Affordable Insurance Exchanges

DEPARTMENT OF HEALTH AND HUMAN SERVICES

CENTERS for MEDICARE & MEDICAID SERVICES

Center for Consumer Information and Insurance Oversight

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The material in this presentation should not be viewed as having any independent legal effect, or relied upon as an interpretation or modification of the related proposed rule or statute. Not all issues or exceptions are fully addressed.

Background for Proposed Rules: Basic Overview

- In March 2010, Congress passed and the President signed into law the Affordable Care Act, which puts in place comprehensive health insurance reforms that will hold insurance companies more accountable, lower health care costs, guarantee more health care choices, and enhance the quality of health care for all Americans.
- Many important benefits are already in place, including:
  - Bans on the worst insurance company abuses
  - Cost savings for seniors, families and small and large businesses
  - Coverage options for many Americans who have been locked out of the insurance market because of a pre-existing condition.
- More information on the Affordable Care Act can be found at healthcare.gov.

Background for Proposed Rules: Basic Overview

- Affordable Insurance Exchanges are State-based competitive marketplaces where individuals and small businesses will be able to purchase affordable private health insurance and have the same insurance choices as members of Congress.
- Exchanges must be operational by open enrollment in October 2013.

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- The Department of Health and Human Services (HHS) has issued two Notices of Proposed Rulemaking (NPRMs) on July 15, 2011:
  - Minimum Federal standards for States setting up Exchanges and health insurers participating in Exchanges, and
  - Standards relating to reinsurance, risk corridors, and risk adjustment.
- Comments are welcome on these proposed rules, which will be taken into account as HHS revises and finalizes them. Comments are due by September 28, 2011.

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Background for Proposed Rule: Basic Overview

- **Exchanges are designed for consumers and small businesses.**
- They are State-based competitive marketplaces where individuals and small businesses can:
  - Find information and compare health plans
  - Determine eligibility for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP)
  - Easily enroll in a health insurance plan that meets their needs.
- The Affordable Care Act and the proposed rules build a number of important consumer protections into Exchanges.

Background for Proposed Rule: Exchange Goals

- **Expanded Coverage:** Exchanges will expand coverage in the individual and small group markets by offering high-value health plans, lowering administrative costs, and increasing purchasing power.
- **Promoting Competition:** Exchanges will be competitive marketplaces with vastly improved transparency and direct comparisons based on benefits, price, and quality.
- **Affordable Options:** Health plans will be more affordable with financial assistance, including premium tax credits, cost-sharing reductions, and Small Business Tax Credits available for coverage purchased through the Exchange.
- **Quality Improvement:** Exchanges will drive quality and delivery system reform, while ensuring consumer protections.

Overview of Exchange Proposed Rule: Exchange Establishment

- A State electing to establish an Exchange will:
  - Submit Exchange Plan to HHS and demonstrate readiness to operate an Exchange;
  - Receive approval or conditional approval of Exchange Plan by 1/1/13.
- If a State does not elect to establish an Exchange or receive approval or conditional approval by 1/1/13:
  - The State can submit an Exchange Plan in subsequent years;
  - The State can assume some Exchange functions through a Partnership Exchange; and
  - The Exchange in the State will be Federally-facilitated.
- A State can choose to have more than one Exchange in the State or join with other States to form a Regional Exchange.

Overview of Exchange Proposed Rule: Exchange Establishment

- For Exchange Plan approval, States will demonstrate that they will:
  - Operate an Exchange that meets the Exchange standards;
  - Cover the entire geographic area of the State;
  - Operate a reinsurance program;
  - Comply with requirements related to premium tax credits.
- Governance
  - A State can establish a non-profit entity or a public/governmental entity to operate an Exchange, or operate an Exchange through an existing State agency.
  - Majority of voting members of an Exchange board must:
    - Not have a conflict of interest;
    - Primarily represent consumer interests;
    - Have relevant experience in health and insurance related fields.

Overview of Exchange Proposed Rule: Proposed Minimum Functions

- Proposed minimum functions in this NPRM:
  - Provide consumer support for coverage decisions
  - Facilitate enrollment in qualified health plans in the Exchange
  - Operate a Small Business Health Options Program (SHOP)
  - Certify health plans as qualified health plans
  - Perform other functions to be addressed in future rulemaking

Overview of Exchange Proposed Rule: Proposed Minimum Functions

- Consumer support for decisions related to health care coverage
  - Toll-free call center
  - Website with qualified health plan comparison tools
  - Personalized calculator to show cost of coverage after potential financial assistance
  - Outreach and education, including Navigators
- States have flexibility to determine role of agents and brokers in an Exchange.

Overview of Exchange Proposed Rule: Enrollment

- Affordable Care Act vision for new enrollment process
  - Offer a consumer-centric shopping experience
  - Coordinate all coverage seamlessly
  - Minimize enrollment barriers for individuals and small businesses to ensure eligible individuals are enrolled in a health plan
- Enrollment standards for Exchanges
  - Create consumer-friendly application filing processes by web, phone, mail and in-person using a single, streamlined application
  - Adopt standardized initial, annual, and special enrollment periods
  - Adhere to standards for termination of coverage

Overview of Exchange Proposed Rule: Small Business Health Options Program (SHOP)

- SHOPs offer competitive insurance marketplace for small businesses:
  - States may choose to keep an upper limit of 50 employees for the first two years, and include businesses with up to 100 employees starting in 2016.
  - States may choose to operate SHOP as a separate program or merge it with the Exchange to offer the same choices to all participants.
- Small businesses become part of a larger risk pool, stabilizing premiums because risk is spread among more people.
- Employees receive better information and have choices that fit their own needs and budgets.
- Employers have simpler way to offer insurance, reducing administrative costs and burden.

Overview of Exchange Proposed Rule: Small Business Health Options Program (SHOP)

SHOPs will provide a new option for employers, allowing employee choice of insurer and plan while employers set their contributions.

Under the proposed rule:

- Employers choose which tier of coverage they offer and determine their contribution toward employee coverage;
- Employees choose among the qualified health plans within the tier offered by their employer.

SHOPs also have great flexibility to determine other ways that employers may offer insurance under the proposed rule, including offering a choice of:

  - a single plan;
  - specific plans;
  - plans across more than one benefit level.

With any option, the SHOP can send a single bill to the employer and the employer can write a single check to the SHOP.

Overview of Exchange Proposed Rule: Certification of Health Plans

Two-pronged test for certification of qualified health plans:

- Meet proposed standards outlined in the Affordable Care Act and the Exchange NPRM:
  - Examples: accreditation, State licensure, transparency data reporting, benefit design standards.*
- Ensure that qualified health plans are in the interest of the consumer:
  - Flexibility in selection method (e.g., allowing any health plan or conducting competitive bidding);
  - State specific standards (examples: marketing requirements, plan service areas), or any standards that go beyond the Federal minimum.

*Minimum standards for plan benefit design (essential health benefits, cost-sharing limits, and actuarial value) will be further defined in future rulemaking.

Overview of Exchange Proposed Rule: State Flexibility

- States will have significant flexibility to create an Exchange that best fits their needs and is responsive to local market conditions.
- For example:
  - Structure of the Exchange;
  - Qualified Health Plan Selection;
  - Network Adequacy Standards;
  - Marketing Standards;
  - Role of Agents and Brokers in Exchange.

Continuum of State Flexibility by Topic

Exchanges NPRM (CMS-9989-P)	State Flexibility	State Flexibility with a Federal Floor	Nationwide Standard
Qualified Health Plan Selection Process	X		
Network Adequacy Standards	X		
Marketing Standards	X		
Agent and Broker Role in Exchange	X		
Streamlined Applications for Coverage and Eligibility		X	
Accountability and Governance Structure		X	
Subsidiary and Regional Exchange Standards		X	
SHOP Employer/Employee Choice Model		X	
Exchange Consumer Tools: Website, Call Center		X	
Navigator Standards		X	
Requirements for Qualified Health Plan Offerings		X	
Qualified Health Plan Accreditation Requirements		X	
Essential Community Providers		X	
Enrollment Periods			X
Approval of State Exchanges			X
Transparency Reporting Requirements			X

What Exchanges Mean for States

- **Establishment of Exchange:** States can choose to have more than one Exchange in the State, to partner with other States for a Regional Exchange, to have it governed by a non-profit or State agency or to not run an Exchange at all.
- **Standards for Health Plan Choices**: States can choose the number, type, and standards for participating health plans.
- **SHOP for Small Businesses:** States can choose how to organize the SHOP for small businesses, merging it with the Exchange or running it separately, and can decide the types of choices that employers and employees have.
- **Partnerships:** States will have opportunity to leverage resources of other States and Federal government through partnership models.

What Exchanges Mean for Consumers

- **Individuals and Families without Affordable Coverage**:
  - Same choice of the competing health plans as Members of Congress;
  - Same clout as large businesses to get the best deal on insurance;
  - Information on choices;
  - Assistance in making health insurance affordable.

- **Small businesses**:
  - Simplified choices of health plans;
  - More options for employees;
  - Lower costs by gaining purchasing power;
  - Access to tax credits for eligible employers for the cost of coverage.

What Exchanges Mean for the Market

- **Significant New Market Opportunity:** Exchanges will offer 25 million consumers health plans options that provide quality, comprehensive care.
- **Flexibility for Innovation:** Standards preserve opportunities for innovation, such that health plans can respond and adapt to the types of care and access that their customers desire. This includes:
  - Flexibility on plan participation;
  - Flexibility on plan's network design;
  - Flexibility on plan's marketing practices.
- **Stable Premiums:** Risk adjustment, risk corridors, and reinsurance will minimize the problems of adverse selection to help provide market stability and more affordable coverage.

Next Steps

- Public comments are welcome on any of the topics covered in the NPRMs, and due by September 28, 2011.
- HHS will convene a series of regional listening sessions to learn from states, consumers, and other stakeholders how the rules can be improved.
- HHS will modify these proposals in the Final Rules based on feedback.
- HHS published a proposed rule on August 17, 2011 regarding Exchange determination of an individual's eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, and CHIP.
- Separate releases of additional Exchange related topics:
  - Essential health benefits and actuarial value;
  - Quality;
  - Oversight and appeals;
  - Risk Adjustment;
  - Basic Health Program.