populations.
  - **Transparency**: Exchanges must publish specified financial information for public inspection and must undergo annual audits by the Secretary of Health and Human Services (HHS).
  - **Financial stability**: Exchange administration must be self-financing by January 1, 2015 (through premiums or other sources). Until 2015, federal grants (described on page 27) can help states implement exchanges.

State Activities and Choices for Implementing Exchanges

Beyond the requirements described on the preceding pages, the Affordable Care Act leaves states with a great deal of flexibility regarding how they will implement and operate their exchanges. There are a number of tasks that states must initiate and complete in order to implement an effective exchange. The Affordable Care Act also leaves states with many options and choices regarding exchange design: Will the state have a separate exchange for businesses and individual consumers, or will they shop in the same exchange, for example. The path that states take will ultimately determine whether exchanges are consumer-friendly and whether consumers are ultimately able to get coverage. On the following pages we discuss a number of state tasks and choices regarding exchanges that must be addressed in the near future, along with relevant issues that advocates may want to consider.



Exchange Governance And Oversight

This section includes the following questions:

1. Will your state have a state- or a federally operated exchange?
2. Will your state join a regional exchange?
3. Will your state create subsidiary exchanges?
4. How will your state ensure adequate consumer input in exchange planning and operations?
5. Does your state have statutory or other legal authority to operate an exchange?

1 Will your state have a state- or federally operated exchange?

Under the Affordable Care Act, if a state chooses not to implement its own exchange, or if it becomes apparent by January 2013 that the state will not be ready to operate an exchange by January 2014, the Secretary of HHS will set one up for that state. HHS still needs to release guidance on how a federally operated exchange would work in a state. In the meantime, issues for advocates and states to think through include the following:

- Does your state have the capacity to operate an exchange that meets all of the requirements of the Affordable Care Act and that works well for consumers? If not, what does your state need to do to build capacity if it intends to operate its own exchange?
- Are there any existing models for arranging or purchasing coverage for residents in your state, such as the state employee plan, that already work well for consumers? For example, you may want to look at how Medicaid and CHIP contract with managed care plans or how the state contracts with private insurers for state employee coverage. Could your state replicate or build on an existing model to implement a state-run exchange?
- Does your state have particular programs or resources for uninsured consumers that you want to make sure continue in the context of an exchange? Does your state have certain benefit mandate requirements that you want maintained, even if they are not included in the federal benefits package? You may want to consider how a state exchange versus a federal exchange would be able to address these and other traditionally state-level issues.

- If your state opts for a federally operated exchange, how will the state coordinate Medicaid eligibility and enrollment with the exchange?
- Will the politics of your state affect its ability to operate an exchange that complies with the Affordable Care Act and that works well for consumers? What strategic work do advocates need to undertake to overcome political obstacles to an effective exchange in your state?

When guidance is available from HHS, there may also be advocacy work needed regarding the design of a federal exchange. Depending on how a federal exchange will operate, some states or advocates may find that a federal option will better allow their state to comply with the Affordable Care Act and to meet the needs of consumers, while other states will opt for a state-run exchange.

2 Will your state join a regional exchange?

The health reform law allows states to band together to form combined, or regional, exchanges, as long as all states involved agree and the Secretary of HHS approves. States could describe any plans they have to form or join a regional exchange in the exchange planning grants described on page 27, along with how they plan to make sure they work well for consumers. Regarding regional exchanges, states and advocates should consider the following:

- Will partnering with neighboring states put your state's consumer protections at risk? Although the Affordable Care Act sets a nationwide floor for consumer protections in insurance markets, there are other protections that are still left up to the states. Some states have very consumer-friendly climates, with many protections to make sure that insurers play fairly in the market, while others exercise little oversight of insurer behavior. Will a regional exchange allow your state to maintain and improve its consumer protections? Or is your state considering partner states with regulatory climates that may lead to an undermining of your own state's protections? Regional exchanges may work well for smaller states, creating a larger market, broader risk pools, and lower administrative costs. However, states must ensure that potential partner states share their goals for consumer protections before joining a regional exchange.
- How will the politics of your state and neighboring states affect the feasibility and success of a regional exchange? The politics of your state may have a big impact on whether and with which partner states your state will form or join a regional exchange. Additionally, political challenges that may result from more than one state sharing authority over an exchange should also be considered. Would a regional exchange be hampered by involvement and oversight from multiple legislatures and

governors' administrations, or would your state partner well with leaders from neighboring states in order to meet consumer needs through a regional exchange?

- How will insurance risk pools in your state be affected by joining a regional exchange? Could combining markets with another state help spread the risk of high-cost residents in your state, or would combining with another state result in higher premiums due to the medical costs of the combined population?
- How would a regional exchange handle any differences in public program eligibility between states? How would a regional exchange conduct data exchanges between multiple states' agencies to make Medicaid and CHIP eligibility determinations?

3 Will your state create subsidiary exchanges?

In addition to allowing regional exchanges, the Affordable Care Act also allows states to have subsidiary, or multiple, exchanges. However, such exchanges cannot overlap or compete but must serve different areas of a state. When thinking about subsidiary exchanges, states and advocates may want to consider the following:

- Will subsidiary exchanges create better insurance markets for consumers by limiting the number of options and creating a more localized approach to delivering coverage? Or will they create markets that are too restricted, with inadequate options, competition, and pooling of risks? Subsidiary exchanges might work well in larger states and may also be useful for including plans like health maintenance organizations (HMOs) that are locally focused around community providers.[3] However, in many states, subsidiary exchanges may have adverse consequences on the insurance market, driving up prices and restricting consumer choice. Therefore, states should analyze the implications carefully when considering subsidiary exchanges.

4 How will your state ensure adequate consumer input in exchange planning and operations?

As described on page 3, the Affordable Care Act requires exchanges to consult with consumer stakeholders. Additionally, the applications for the exchange planning grants (described on page 27) required states to explain how they will involve consumers, including those who have disabilities or long-term illnesses, and give them meaningful input into exchange planning. However, advocates have an important role to play in ensuring that consumer input is actually received and considered. Some relevant issues for advocates and states to consider include the following:

- Is your state making it easy for consumers to provide input on exchange implementation during the planning stages? Are there meetings, such as those of an implementation task force, for receiving public comment? Is there adequate advance notice of the meetings, and are they ever held during non-work hours so that members of the public can attend? Providing comments at public meetings is a critical way for advocates and the general public to help ensure that exchanges are implemented in a consumer-friendly way.
- Will your state's exchange have a governing board? If so, how can you ensure that there is mandatory and significant consumer representation, along with geographic and ethnic diversity, on the board? How a board is appointed and how much consumer representation and diversity it includes may be something to address in exchange-authorizing legislation.[4] Also, will your state ensure transparency by requiring board meetings to be open to public attendance and comment? The meetings of Massachusetts's existing exchange ("Connector") board, for example, are open to the public, and minutes from its meetings are available on the Connector's website.[5]
- If your state's exchange has a governing board, will it include representation from the health care industry, such as from insurers? Having industry representatives on the board can be helpful due to their expertise, but it can also be risky in terms of making sure that the board makes consumer-friendly decisions. Presumably for this reason, SB 900, one of the two exchange-creating bills that California's legislature passed this year, explicitly prohibits representatives of insurers, agents or brokers, or health care providers or facilities from serving on the board.[6] If your state's exchange board does include industry representation, how will your state ensure that there are strong protections against conflicts of interest in exchange decision-making?[7]
- Will your state set up focus groups before the exchange is operating to ensure that its features, such as the web portal, work for consumers (particularly those with low incomes and those with special needs)?
- Once the exchange is up and running, will there be ways for consumers and advocates to provide feedback about how it's working and any problems they discover? Will there be a formal system for consumer assistance and ombudsman programs, navigators, and enrollment specialists to inform officials of problems that consumers experience with the exchange (a "feedback loop")?[8]
- Would your state benefit from requiring an outside, independent evaluation of consumer experience in the exchange? Conducting such an evaluation at regular intervals and making the results available to the public may help ensure that the exchange meets consumer needs.

5 Does your state have statutory or other legal authority to operate an exchange?

Your state's laws or rules will likely need to change to authorize the implementation of a health insurance exchange that complies with the Affordable Care Act. Some states may make such changes through their legislatures, whereas others may also use administrative rulemaking or executive orders. One of the functions of the federal exchange planning grants for states (described on page 27) is to help states determine the statutory, regulatory, or other administrative changes that will be needed to set up an exchange. Regarding this task, advocates may want to consider the following:

- If your state will be considering legislation to implement a health insurance exchange, what would you like included? It may be helpful to have many of the other issues described in this guide addressed in legislation so that they become legal requirements in your state. For early examples of state legislation authorizing a health insurance exchange in accordance with the Affordable Care Act, see California SB 900 and AB 1602, which address some of the issues discussed in this guide. Additionally, the National Academy of Social Insurance (NASI) plans to develop model legislation to help states implement exchanges.[9]
- The National Association of Insurance Commissioners (NAIC) will draft a model law for exchanges. Advocates can provide input during this drafting process, which is important, since NAIC model laws are often adopted by states because they provide a convenient source of statutory language drafted by experts (although states can always add additional provisions to an NAIC model law under consideration). You can visit the NAIC's website at www.naic.org to follow its health reform decision-making process and learn how to weigh in on exchange issues.

6 What entity will run your state's exchange?

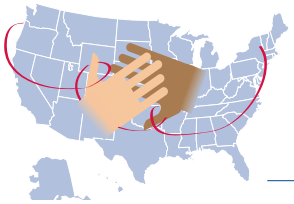
States have a number of options for where they house their exchanges. An exchange could be operated by an existing agency, such as the Medicaid agency or the insurance department, or some combination of these or other existing agencies. Or a state could create a new agency to operate the exchange, as California plans to do under SB 900.[10] Finally, states also have the option to contract with a nonprofit entity to operate the exchange. Any operating entity may contract with other agencies to deliver certain exchange functions. The best option for exchange governance will vary by state. However, in thinking about which entity would be best, advocates and states should consider the following:

- Do existing agencies have the capacity to expand to take on new functions that will be required of an exchange? How would their current funding and funding needs for operating an exchange affect their ability to effectively run an exchange?
- How will your state ensure adequate communication and coordination between the exchange operator and other state agencies? This question is critical for the operation of an exchange, since exchanges need to accomplish the dual purposes of functioning as a well-regulated health insurance marketplace and of providing an easily accessible, efficient access point for people to find, and enroll in, coverage options, including public programs for low-income people. How will your state ensure that the exchange and other agencies communicate effectively to achieve these objectives, both through their personnel and through their information systems?
- Does your state exchange planning process include representatives from the state Medicaid agency, the state CHIP agency, and/or the human services agency (if these are housed at different locations or are not directly running the exchange)? It will be important to make sure that the agencies that determine eligibility for Medicaid and CHIP are involved in the exchange planning process from the beginning, because decisions about structure and governance will have an impact on the right design for eligibility and enrollment systems.
- If the state does not house the exchange within an existing agency, will the new exchange agency assume any responsibilities that were previously handled by another agency (for example, Medicaid eligibility for families and children)?
- Will your state's exchange be subject to existing laws for state agencies regarding contracting processes, hiring, and setting salaries? These laws may protect the integrity of these processes, thereby protecting consumers. However, given the urgency of setting up an exchange, the laws' requirements may be too burdensome, requiring some exemptions or separate authority for the exchange (see California AB 1602).[11]

7 How will your state make sure that the entity operating the exchange makes it work well for consumers?

How the exchange-operating entity functions will have a great impact on whether the exchange can meet consumers' needs. Regarding the exchange-operating entity, issues to consider include the following:

- How will your state ensure that the entity that operates the exchange keeps consumer needs at the forefront of its mission? The exchange will have to serve a broad spectrum of the population, including those with different income levels, reading levels, English-proficiency levels, and internet-skill levels. How will the exchange operator meet the needs of all segments of the population?
- How will your state make sure that the exchange operator maintains a commitment to transparency, allowing public oversight and input? Are open meeting laws or other protections in place to guarantee that the public has access to exchange decisions and operations?



Making Exchanges Work For Consumers

This section includes the following questions:

1. Who will be able to buy coverage through your state's exchange, and where will they shop?
2. How will people apply for private plans, premium tax credits, Medicaid, and CHIP?
3. How will your state determine if people are eligible for Medicaid, CHIP, or premium tax credits for coverage?
4. How will your state make sure that people are enrolled in coverage as soon as they are eligible and stay enrolled as long as they are eligible?
5. How will your state make sure that "navigators" meet the needs of consumers?

1 Who will be able to buy coverage through your state's exchange, and where will they shop?

Starting in 2014, states must be able to sell coverage to individuals and small businesses through an exchange. In 2017, states may also opt to allow large businesses to purchase coverage through the exchange. States have many choices to make regarding who can purchase coverage in their exchange and where they will shop. Issues to consider include the following:

- Will your state have separate exchanges for businesses and individuals and families, or will it combine exchanges? The Affordable Care Act envisions both a Small Business Health Options Program (SHOP) exchange and an exchange where individuals and families will shop for coverage. It is up to states to decide if these will operate as one entity or if they will be separate exchanges. Would having one exchange deliver the best options to all potential enrollees in your state, allowing them a wider array of choices and easier enrollment?
- Will your state's exchange have the capability to collect premiums and deliver them to insurers on behalf of enrollees? The Affordable Care Act states that enrollees must have the option to pay insurers directly, but this should not preclude exchanges from setting up a system where they can collect and distribute

premiums on behalf of enrollees. Such a system may be advantageous to consumers, particularly if they are eligible for tax credits that must also be paid to insurers. It may also be helpful to small employers, whose workers may each be enrolled in plans from different companies, to have a centralized entity that can accept and distribute premiums to different insurers. For example, California AB 1602, one of the two exchange-creating bills that the state's legislature passed this year, specifies that the state's exchanges can collect and administer premiums for small employers.[12]

- Will your state maintain the definition of a small employer as a firm with up to 100 workers? In 2014 and 2015, states can opt to define small businesses as those with up to 50 workers, instead of up to 100 workers, which is the new definition under by the Affordable Care Act. Defining small businesses as those with up to 50 workers may have different effects in different states, so states may want to conduct studies of their insurance markets to see how this option would affect consumers. For example: How would this option affect the exchange's risk pool? What will the implications be for the application of both state and federal consumer protections if small employers are defined as those with up to 50 workers? Will employers with 51-100 workers change their premium contributions? How would employees' benefits packages change?
- Will your state allow large employers to buy coverage through the exchange in 2017? How will your state prepare in the meantime for such an expansion of the exchange? Bringing in larger groups may help the exchange to be stronger and more stable and could also extend more consumer protections to enrollees in large group plans. However, your state may want to conduct a study of other potential effects of this option on employer behavior and consumer well-being before proceeding.

2 How will people apply for private plans, premium tax credits, Medicaid, and CHIP?

The Affordable Care Act envisions a uniform, simple process for applying for and enrolling in health coverage through the exchange, including coverage in Medicaid and CHIP. Individuals and families should be able to apply for health coverage through a public program or a private exchange plan using a single application form, and that form should be accepted online, by mail, by phone, or in person. For more information, see *Enrollment Policy Provisions in the Patient Protection and Affordable Care Act,* available online at http://www.familiesusa.org/assets/pdfs/health-reform/Enrollment-Policy-Provisions.pdf. Regarding the application process, issues for advocates and states to consider include the following:

- How will your state operationalize a "No Wrong Door" policy to make sure that consumers are enrolled in the coverage for which they or their family members are eligible, regardless of which state agency the family contacts or to which agency it applies first?
- The Affordable Care Act requires that an online application be available for all coverage available through the exchange, including private coverage, premium tax credits, Medicaid, and CHIP. How will your state operationalize these requirements? Does your state already use an electronic screening program or application for any of its health coverage programs that it could build on?
- How will your state simplify the application process for people who do not use an online application at the same time that it is developing a simplified online application for coverage?

3 How will your state determine if people are eligible for Medicaid, CHIP, or premium tax credits for coverage?

The Affordable Care Act requires states—to the maximum extent possible—to use electronic data matching for determining eligibility in order to minimize the information required on an application for health coverage. And, as described on page 2, the law requires that state exchanges be able to screen for eligibility for Medicaid and CHIP and enroll people in these programs. Issues to consider include the following:

- Does your state Medicaid agency already conduct data matching with the Social Security Administration to verify applicants' citizenship? Does the state use data matching with any other federal databases or between means-tested programs like WIC, SNAP, TANF, or the Free and Reduced Price School Meals Program? Does your state have the capacity to electronically match data with other state agencies, such as the Department of Motor Vehicles, state vital statistics, or the state treasurer's office?

- How will your state handle the transition to Modified Adjusted Gross Income (MAGI) in Medicaid and ensure that there are no gaps in how MAGI is applied that would allow a low-income consumer to be determined ineligible for both Medicaid and premium tax credits? When the Medicaid expansion occurs in 2014, states will be required to change how they determine eligibility for Medicaid for children, pregnant women, parents, and childless adults in order to align the process more closely with eligibility determinations for premium tax credits. While the changes will make the process for figuring out whether a family is eligible for premium tax credits or Medicaid easier, there are still a few differences between eligibility for premium tax credits and for Medicaid. States will have to design the process to ensure that people who have income right on the margin are enrolled in the proper coverage.
- Does your state conduct presumptive eligibility for Medicaid or CHIP now? Are there plans to expand this option for those who are newly eligible as a result of the new law? How will the state ensure that individuals who are presumed eligible are connected to the exchange if they ultimately turn out to be ineligible for Medicaid?
- How will consumers whose income changes between the time when the most recently available tax data are reported and the time of application be able to note the change and have their eligibility for a tax credit (and the size of the credit for which they qualify) be determined using the most up-to-date information? How will consumers who experience a change in circumstances during the year that alters their eligibility for Medicaid, CHIP, or premium tax credits be able to easily report that and have their coverage changed appropriately?

4 How will your state make sure that people are enrolled in coverage as soon as they are eligible and stay enrolled as long as they are eligible?

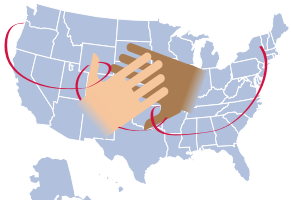
States will need to make sure that they can process applications in a timely way and make it easy for people to start coverage as soon as possible. Exchanges will have open enrollment periods for private plans, but people must be able to apply for, and enroll in, Medicaid any time during the year. States will have to simplify and streamline the process of renewing coverage, as well as the initial application process to help people stay insured, and they'll need to make sure that it is easy for people to move between private coverage and Medicaid as their circumstances change. Issues to consider include the following:

- When will the first open enrollment period for exchange coverage take place in your state? Will the Medicaid eligibility expansion to 133 percent of poverty have been implemented in your state by that time? How will those who apply for exchange coverage and are determined to be eligible for Medicaid be directed to Medicaid? Will their information be captured to ensure that they are enrolled when the Medicaid expansion is implemented if the expansion has not already taken place?
- Can your state proactively notify parents whose children are already enrolled in Medicaid that they will be eligible once your state expands coverage to 133 percent of poverty? Since the state already has current income and household information for these parents on file, can it use that data to streamline the enrollment process for them in advance of the expansion in January 2014?
- People who are eligible for Medicaid can apply anytime during the year, while exchanges may hold open enrollment periods for private coverage. How will your state ensure that people are able to apply for coverage anytime during the year and enroll in Medicaid immediately if they are eligible?
- How will your state streamline the renewal process to maximize the number of people who retain appropriate health coverage in Medicaid, CHIP, or private plans with premium tax credits? States will also need to streamline and simplify the process of renewing coverage. How and when renewals happen will have a significant impact on continuity of coverage.
- Will your state contribute additional state dollars to make premiums more affordable for low-income people receiving tax credits? Although the premium tax credits in the Affordable Care Act will help offset a significant portion of the cost of coverage, some lower-income families may still have difficulty with their share of the premium. States are allowed to subsidize the remaining cost of coverage with their own funds, if they wish.
- How will your state ensure that people who are enrolled in Medicaid or who receive premium tax credits have a smooth transition to Medicare when they turn 65 or, for people with disabilities, when their 24-month waiting period ends?
- How will your state make sure that people returning to the community from institutional facilities or incarceration are quickly enrolled in coverage when they are eligible?

5 How will your state make sure that "navigators" meet the needs of consumers?

As described in "Exchange Requirements in the Affordable Care Act" on pages 2 and 3, navigators are individuals or entities that help consumers and employers learn about, and enroll in, coverage options. The health reform law requires states to provide grants to entities that have (or could readily establish) relationships with employers and employees, consumers (including those who are uninsured and underinsured), or self-employed individuals to serve as navigators. Regarding navigators, issues for advocates and states to consider include the following:

- Which entities would be most capable of meeting consumer needs as navigators? The law lists many examples of entities that may serve as navigators, ranging from community and consumer-focused nonprofit organizations to chambers of commerce to licensed insurance agents and brokers (although entities that are receiving finances from insurers for enrolling people in health plans may not be navigators). Which of these entities would best serve consumers and businesses in your state? How will you make sure that your state makes the best decision for consumers regarding navigators?



Exchanges and Insurance Regulation: Building a Consumer-Friendly Marketplace

This section includes the following questions:

1. How will your state decide which plans can sell in the exchange?
2. How will your state make sure that the right benefits are covered in exchange plans?
3. How will your state make sure that premiums for exchange plans are reasonable?
4. How will your state make sure that the exchange doesn't suffer from adverse selection (attracting a disproportionate share of sicker enrollees)?

1 How will your state choose which plans can sell in the exchange?

Will plans compete on quality and price, will the state negotiate with insurers about their proposed premiums, or will all qualifying plans be able to participate? The Affordable Care Act does not require states to use a selective contracting or negotiation process to choose or limit which plans can participate in the exchange. However, such a process could help ensure that all plans in the exchange are of high quality and value to consumers. States could select plans in a variety of ways. For example, they could put out a request for proposals and choose only the plans that scored the highest on a number of criteria. Or they could set out their price expectations and negotiate with a set of qualified insurance companies interested in participating until they came close to that price. (Note, however, that the law prohibits exchanges from excluding plans based on "the imposition of premium price controls," so we may see more federal guidance on what type of negotiation is allowed.) The application for exchange planning grants (described on page 27) asked for a description of states' plans for bidding processes, and HHS's request for information on exchanges (see page 28) also asks about plan bidding. In addition, AB 1602, recently passed by the California legislature, creates a "competitive process" for selecting carriers for the state's future exchange.[13] Some issues to consider regarding plan selection include the following:

- What criteria will your state use to choose exchange plans? Will your state consider factors important to consumers, such as premiums and historical premium increases, quality indicators, and provider network standards, in a selective contracting or competitive process?[14]
- Can a competitive or negotiation process help your state make sure that the exchange offers a manageable—not overwhelming—number of plan choices for consumers? When people face too many plan choices, particularly if the choices aren't truly distinct, it becomes harder for them to make a good, informed decision. For example, this problem was encountered by many Medicare Part D enrollees, who were overwhelmed by the large number of prescription drug plan choices in their region.[15] As a result, starting in 2011, the Centers for Medicare and Medicaid Services (CMS) will limit the number of Part D plans that insurers can offer in each region.[16] Contracting only with selected plans can ensure that plans offered in the exchange each provide a valuable, distinct choice to consumers so that consumers can make informed decisions based on their individual needs.
- Are there existing health plan contracting models in your state that might work well for the exchange? Your state may want to look at the processes it uses to contract with Medicaid and CHIP managed care plans or state employee health plans to see if they can inform the exchange contracting process. Additionally, it may be helpful to consumers for the exchange contracting process to align with the processes used by these other large health care purchasers in your state so that together they can all encourage insurers to operate with high standards for quality and value. (Note that eventually these larger purchasers may actually combine with the exchange.)[17]

2 How will your state make sure that the right benefits are covered in exchange plans?

The Affordable Care Act outlines broad categories of essential benefits that must be covered in every health plan sold in an exchange (as well as in new individual market and small group plans sold outside of the exchange). These categories include the following: ambulatory patient services (such as doctor visits); emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; prevention and wellness services and chronic disease management; and pediatric services, including oral and vision care. In future regulations, the Secretary of HHS will provide comprehensive details about the specific services that will be covered in the essential benefits package. However, advocates and states should consider the following important benefits issues:

- Are your existing state benefit mandates likely to be included in the essential benefits package? States currently have many mandated benefits that insurers licensed in their state must cover for enrollees. These hard-won mandates have been important to consumers with many different health care needs. Advocates may therefore want to weigh in on the federal decision-making process for the essential benefits package to make sure that any important mandated benefits in their state are included in the federal essential benefits package. (If coverage for state benefit mandates is not included in the federal essential benefits package, states may still apply the mandates in the exchange. However, the state will have to bear their cost for all enrollees, although the law allows insurers to voluntarily cover additional benefits beyond those covered in the essential benefits package.)
- Would it be beneficial to consumers for your state to further standardize plan options beyond the benefits and coverage-tier requirements included in the law (see pages 2 and 3)? For example, will your state limit the number of different deductibles, co-insurance, and copayment combinations available in each plan tier to make it easier for consumers to choose an appropriate plan?[18]
- How will your state ensure continuity of benefits for the lowest-income consumers, who may fluctuate between being eligible for Medicaid and for tax credits to purchase coverage through the exchange? Very low-income adults without dependent children are more likely to be in poorer health and have greater mental health needs than similar adults with higher incomes,[19] so private plans that serve lower-income consumers in the exchange must have benefit designs that meet these needs. Additionally, are there ways that your state can ensure that consumers have access to some of the same providers if they move from Medicaid to a private exchange plan or vice versa?

3 How will your state make sure that premiums for exchange plans are reasonable?

The Affordable Care Act increases oversight of insurer premium rates through various mechanisms. It requires insurers to meet medical loss ratio requirements as follows: Plans in the large group market must spend at least 85 percent of the premiums they collect on delivering care and improving quality, and this standard is set at 80 percent for plans in the individual and small group markets. The law also requires that insurers participating in the exchanges justify premium increases before they implement them and post information online for public viewing about why they are increasing premiums. States are required to consider whether plans have had unreasonable rate

hikes in the past before certifying them as qualified health plans that can sell coverage through the exchange. The health reform law includes $250 million over five years in grants to help states with "rate review" tasks. First-round grant awards were announced in early August 2010, and states will have additional opportunities to apply for rate review grants in the future.[20] However, finding effective ways to deal with unreasonable premium increases has always been a challenge. States may want to consider the following issues and options (with the help of grant funds, where applicable) to make sure that rate increases are reasonable and justified. These options could apply for plans both inside and outside of the exchange:

- Will your state set a general standard for an unreasonable rate hike, such as any increase that exceeds medical inflation by a specific percentage? Future federal regulation may set such a standard, but states can also apply their own standard to protect consumers. Rate hikes that exceed such a standard could automatically be deemed unreasonable unless the insurer presents convincing evidence that they are necessary.
- When determining if a premium increase is reasonable, will your state consider factors beyond whether the hike is actuarially (or mathematically) sound, such as whether rate increases are reasonable given an insurer's profit margin, surplus, and executive salaries, and whether higher rates will be affordable for consumers? Considering these factors in a rate approval process can help make sure that rate increases are fair.
- Will your state have public hearings on proposed rate increases before they go into effect? Hearing testimony from plan enrollees and consumer advocates can help state regulators and exchange authorities decide whether insurers' proposed premium increases are reasonable.

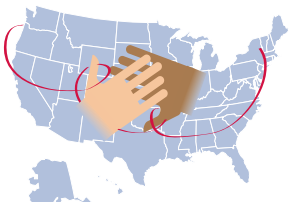
4 How will your state make sure that the exchange doesn't suffer from adverse selection (attracting a disproportionate share of sicker enrollees)?

The Affordable Care Act includes a number of measures to make sure that exchanges don't suffer from adverse selection (in which sicker people enroll in coverage through the exchange, leaving healthier, lower-cost enrollees in the outside market). The law states that insurers must put all small group enrollees in the same risk pool if they purchase the same plan, regardless of whether they purchase it inside or outside the exchange. Similarly, insurers must put all individual enrollees who purchase the same plan in the

same risk pool, regardless of where they buy coverage. (These pools may be further combined if a state merges the small group and individual markets.) Additionally, if the same health plan is sold in and out of the exchange, the premium must be the same in both places. And the law creates a risk adjustment system to compensate plans that have a disproportionate number of sicker enrollees, whether the plan is in or out of the exchange. However, even with these protections, there are a number of ways that adverse selection may occur in the exchange and a number of extra protections that states can consider to prevent this from happening, as follows:

- Will your state require insurers selling plans outside the exchange to meet the same requirements as those inside the exchange? Many protections in the law apply to health plans in both markets, but some don't. By requiring that protections applying only to exchange plans under the Affordable Care Act—such as those pertaining to plan marketing, provider networks, disclosure of plan and rate information, and quality standards—apply in the outside market as well, your state can help level the playing field to protect against adverse selection. If your state creates standards for exchange plans that go beyond those required in the law, such as further standardization of plan offerings (described on page 21), applying those requirements to plans sold outside the exchange will also help protect against adverse selection.
- Will your state require insurers selling plans outside the exchange to comply with the same restrictions that govern them when they sell plans in the exchange regarding the sale of less comprehensive coverage? Plans in the exchange can only sell bronze level and catastrophic plans if they also sell more comprehensive silver and gold plans (see page 3). Applying these requirements to insurers outside of the exchange as well will prevent companies from selling only thin coverage in the outside market as a way to attract younger and healthier people out of the exchange. Your state may even wish to prohibit insurers from selling the bronze and catastrophic coverage tiers outside of the exchange at all.[21]
- Will your state take steps to make sure that brokers do not have incentives to direct people away from the exchange? Prohibitions on higher broker commissions for selling plans in the outside market (versus the exchange) can help address this potential problem.[22]

- Will your state combine the small group and individual markets into one risk pool? Having a larger risk pool could attract more insurers to the exchange and spread risks better among enrollees. It could also help reduce administrative costs. Combining markets may cause some shift in premiums (for example, increased rates for small employers and lower rates for individuals), so states may want to study the effects of merging these markets before proceeding. States can also wait a few years after the exchange starts to merge the markets, leaving time for both the small group and individual markets to adjust to the new rating rules under the Affordable Care Act.[23]
- Will your state prohibit insurers that do not sell in the exchange from operating outside of the exchange? Requiring all the same insurers, or even the same products, in both markets would have a large impact on preventing adverse selection, although it may not be possible if your state wants to pursue a selective contracting arrangement to limit the number of plans sold in the exchange.[24]



State Insurance Exchanges: Alternative Models in the Affordable Care Act

This section includes the following questions:

1. Will your state develop a Basic Health Plan for lower-income exchange enrollees?
2. Will your state include innovative coverage models, like public plan options or insurance cooperatives (co-ops), in its exchange?

1 Will your state develop a Basic Health Plan for lower-income exchange enrollees?

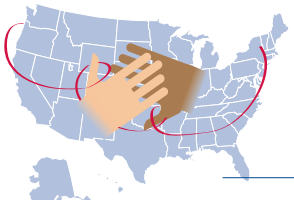
States have the option to create a Basic Health Plan that would provide coverage for people who have incomes between the upper Medicaid eligibility limit and 200 percent of the poverty level and who would otherwise be eligible for tax credits to purchase coverage through the exchange. The state would be able to use 95 percent of the amount the federal government would have spent on tax credits for enrollees in the Basic Health Plan to fund the plan. Issues to consider regarding the Basic Health Plan include the following:

- Can the state provide adequate benefits for this population using 95 percent of the tax credit value?
- What would the impact be on plan participation and rates in your exchange if the pool was limited to individuals with incomes over 200 percent of the federal poverty level?
- Does your state already cover adults with incomes greater than 133 percent of poverty through Medicaid or CHIP? How do the benefits these individuals receive compare with the benefits this group might receive through the exchange? Could the state use the Basic Health option to continue to provide Medicaid-like coverage to these adults?
- If your state is contemplating a Basic Health Plan option, would it be beneficial to consumers to coordinate coverage for adults in a Basic Health Plan with existing coverage in your state's CHIP plan, which is already available to cover children in families with incomes up to at least 200 percent of poverty?

2 Will your state include innovative coverage models, like public plan options or insurance cooperatives (co-ops), in its exchange?

Although a public plan option was not included in the final version of the Affordable Care Act, the law does not preclude states from establishing their own public plans. Regarding co-ops, the law provides incentives for their creation through start-up loans. In thinking about these models, states and advocates should consider the following:

- Will these unique options allow consumer needs to be met more efficiently and effectively? How will the politics of your state affect its ability to offer these coverage options? Depending on how they are designed and implemented, innovative coverage models like public plan options and co-op plans may be able to improve the way that care is delivered to patients and the value that consumers get for their dollar. Their presence in a state's market could also encourage other insurers to improve quality in order to compete effectively.



More Information And Resources

State Planning and Establishment Grants for Exchanges

On July 29, 2010, HHS announced the opportunity for states to apply for initial "State Planning and Establishment Grants for the Affordable Care Act's Exchanges." Applications were due on September 1, 2010, for the initial grants, which states can use to conduct background research on residents' health coverage needs; work with stakeholders on exchange planning; prepare to coordinate Medicaid, CHIP, and other programs with the exchanges; build up staff and other resources; set up technical infrastructure; and think through a number of other exchange issues, such as how states will determine eligibility, choose and certify exchange plans, oversee premium rates, and enact legislation or other authoritative measures to start an exchange. This broad array of acceptable uses for the first round of federal exchange funding allows states at different stages of planning—from those that haven't yet decided whether they'll establish an exchange to those that have already passed legislation to create an exchange—to all benefit from planning and establishment grants if they met the application guidelines.

Different state agencies and entities could apply for these initial grants, as long as the governor indicated approval of the application and a commitment to grant activities. (Nonprofits or other non-governmental entities could not apply for the grants, but states receiving funding can contract with them to carry out grant-funded activities.) On September 30, 2010, HHS announced that 48 states and the District of Columbia will receive an initial planning grant. Information about how states intend to use the funds is available online at www.healthcare.gov. HHS will continue to release new exchange grant funding opportunities for states through January 2015, when exchanges must be self-sustaining.

Additional Resources on Exchanges

For further discussion of issues raised in this guide, see the following resources:

- California State Legislature, AB 1602 and SB 900, 2010 Session. (Bills passed by the California legislature to implement a state exchange in accordance with the Affordable Care Act.) Available online at http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100825_enrolled.pdf and http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100831_enrolled.pdf.
- Request for Comments (RFC) Regarding Exchange-Related Provisions in the Affordable Care Act: On August 3, 2010, HHS released an RFC to solicit public input on the implementation of exchanges. To view the RFC and submitted comments, visit www.regulations.gov.
- State Coverage Initiatives: Expert PowerPoints on Health Insurance Exchanges, available online at http://www.statecoverage.org/meetings/past.

Publications

- Stan Dorn, *State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals* (Washington: Academy Health State Coverage Initiatives, July 2010).
- Patrick Holland and Jon Kingsdale, *Health Benefit Exchanges: An Implementation Timeline for State Policymakers* (Washington: Academy Health State Coverage Initiatives, July 2010).
- Dawn C. Horner and Sabrina Corlette, *Health Insurance Exchanges: New Coverage Options for Children and Families* (Washington: Georgetown University, August 2010).
- Sarah Lueck, *States Should Structure Insurance Exchanges to Minimize Adverse Selection* (Washington: Center on Budget and Policy Priorities, August 17, 2010).
- Mike Russo, Laura Etherton, and Larry McNeely, *Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform* (Boston: U.S. PIRG Education Fund, July 2010).
- Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).

Endnotes

[1] The Department of Health and Human Services (HHS) will create a template that states can use to develop their own web portals. States can also provide additional online information regarding coverage options if they think it is necessary to meet the needs of all of their residents. See California State Legislature, SB 900, 2010, available online at http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100825_enrolled.pdf.

[2] The share of costs that a plan covers for a standard population is also referred to as its "actuarial value."

[3] Timothy Stoltzfus Jost, *Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues* (New York: The Commonwealth Fund, July 2010).

[4] See California State Legislature, SB 900, 2010, available online at http://www.leginfo.ca.gov/pub/09-10/bill/sen/sb_0851-0900/sb_900_bill_20100825_enrolled.pdf.

[5] Amy M. Lischko, Sara S. Bachman, and Alyssa Vangeli, *The Massachusetts Commonwealth Health Insurance Connector: Structure and Functions* (New York: The Commonwealth Fund, May 2009), available online at http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Issue%20Brief.pdf.

[6] California State Legislature, op. cit.

[7] Mike Russo, Laura Etherton, and Larry McNeely, *Delivering on the Promise: A State Guide to the Next Steps for Health Care Reform* (Boston: U.S. PIRG Education Fund, July 2010).

[8] Ibid.

[9] National Academy of Social Insurance, *Developing Health Insurance Exchanges: Design Issues and a Model Statute for the States* (Washington: NASI, August 2010), available online at http://www.nasi.org/research/2010/developing-health-insurance-exchanges-design-issues-model.

[10] California State Legislature, SB 900, op. cit.

[11] California State Legislature, AB 1602, 2010, available online at http://www.leginfo.ca.gov/pub/09-10/bill/asm/ab_1601-1650/ab_1602_bill_20100831_enrolled.pdf.

[12] Ibid.

[13] Ibid.

[14] Mike Russo, Laura Etherton, and Larry McNeely, op. cit.

[15] Jonathan Gruber, *Choosing a Medicare Part D Plan: Are Medicare Beneficiaries Choosing Low-Cost Plans?* (Washington: Kaiser Family Foundation, March 2009).

[16] Centers for Medicare and Medicaid Services, *2011 Part D Plan Benefit Package (PBP) Submission and Review Instructions* (Washington: CMS, April 16, 2010), available online at https://www.cms.gov/PrescriptionDrugCovContra/Downloads/Plan%20benefit%20Memo%20for%20CY%202011%20-%2004%2016%2010%20FINALwo%20disclaimer.pdf.

[17] Mike Russo, Laura Etherton, and Larry McNeely, op. cit.

[18] Timothy Stoltzfus Jost, op. cit.

[19] Matt Broaddus, *Childless Adults Who Become Eligible for Medicaid in 2014 Should Receive Standard Benefits Package* (Washington: Center on Budget and Policy Priorities, July 6, 2010).

[20] See Department of Health and Human Services, *New Resources Help States Crack Down on Unreasonable Health Insurance Premium Hikes* (Washington: HHS, 2010), available online at http://www.healthcare.gov/news/factsheets/rates.html.

[21] Sarah Lueck, *States Should Structure Insurance Exchanges to Minimize Adverse Selection* (Washington: Center on Budget and Policy Priorities, August 17, 2010).

[22] Timothy Stoltzfus Jost, op. cit.

[23] Sarah Lueck, op. cit.

[24] Ibid.

Acknowledgments

This guide was written by:

Claire McAndrew
Health Policy Analyst

with

Rachel Klein
Deputy Director, Health Policy

and

Jennifer Sullivan
Senior Health Policy Analyst

The following Families USA staff assisted in the preparation of this guide:

Kathleen Stoll, Deputy Executive Director. Director of Health Policy

Cheryl Fish-Parcham, Deputy Director, Health Policy

Marc Steinberg, Deputy Director, Health Policy

Michealle Gady, Health Policy Analyst

Peggy Denker, Director of Publications

Ingrid VanTuinen, Senior Editor

Colleen Haller, Publications Associate

Nancy Magill, Senior Graphic Designer

1201 New York Avenue NW, Suite 1100 • Washington, DC 20005
Phone: 202-628-3030 • Fax: 202-347-2417 • Email: info@familiesusa.org
www.familiesusa.org