

Everything about Exchanges you've wanted to know . . .

HHS Issues Proposed Rules



New Proposed Rules set standards, certify health plans, and ensure premium stability

Just issued by the Department of Health and Human Services (HHS) are two new proposed rules to implement the new Affordable Insurance Exchanges under Title I of PPACA, effective in 2014. Insurance companies that offer product on the Exchanges will be competing for business on a transparent, level playing field. This competition is expected to drive down costs and make coverage more competitive and affordable. This fact coupled with PPACA's personal mandate to obtain coverage in sickness or health will increase the risk pool – a necessity to minimize what might otherwise be adverse selection of extreme proportions during the first few years of the Exchanges. Remember, insurers will be encouraged (mandated) to keep premiums lower while also implementing new reforms that will increase their potential costs, for example the mandate against pre-existing conditions.

The new proposed rules offer States guidance and options on how to structure their Health Care Exchanges in two key areas: 1) ensuring premium stability, and 2) setting standards for operations, including certifying health plans.

Ensuring Premium Stability

PPACA established 1) transitional reinsurance, 2) temporary risk corridor programs and 3) a permanent risk adjustment program to provide payments to health insurance issuers that cover higher-risk populations. These three programs provide the necessary tools to help stabilize insurance premiums, minimize the effects of adverse selection and help foster a stable marketplace.

PPACA structured reinsurance and risk adjustment as State-run programs with Federal guidelines on methodology. The new rules provide the standards related to all three programs. For more information on the guidelines please click the following link for the Federal Register website. I will warn you ahead of time it is not an easy read: <http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf>

At a very high level, the purpose of the State-based transitional reinsurance program is to “reduce the uncertainty of insurance risk in the individual market by making payments for high-cost cases.” The temporary Federally-administered risk corridor program will serve to “protect against rate-setting uncertainty in the Exchange by limiting the extent of issuer losses and gains.” The permanent State-based risk adjustment program is intended to “protect health insurance issuers that attract high-risk populations such as individuals with chronic conditions.”

Setting Standards

HHS was careful to offer States the flexibility they need to design Exchanges that best fit their unique insurance markets. This also allows them to be consistent with the steps some States have already taken to develop their own Exchanges which, under PPACA, must be operational by January 1, 2014, following a fall 2013 enrollment. *Note: employers must begin explaining in 2013 to their employees how the Exchanges will operate.*

Key Points

- ✓ The Exchange must be a governmental agency or non-profit entity established by a State.
- ✓ Each State Exchange must be approved by HHS no later than January 1, 2013.
- ✓ Approval standards include: 1) covering the entire geographic area of the state with one or more Exchanges, 2) agreeing to perform the responsibilities related to the operation of a reinsurance program, 3) having the ability to carry out the required functions (see details below) and 4) having the ability to carry out the information requirements described in the Code.

What is an Exchange?

As described in the Patient Protection and Affordable Care Act (PPACA), Exchanges are State-based competitive marketplaces where individuals and “small” employers will be able to purchase affordable private health insurance beginning in 2014. Larger businesses may purchase from the Exchanges beginning in 2017. States may choose to operate their Exchanges or opt for a Federally-facilitated Exchange operated through HHS. States that are unable to demonstrate their readiness in early 2013 may automatically join the Federally-facilitated Exchange. States are also permitted to join a regional Exchange (two or more states).

Exchanges will provide a choice of plans to fit various consumer needs while offering the same purchasing power of large employers. Individuals and employers will have the ability to compare health plans, enroll in a health plan, get answers to questions about health coverage options and determine eligibility for health programs or tax credits that make coverage more affordable. The Small Business Health Options Program (SHOP) is for employers. The rules define a small employer as one that employees 100 or fewer employees. However, until 2016 States can set the size of the small group market to 50 or fewer if they choose rather than 100 or fewer. Beginning in 2017, States have

Who is a Small Employer?

For purposes of determining which employers may secure coverage through SHOP, the Rules provide that a small employer has 100 or fewer employees.

However, states can set the size of the small group market to 50 or fewer.

the option to permit businesses with more than 100 employees to buy large group coverage through the SHOP.

Small employers participating in SHOP may be eligible for a tax credit of up to 50% of their premium payments if they have 25 or fewer employees, pay employees an average annual wage of less than \$50,000, offer all full time employees coverage and pay at least 50% of the premium. Employees offered affordable, quality health insurance by their employer, however, are not eligible for premium credits for coverage purchased through the Exchange.

As an aside, once the Exchanges become operational in 2014, members of Congress will receive their health insurance through an Exchange.

Exchanges must communicate with stakeholders

Each Exchange must regularly consult with its key stakeholders, this includes:

- Consumers enrolled in one of the Exchanges' qualified health plans (QHPs)
- Individuals and entities with experience in facilitating enrollment in health coverage
- Advocates for enrolling hard-to-reach populations
- Small businesses, self-employed individuals, large employers
- State Medicaid and CHIP agencies
- Public health experts
- Health care providers
- Health insurance providers
- Agents and brokers

Exchanges must provide consumer assistance tools in compliance with ADA and also linguistically appropriate, including:

- Toll-free call center
- Consumer Assistance & Navigator program (a "Navigator" cannot be an insurer or receive any compensation from an insurer in connection with enrollment activities)
- Exchange outreach and education programs

- Up-to-date Internet website that hosts a provider directory, and comparative data on each qualified health plan, as well as an electronic calculator to compare rates, calculate tax credits and any cost-sharing reductions
- Results of enrollee satisfaction surveys

Enrollment in Exchanges

The initial open enrollment is expected to begin October 1, 2013, and extend through February 28, 2014. During the open enrollment period a qualified individual may enroll in or change a qualified health plan. Exchanges must also offer special enrollment periods to address changes in status.

Under the SHOP, a qualified employer may join at any point during the year. The 12-month plan year begins with the qualified employer's effective date of coverage.

The Exchanges must use a single "standard" application form to enroll either an individual or an employer.

Certifying Qualified Health Plans (QHPs)

A plan defined as a multi-state plan is exempt for the certification process. These plans are offered by a health insurance provider under contract with the US Office of Personnel Management (OPM) to offer a multi-state qualified plan. Otherwise, each Exchange must establish procedures for the certification and ongoing recertification (or decertification) of qualified health plans prior to the open enrollment period.

The standards to be certified are extensive; for example, a provider must:

- ✓ be licensed and in good standing in each State in which it offers health insurance coverage
- ✓ comply with all state laws and regulations regarding marketing by health insurers
- ✓ comply with all requirements and benefit design standards of PPACA
- ✓ implement and report on quality improvement strategies related to health care quality and outcomes
- ✓ offer at least one QHP in the silver coverage level and one in the gold coverage level as described in Section 1302(d)(1) of PPACA.
- ✓ comply with provider network adequacy standards

Funding of operations

No Federal funds will be provided for State Exchanges after January 1, 2015, so States must provide for funding after this date. One way States are permitted under the rules to fund ongoing operations is by charging assessments or user fees on participating insurance providers.

For more information, visit www.Healthcare.gov/exchanges or for a link to the Proposed Rule: http://www.ofr.gov/OFRUpload/OFRData/2011-17610_PI.pdf

About the Author



Trish Neely, CFCI has worked in the benefits field nearly 25 years; 10 years overseeing FBMC’s Legal and Compliance division. She is Editor of the award winning *Quarterly Review* newsletter, FBMC’s practice leader and trainer on regulatory matters and a frequent seminar speaker. Her most recent 60-minute webinar through **ExecSense Webinars** was titled “What Compliance Executives Need to Know About Health Care Reform.”

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