Spotlight on the States

Key State Policy Issues for Health Care Reform Implementation
September 2010

Issue Brief #2:
Health Insurance Exchanges: Powers and Issues[1]

Introduction

A central part of the Affordable Care Act (ACA) signed into law by President Obama in March[2] requires states (or the federal government by default) to establish health insurance exchanges, known in the law as "American Health Benefits Exchanges" and "Small Business Health Options Programs (SHOP)." These new virtual marketplaces, for individuals and small businesses to purchase health insurance, must be operational by 2014, but many states have already begun what will almost certainly be a very extensive and complex planning process. On July 29, 2010, the Department of Health and Human Services (HHS) announced the availability of $51 million for states to begin planning for the establishment of these exchanges (up to $1 million per state) with grant applications due September 1, 2010. On August 3, 2010, HHS requested public comments relating to a series of exchange implementation issues and options, and set an October 4 deadline for submission of these comments (75 Fed Reg. 45584 et seq.).

Each state has broad options for implementing their exchange – including electing to NOT implement a state administered exchange at all. PCAs should begin collecting intelligence immediately about their state's intentions for a health insurance exchange. For example,

- how the state determines to implement the exchange;
- the role it lays out for the exchange in the exchange's negotiations with health plans;
- whether the exchange has clear authority to establish concrete quality standards and proof of outcome measures from health plans;
- how the exchange can minimize adverse selection;
- whether the exchange can limit the number of plans (versus "any willing" plan); and
- the approach the exchange takes in bringing in safety-net plans and in assuring that health plans contract with and adequately pay Federally Qualified Health Centers (FQHCs)—(the effective use of the exchanges in this critically important element of health care reform – may well be determined in these next months and year, as states decide the role and authority of the exchange).

It is critically important, therefore, that PCAs gain as much knowledge as possible now and be an active part of the decision making process, considering what role they and the health centers in their states will play in interfacing with their state Medicaid or health insurance offices on these issues. Appendix A offers a list of suggested questions PCAs and health centers should be asking in preparation for the exchanges.

What are Insurance Exchanges?

Health insurance exchanges are essentially organized markets for health insurance. The ACA establishes "American Health Benefits Exchanges" and "Small Business Health Options Programs" (known as SHOP Exchanges), to be operated by states that elect to establish exchanges for individuals and employer groups

[1] With appreciation to Sara Rosenbaum of The George Washington University for her thorough summary of Health Insurance Exchange powers.
[2] PL 111-148

through which they can buy "qualified health plans." Massachusetts' Commonwealth Health Insurance Connector Authority, established as part of the State's 2006 health reform legislation, is probably the best known example of a health insurance exchange.

Exchanges may be either governmental entities or nonprofit agencies. A health insurance exchange might carry out numerous functions, including:

- calculating the price that specific purchasers (e.g., individuals vs. families; older vs. younger individuals; small vs. larger employer groups) will pay for coverage;
- selecting the health plans that will be permitted to offer their products;
- providing information about the plans and negotiating prices;
- helping purchasers gain access to available subsidies for both premiums and cost sharing; and
- assuring that premium payments to plans are adjusted to reflect the level of health risk among enrollees (a practice known as risk adjustment) in order to assure payment fairness (For example, seemingly similar health plans may attract sicker versus healthier populations, due to variations in elements such as the generosity of their prescription drug benefits or the breadth of their provider networks. Premium payments will be adjusted to reflect the relative risks associated with the patient populations attracted to various plans).

Structure

On July 29, 2010, the Secretary announced the availability of $51 million in grants of up to $1 million per state for planning the establishment of an American Health Benefit Exchange. State applications for the funding were due to HHS by Sept. 1, 2010 and the anticipated award date is September 30, 2010 for a 12 month budget period[3]. States that elect to establish exchanges must complete their operational planning by January 1, 2014.

As mentioned earlier, states have several options available to them with regard to the structure of their exchange. The Secretary of HHS must issue regulations related to the establishment and operation of exchanges. States may elect to establish exchanges, or they may elect not to. If a state elects not to do so, or if the Secretary determines by January 1, 2013 that a state has not taken the necessary steps to establish an exchange and reform its insurance laws as required under the Act, then the Secretary must establish and operate an exchange in that state.

States may elect to establish an exchange for individuals and a separate exchange for small businesses (under 100 employees or under 50 employees at state discretion through 2016), or merge the two into a single exchange, "but only if the exchange has adequate resources to assist such individuals and employers".

Exchanges can operate in more than one state if each state in which the exchange operates permits operation and if the Secretary approves a regional or interstate exchange. States may also operate more than one sub-state exchange if each such exchange serves a geographically distinct area and the Secretary approves the size of each exchange's premium rating area.

In all cases, states are permitted to contract with "eligible entities" to carry out one or more exchange responsibilities. Eligible entities include corporations that are not health insurers or controlled by health insurers or state Medicaid agencies.

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[3]U.S. Department of Health and Human Services Office of Consumer Information and Insurance Oversight. Funding Opportunity Number: IE-HBE-10-001. CFDA: 93.525

Payment and Participation of Health Centers

The law aligns health center payment within private insurance plans with reimbursement under the Medicaid program to ensure that health centers do not lose revenue when they treat patients covered by the new exchange-based plans. Under the new law, health centers will receive no less than their Medicaid PPS rate from private plans offered through the new exchange.[4] This requirement applies to all FQHCs and Look-Alikes.

The law also includes a provision that mandates full participation by safety-net providers in exchange plans; that is, exchange plans are required to contract with all safety net providers. Safety net providers are defined in the new law as those eligible to participate in the 340B drug discount program – including all FQHCs and other entities that serve predominately low-income, medically underserved individuals (see "Essential Health Benefits and Certification of 'Qualified Health Plans'").

Essential Health Benefits and Certification of "Qualified Health Plans"

In order to have their products certified as "qualified," insurers must offer their plans (at least at the "silver" and "gold" levels) through an exchange. Insurers can offer qualified health plans outside of exchanges but must charge the same premium rate as plans offered through the exchange. Essential health benefits must be covered by exchange plans and must include at least the following items and services: ambulatory patient services; 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; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.[5]

States may require qualified health plans operating in exchanges to "offer benefits in addition to the essential health benefits" required under the Act. States that do require additional benefits "must assume the cost" and "make payments to an individual" or "on behalf of an individual directly to the qualified health plan in which the individual is enrolled."

The Secretary must also, "by regulation, establish criteria for the certification of health plans as qualified health plans" that may be sold in state exchanges, including requirements that plans, in order to be certified, must:

- meet marketing requirements and not employ "marketing practices" or "benefit designs" that "have the effect of discouraging the enrollment in such plan by individuals with significant health needs;"
- ensure a "sufficient choice of providers (in a manner consistent with applicable network adequacy provisions under Section 2702(c) of the Public Health Service Act),[6] and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers;" and
- include within health insurance plan networks "essential community providers, where available, that serve predominantly low income, medically underserved individuals, such as health providers defined in Section 340B of the Public Health Service Act."[7]

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[4] Section 10104 (b)(2): Section 1302 of this Act is amended by adding at the end the following: ''(g) PAYMENTS TO FEDERALLY-QUALIFIED HEALTH CENTERS.— If any item or service covered by a qualified health plan is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Social Security Act (42 U.S.C. 1396d(l)(2)(B)) to an enrollee of the plan, the offeror of the plan shall pay to the center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of such Act (42 U.S.C. 1396a(bb)) for such item or service.''

[5] Section 1302 (b)

[6] Section 2702(C) of the Act establishes network adequacy standards to assure that plans that operate using provider networks limit their enrollment to individuals who live, work, or reside within their service areas. Plans may close enrollment to additional members if they can demonstrate that they are applying their capacity measures uniformly and in fact do not have the capacity to serve additional enrollees.

[7] Section 340B of the PHSA provides access to discounted drugs for certain health care providers that serve low income populations. These providers are specifically listed in Section 340B and include, among others, federally qualified health

Exchanges will be required to implement procedures for the "certification, recertification, and decertification of qualified plans, consistent with guidelines developed by the Secretary.

Eligibility and Premium Assistance for Enrollees

Exchanges are conceived as the principal gateway to affordable insurance for low and moderate income individuals, since they must have the capacity not only to make plans available but also to facilitate enrollment on a subsidized basis. The ACA allows individuals to enroll in any qualified health plan available and for which the individual is eligible and permits employers to provide support for coverage of employees under a qualified health plan by selecting a level of coverage recognized in the Act with respect to qualified health plans. Qualified individuals are limited to state residents who are either citizens or nationals or "aliens lawfully present" in the U.S.

Exchanges must inform individuals of Medicaid and CHIP eligibility requirements in their state "or any applicable state or local public program" and "if the Exchange determines that such individuals are eligible for any such program, enroll such individuals in such program."

The federal government will offer premium assistance in the form of subsidies for individuals between 133% and 400% FPL (that's $29,460 - $88,600 for a family of 4 in 2009). These subsidies will be offered on a sliding scale basis and will limit the cost of the premium to between 2% of income for those up to 133% of the poverty level and 9.5 % of income for those between 300-400% of the poverty level. Cost-sharing subsidies will also be available to people with incomes between 100-400% of the poverty level to limit out-of-pocket spending.[8]

Other Roles and Responsibilities of Exchanges

In addition to the powers and responsibilities discussed above, the law provides that exchanges must

- Operate toll-free assistance hotlines;
- maintain an Internet website through which enrollees and prospective enrollees may obtain standardized comparative information on plans;
- use a standardized format for presenting health plan options including a uniform outline of coverage;
- establish and "make available by electronic means" a calculator to determine the actual cost of coverage "after the application of any premium tax credit" and "any cost sharing reduction;"
- grant a certification in cases in which "an individual is exempt from the individual requirement or from the penalty imposed" because there is no affordable qualified health plan available, or because the individual meets the Act's other exemption requirements;
- identify employees who are deemed eligible for the premium tax credit either because the employer did not provide minimum essential health coverage or because the coverage provided did not meet "required minimum actuarial value;" and
- establish Navigator programs using experienced and knowledgeable individuals (who may not work for insurers or be paid by insurers) to assist individuals and small employers to participate in the exchange.

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centers, urban Indian health clinics, tribal clinics, and family planning clinics receiving funding under Title X of the Public Health Service Act.

[8] "Summary of Coverage Provisions in the Patient Protection and Affordable Care Act", Kaiser Family Foundation, 2010.

APPENDIX A

What Can State Primary Care Associations and Health Centers Do to Prepare?

The following questions are a basic primer on the information PCAs and health centers need to gather to begin developing an action plan in their state.

- Does your state plan to operate an exchange?
  - If so, does your state plan to combine its American Health Benefits Exchange and its SHOP Exchange, or to operate them separately?
  - If so, which state agency (or agencies), or which nonprofit entity(ies) will operate the exchange(s)?
  - If so, does your state plan to –
    - Join with other neighboring state(s) to operate a multi-state exchange, or –
    - Operate more than one sub-state exchange?
- Does your state plan to require insurers to offer benefits in addition to the "essential health benefits" that all qualified plans are required to offer?
- Does your state plan to contract with other entities to carry out certain exchange functions (especially enrollment assistance and subsidy eligibility determination)?
  - If so, will the PCA and/or Health Center Networks be eligible to apply/bid to offer such services?
  - Even if not, will the PCA and/or health center networks be able to assist the state in these functions?
- How will your state enforce the network adequacy standards required by the ACA, including the requirement that qualified plans must contract with "essential community providers"? Will such providers include all FQHCs that are located in or serve an area in which a plan intends to make its coverage available?
- How will your state enforce the ACA requirement that qualified health plans pay FQHCs a rate that is no less than their Medicaid PPS rates?
- What process does your state plan to use to determine individual and family eligibility for subsidies, and to enroll them in subsidy assistance?
  - Which plans will subsidy-eligible individuals and families select from (especially in terms of the extent to which they include all appropriate health centers in their provider networks)?
- How will your state synchronize its exchange subsidy eligibility determination and its Medicaid/CHIP eligibility determination and enrollment processes?
  - What types of assistance/counseling will the PCA, Health Center Networks, and health centers be able to provide to their patients and others?
- What information will the state/exchanges make available to individuals and families regarding qualified health plans prior to plan selection (e.g. list of network providers)?
  - How will this information be made available?
  - What types of assistance/counseling will the PCA, health center networks, and health centers be able to provide to their patients and others (including serving as navigators within the exchange(s))?

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