

# Affordable Insurance Exchanges

Center for Consumer Information and Insurance Oversight  
Centers for Medicare & Medicaid Services  
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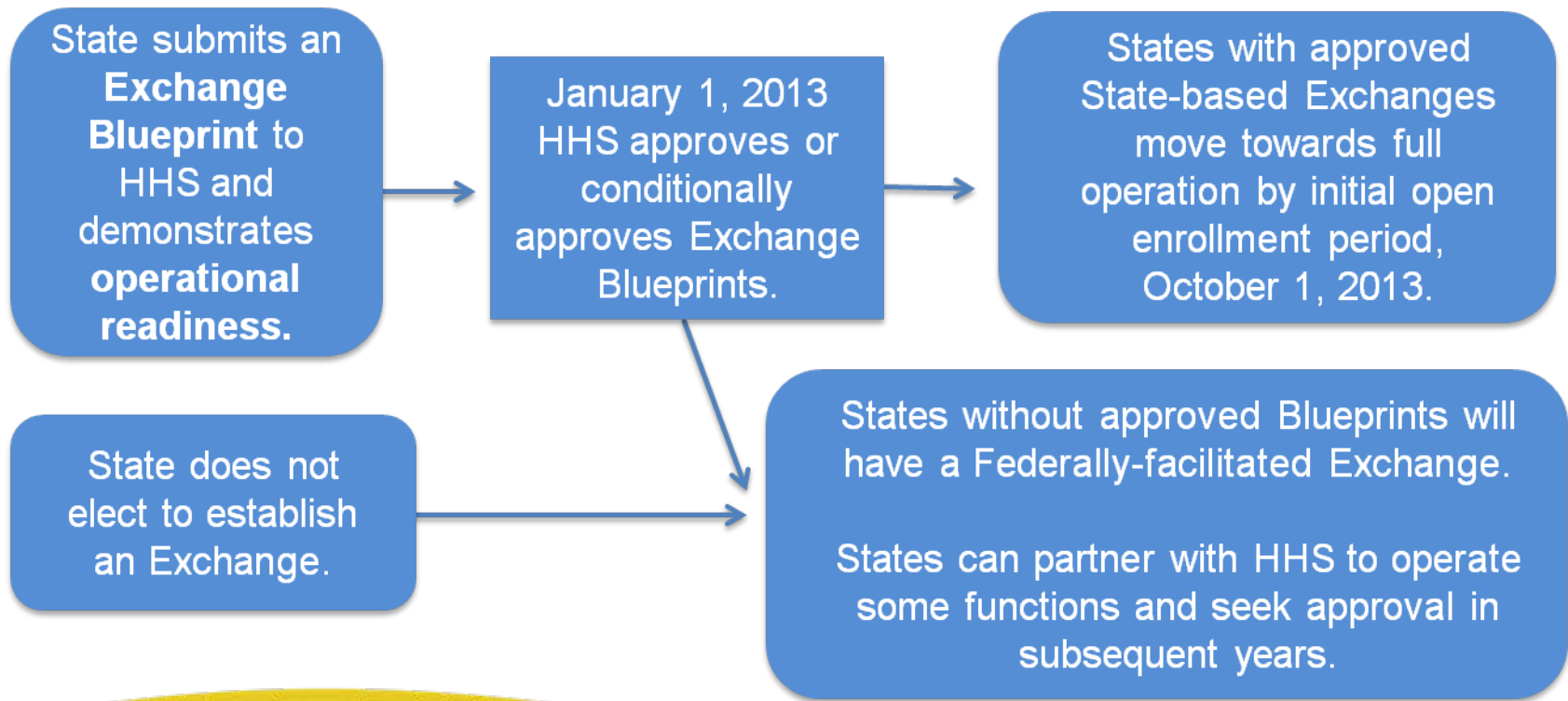
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# Exchange Establishment

A State has substantial flexibility in establishing an Exchange that meets the needs of its citizens.



# Exchange Establishment

- A State can operate an Exchange through a non-profit established by the State, an independent governmental entity, or an existing State agency.
- Exchanges operated under a non-profit or independent governmental entity must have a governing board that meets minimum conflict of interest standards that a State can exceed.
- States must consult with various stakeholders.
- Exchanges must be self-sustaining by January 1, 2015, and have discretion in generating funds, including, for example, through user fees.

# Exchange Establishment: Partnership

- Partnerships are based on a Federally-facilitated Exchange where States can assist with some key functions of the Exchange.
- HHS is responsible and accountable for ensuring the Exchange meets all of the standards.
- States entering into Partnership will agree under the terms of their Exchange establishment grants to ensure coordination.
- As part of a Partnership agreement, States may choose to operate plan management functions and/or certain consumer service functions.

# Minimum Exchange Functions

- As set forth in the final rule, Exchanges must:
  - Provide consumer support for coverage decisions,
  - Facilitate eligibility determinations for individuals,
  - Provide for enrollment in qualified health plans in the Exchange,
  - Certify health plans as qualified health plans (QHPs), and
  - Operate a Small Business Health Options Program (SHOP).
- Contracting ability: Exchanges can contract with certain entities to carry out these minimum functions.

# Minimum Function: Consumer Support

- Consumer support for decisions related to health care coverage:
  - Toll-free call center,
  - Outreach and education, including the Navigator program, and
  - Website with plan comparison tools.
- Exchanges must establish a grant program to fund entities or individuals called “Navigators” that will provide consumer assistance.
- States have the flexibility to use agents and brokers, including web-brokers, to assist individuals enroll through the Exchange in a way that supports individuals’ access to advance payments of the premium tax credits.

# Exchange Privacy and Security

- The final rule establishes strong standards to protect and secure the privacy of personally identifiable information (PII) provided by an applicant.
- An Exchange may use or disclose PII that is created or collected for determining eligibility for enrollment in a QHP, insurance affordability programs, or exemptions only to the extent necessary to perform Exchange minimum functions.
- The Exchange may not create, collect, use or disclose any personally identifiable information needed to perform minimum functions unless it does so in a manner consistent with privacy and security standards in the final rule.
  - Contractors, Navigators, agents, or brokers that gain access to personally identifiable information pursuant to an agreement with the Exchange must comply with these standards as well.
- Additional requirements are established in the final rule, including standards related to monitoring and updating security controls and electronic interfaces.



# Seamless, Streamlined System of Eligibility and Enrollment

Submit single, streamlined application to the Exchange

- Online
- Phone
- Mail
- In Person

Verify and determine eligibility

- Supported by the Federally-managed data services hub
- Eligibility for:
  - Enrollment in a QHP
  - Advance payments of the premium tax credit and cost-sharing reductions
  - Medicaid and CHIP

Enroll in affordable coverage

- Online plan comparison tool available to inform QHP selection
- Advance payment of the premium tax credit is transferred to the QHP
- Enrollment information transferred to QHP or Medicaid/CHIP

# New Options for Conducting Eligibility Determinations (IFR)

- The final rule provides new options for structuring the streamlined and coordinated system for determining eligibility for insurance affordability programs.
- In addition to the option for the Exchange to conduct eligibility determinations for enrollment in a qualified health plan through the Exchange and insurance affordability programs either directly or by a contract with an eligible entity, States now have two additional options:
  - The Exchange may conduct assessments of eligibility for Medicaid and CHIP, with the State Medicaid and CHIP agencies making final Medicaid and CHIP determinations; and
  - The Exchange may use Federally managed services for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions.

# New Options for Conducting Eligibility Determinations: Medicaid and CHIP (IFR)

- The Exchange may conduct assessments of eligibility for Medicaid and CHIP, rather than eligibility determinations for Medicaid and CHIP.
- Assessments will be made using the applicable Medicaid and CHIP income standards and rules regarding citizenship and immigration status and using verification rules consistent with Medicaid and CHIP regulations and other State-specific policies, to the extent possible and agreed upon by both the Exchange and Medicaid/CHIP agencies.
- The Exchange and Medicaid/CHIP agencies must enter into agreements outlining the responsibilities of each entity to ensure a seamless and coordinated process.

# Verifications Needed to Support Eligibility Determinations

Exchanges ensure the following determinations are made *promptly and without undue delay (IFR)*:

Determinations	Verifications Supporting Eligibility Determination	Entity Responsible for Eligibility Determination
Enrollment in a QHP*	Residency Citizenship / Immigration Status Incarceration	Exchange
Medicaid and CHIP based on MAGI	Residency Citizenship / Immigration Status MAGI and household size	Exchange or State Medicaid / State CHIP agency (IFR)
Advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR)	MAGI and family size Eligibility for other minimum essential coverage Whether an individual is an Indian**	Exchange or HHS (IFR)

\*After an eligibility determination has been made, to select a plan, a qualified individual would need to qualify for an enrollment period, as described in subsequent slides on enrollment.

\*\* Indian status is not a condition of eligibility for enrollment in a QHP, but is considered for special cost-sharing provisions and special enrollment periods.

# Eligibility Determinations: Redeterminations

## Redeterminations During a Benefit Year

- Exchange must ensure that enrollees report changes related to eligibility promptly to the Exchange to ensure eligibility reflects current situation.
- The final rule allows flexibility to expand limited data matching to identify changes affecting eligibility during the benefit year.

## Annual Redeterminations

- Exchanges must redetermine eligibility based on updated data on notice unless individual responds with updated information.
- Exchanges must send the notice of annual redetermination and annual open enrollment as a single, coordinated notice.
- Exchanges must maintain current authorization from enrollee to obtain updated tax return information on notice.

# Single, Streamlined Application

## How can an application be filed?

- Via an internet web site
- By telephone
- By mail
- In person, with reasonable accommodations for those with disabilities

## Who can file an application?

- **Application filer, including:**
  - An applicant,
  - An adult in the applicant's household or family
  - Authorized representative
  - If the applicant is a minor or incapacitated, someone acting responsibly for an applicant.

## The Exchange application will be used to determine eligibility for:

- Enrollment in a QHP
- Advance payments of the premium tax credit
- Cost-sharing reductions
- Medicaid, CHIP, or the BHP, if applicable

**The Exchange may use an alternative application approved by HHS as long as it captures all information necessary for the eligibility determinations above.**

# Minimum Function: Enrollment

Enrollment Period	Length	Dates	Effective Date
Initial	6 months	October 1, 2013 – March 31, 2014 (extended in final rule)	<ul style="list-style-type: none"> <li>❖ Qualified individuals must select their QHP by the 15<sup>th</sup> of the month for coverage to be effective on the 1<sup>st</sup> of the following month.</li> <li>❖ QHP selections made after the 15<sup>th</sup> become effective the 1<sup>st</sup> of the second following month.</li> <li>❖ Effective dates can be earlier if all QHP issuers agree.</li> </ul>
Special	60 days	Period lasts 60 days from triggering event	Same as initial enrollment period.
Annual	53 days	October 15 – December 7 (Notice sent between September 1 and 30)	January 1 <sup>st</sup> of new benefit year

No coverage is effective prior to January 1, 2014.

# Minimum Function: Enrollment

## QHP Selection

- Qualified individuals can compare qualified health plans and select one for enrollment

## Data Transmission

- The Exchange sends eligibility and enrollment information to QHP issuers and to HHS

## Acknowledge and Enroll

- The QHP acknowledges receipt of eligibility and enrollment information from the Exchange
- The QHP enrolls the qualified individual

## Reconcile

- The QHP, the Exchange and HHS reconcile enrollment records each month



# Termination of Coverage

## Enrollees may terminate their own coverage if they:

- Provide reasonable notice to the QHP
- Are newly eligible for Medicaid, CHIP, or the Basic Health Program, if applicable

## Exchanges and QHPs may terminate coverage through the Exchange if the enrollee:

- Changes to another QHP
- Commits fraud
- Loses eligibility for the Exchange
- Fails to pay premiums
- Is enrolled in a terminated or decertified QHP

**The Exchange must maintain termination records and transmit them to QHP issuers and HHS.**

# Minimum Function: Qualified Health Plan Certification

Two-pronged test for certification of qualified health plans (QHPs):

1. Meet standards outlined in the Affordable Care Act and the Exchange final rule.
2. Ensure that offering the qualified health plans are in the interest of the consumer, as determined by the Exchange, through:
  - Flexibility in selection method (e.g., allowing any health plan or conducting competitive bidding), and
  - State-specific standards (examples: marketing requirements, plan service areas), or any standards that go beyond the Federal minimum.

The Exchange has significant flexibility to design the certification, recertification, and decertification processes within the parameters established in the final rule.

# QHP Certification Standards

To participate in an Exchange, a health insurance issuer must meet the following minimum criteria:

<b>Licensure</b>	Licensed and in good standing in each State in which it intends to offer QHPs
<b>Solvency</b>	Meets State financial and solvency standards.
<b>Marketing</b>	Complies with all applicable State law governing marketing of health plans.
<b>Benefit designs</b>	Does not employ benefit designs discouraging enrollment by higher-need consumers.
<b>Rate and benefit reporting</b>	Provides information on rates and covered benefits, and submits a justification for any rate increases.
<b>Network adequacy</b>	Maintains provider networks that are sufficient in number and types of providers to assure that all services will be accessible without unreasonable delay.
<b>Accreditation</b>	Receives accreditation for QHPs within a timeframe specified by the Exchange.
<b>Essential community providers</b>	Includes in the provider network essential community providers, that serve low-income and medically-underserved populations.
<b>Service area</b>	QHP issuers cannot establish service areas that are discriminatory.
<b>General Process</b>	Complies with any additional standards and processes established by an Exchange.

# QHP Certification

- The Affordable Care Act calls for the inclusion of several unique plans in an Exchange:
  - **Stand-alone dental plans**, provided that they meet the applicable QHP certification standards and cover, at a minimum, a set of pediatric dental benefits called for as part of the essential health benefits.
  - **CO-OP QHPs**, which are member-run private health insurance plans developed with loan funding under the Consumer Operated and Oriented Plan program.
  - **Multi-state Plans**, provided that they are offered under contract with the U.S. Office of Personnel Management.

# Minimum Function: Small Business Health Options Program (SHOP)

- **General:** Exchanges must establish a SHOP for qualified employers to offer QHPs to their employees. A State may operate its SHOP separately from its Exchange.
- **Eligibility:** Employers with fewer than 100 employees may participate, although States may limit eligibility to employers with 50 or fewer employees for the first two years.
- **Enrollment:** Open enrollment occurs on a rolling basis when a qualified employer offers coverage to employees, and begins on October 1, 2013.
- **Premium payment:** The SHOP will deliver a single bill to the employer.
- **Plan selection:** Qualified employers determine their contribution towards employee coverage and choose which QHPs are offered to their employees through a method allowed by the SHOP.

# Next Steps

- This final rule is one of many sources of information about Exchange standards and other insurance reforms established under the Affordable Care Act. HHS has also published:
  - A final rule regarding Medicaid eligibility,
  - A final rule regarding standards for reinsurance, risk adjustment and risk corridors,
  - An essential health benefits bulletin, and
  - An actuarial value and cost-sharing reduction bulletin.
- As noted earlier, several provisions included in this final rule are being issued as interim final rule provisions, and are therefore subject to comment. The comment period closes May 11, 2012.
- Future guidance and rulemaking will continue to provide information about the Exchange program.