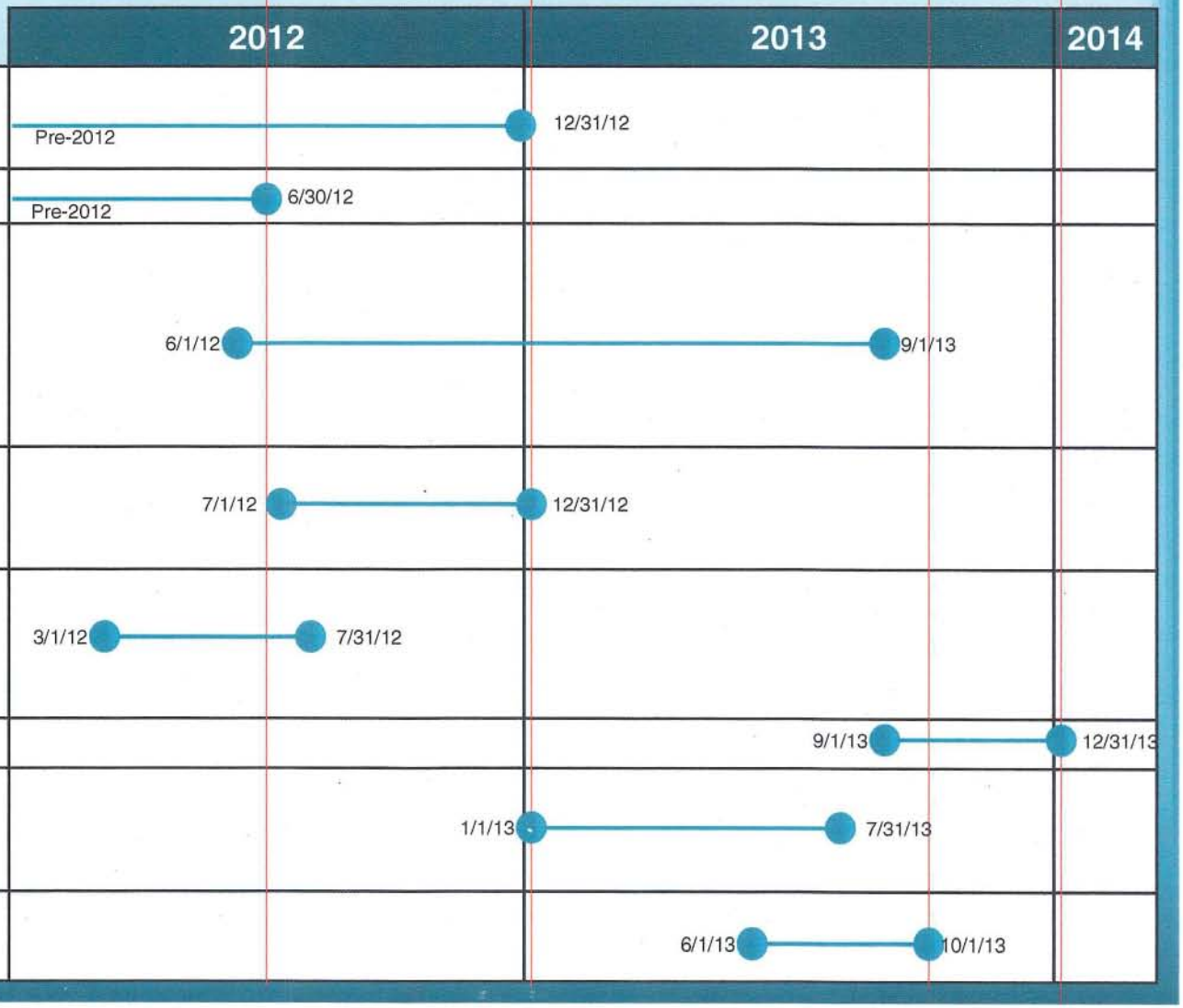
Timeline for State Exchange Implementation

6/1/12
- State legislative sessions end
- States elect benchmark EHB package

1/1/13
- HHS decides whether state exchanges will be ready by October

10/1/13
- Exchanges begin enrolling

1/1/14
- Exchange coverage begins



Planning and Designing	• Governing Board • Hiring/Space • Implementation Plan
Contracting	• IT/Website Contracting
	Other IT /systems data • Develop and test systems for: enrollment & eligibility, web portal, payment and billing • Develop and test user interfaces w/QHPs, federal hub, state agencies, call centers
Eligibility & Subsidy Administration	• Dev't of federal eligibility screening system & process • States ensure systems meet federal specs; develop secure e-interfaces
Marketing & Outreach	• Create strategy • Issue RFP; select vendor(s) • Navigator selection • Call center development • Finance
	• Execute strategy
QHP Administration	• Release QHP solicitation • Screen, accept, & certify applicants • Develop & test IT interfaces with QHPs
	• Collect and load QHP data onto website

Exchange White Paper

Executive Summary

Beginning in 2014, millions of Americans will purchase health insurance through new health insurance marketplaces called exchanges. While the Patient Protection and Affordable Care Act intends for states to establish exchanges, it requires the federal government to step in and set up a federal exchange where it has determined that a state has failed to make progress by January 1, 2013. A federal exchange would give the federal government unprecedented control over a state's insurance market, extending their new regulatory authority well beyond exchanges.

Importance of State Development of Exchanges

The Choice and Competition Coalition (CCC) strongly supports state development of exchanges. Health insurance exchanges can make it easier for individuals and employers to shop, compare, and enroll in health insurance coverage while fostering competition and providing a wide array of choices to consumers. Ideally, exchanges will help more people enroll in affordable, high-quality coverage.

Rather than accept a one-size-fits-all federal regulatory approach, states should develop their own exchanges that meet local needs and ensure consistency with state regulation of insurance. States have traditionally been the primary regulators of the insurance market and already have the infrastructure, including highly trained staff, to design, oversee, and enforce these regulations. State implementation of exchanges will be critical to ensure effective coordination with state insurance regulators.

Recommendations for Federal Action

Successful implementation of exchanges is an enormous undertaking for states, health plans, businesses, and the federal government. The federal government's requirements for state exchanges must: be issued on a timely basis; allow for simple and flexible state implementation, and; provide a complete set of requirements. Timely, simple, and complete rules are necessary for states to be able to establish a competitive exchange within the statutory timeframes.

- *Final rules must be issued on a timely basis*. In order for states to implement exchanges, all proposed rules on exchanges should be finalized in the first quarter of 2012.

- *Final rules must be simple for states to follow and provide states the flexibility needed to establish an exchange.* The federal government should provide states with the opportunity to receive conditional certification of an exchange based on clearly defined criteria in a final rule.

- *Final rules must provide a complete set of requirements for states and all other stakeholders*. Such requirements should promote private market competition and choice. Whether operated by a state or the federal government, all qualified plans should be permitted to offer coverage.

Recommendation #1: Final Rules Should Be Issued on a Timely Basis

All proposed rules on exchanges need to be finalized in the first quarter of 2012 to provide states a realistic opportunity to implement an exchange that will be operationally ready to accept enrollment beginning in 2013. Given the interwoven nature of exchanges and all the law's reforms for health plans, it will also be necessary for final rules on all other reforms to be issued within this timeframe in order for such reforms to be fully in place by 2014.

- **Tight timeline for states:** Final rules on exchanges and the reforms for health plans are needed by this date to provide states adequate time to build exchanges and alter their state insurance rules; health plans will need to file products with their states in early 2013 to be ready for open enrollment in the fall. Unless complete guidance is issued early this year, states will not have enough time to build an exchange which will force more states to rely on a federal fallback exchange.

- **Many significant changes for states:** The level of change and workload that will be required to implement healthcare reform is unprecedented, placing an enormous demand on employers and the entire health care industry at large. The list that follows demonstrates the breadth of changes necessary to ensure that exchanges are up and running by late 2013.

    - To establish exchanges, the Department of Health and Human Services (HHS) proposed rules say states must:

        - **Consult with stakeholders:** States must establish a mechanism to solicit input on exchange design and function by stakeholder groups; and hold stakeholder meetings throughout the state.
        - **Pass legislation and promulgate regulations**: States must draft and introduce enabling legislation, implementing regulations, or other mechanisms that provide the legal authority to establish and operate an exchange.
        - **Establish governance**: States must appoint a governing board and a management team sufficient to oversee the operations of the exchange; develop a formal operating charter or by-laws; determine whether the exchange should be housed in a state agency, quasi-governmental agency, or non-profit.
        - **Set up exchange information technology (IT) systems**: States must conduct gap analysis of existing systems, develop IT and integration architecture, business requirements and interim detailed design, and system requirement documents. Develop final requirements and baseline system including software and hardware. Complete testing of system components.
        - **Integrate entitlement programs:** States must create detailed business process documentation to reflect current and future state business processes that support exchange operational requirements; develop work plans for collaboration among appropriate state agencies, Department of Insurance (DOI), Medicaid, Human Services); determine roles and responsibilities of the DOI as they relate to qualified health plans offered inside and outside the exchange; determine roles and responsibilities of Medicaid and other relevant state programs related to eligibility determination, verification, and enrollment; determine standards for interactions between an exchange and state programs; develop cost allocation between exchange grants and other Medicaid federal grant programs, execute intra-agency agreements as necessary; collaborate on procurement and development of exchange and Medicaid IT systems needed to facilitate "no wrong door" for eligibility determinations.
        - **Certify Qualified Health Plans (QHPs):** States must develop standards that will be required for certification of a qualified health plan.

- **Create an exchange website and subsidy calculator:** States must develop requirements, systems and program operations for online comparison of QHPs; selection and enrollment; cost calculator functionality; requests for assistance; and linkages to other state programs (i.e. Medicaid).
- **Design navigators:** States must establish responsibilities for new Navigator grant program; detail training and licensing requirements; determine targeted organizations in the state who would qualify to function as Navigators; develop contract requirements, solicit applicants and make funding awards.
- **Finalize an eligibility process:** States must develop requirements for the exchange and other appropriate program agencies (Medicaid, Children's Health Insurance Plan (CHIP)) to integrate or interface to support enrollment transactions and eligibility referrals; coordinate appeals, applications and notices; manage transitions; communicate enrollment status; develop requirements, systems and program operations to customize plan information to individuals based on eligibility and QHP data; submit enrollment transactions to QHPs; receive acknowledgements of enrollment transactions from QHPs.
- **Develop an enrollment process:** States must implement processes for enrolling consumers into qualified health plans; detail transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions.
- **Formalize an exemption process:** States must develop requirements, systems and program operations to accept requests for exemptions from individual mandate requirements; review and adjudicate requests; exchange relevant information with HHS.
- **Create a process to notify and adjudicate appeals:** States must develop requirements, systems and program operations for adjudication and notification of individual eligibility and employer liability appeals.
- **Program reporting systems:** States must develop requirements, systems, and program operations to capture necessary information for reporting to HHS, Internal Revenue Service (IRS), enrollees, QHPs, Medicaid, etc.
- **Craft outreach and education materials:** States must develop outreach and education plan including environmental, market and demographic assessment, develop communications and media plan, create tools and materials.
- **Create Small Business Health Options Program (SHOP):** States must develop requirements, systems, and program operations.
- **Develop financial management:** States must establish procedures for reporting on financial integrity. Provide necessary resources for implementation of risk adjustment, reinsurance, and risk corridor programs.

Recommendation #2: Final Rules Must be Simple For States to Follow and Provide States the Flexibility Needed to Establish an Exchange

Implementation of the law is placing an enormous demand on the entire health care industry. The level of change and workload is unprecedented. To minimize the burden and costs on the industry, and help ensure that states and health plans will be ready by 2014, requirements need to be streamlined, not go beyond the already extensive statutory requirements, provide broad flexibility for states, and ensure reasonable standards for participating health plans to encourage their participation.

Simple requirements will minimize barriers to implementation and allow exchanges to keep administrative costs low. Implementing cost-effective and efficient exchanges is vital to keeping costs manageable and participation attractive for states, consumers, employers, and health plans. Streamlined administrative procedures will help make coverage available to small employers and families in a seamless, cost-effective, and efficient manner.

To ensure that federally issued requirements are appropriately simple and flexible, HHS must:

- **Make implementation feasible for states to accomplish.** If HHS issues complex and prescriptive requirements, states will be more likely to leave the exchange to HHS. As illustrated earlier in this paper, the level of change and workload to implement the law is unprecedented and is placing an enormous demand on the entire health care industry. HHS should be careful not to make implementation so difficult that it effectively leads to more states with HHS operating an exchange.

- **Provide states broad flexibility to implement a partial set of core functions for HHS to certify their exchange by 2013.** The development of exchanges should focus on basic exchange functions and requirements. Federal certification criteria should ensure that states and plans can be ready by 2014. HHS should allow states to streamline existing requirements and avoid imposing duplicative regulatory requirements on health insurers. At a minimum, federal criteria for states should not go beyond the already extensive statutory requirements.

- **Issue final rules that reflect the substantial flexibility accorded to states by the law to structure exchanges to best meet the needs of their residents.** Such flexibility is needed to address the substantial differences in state-to-state health insurance markets, regulatory environments, and consumer preferences, and will be critical to harness state innovation to ensure that exchanges meet local consumer needs and ensure that states are invested in creation and ongoing management of exchanges.

- **Allow states ongoing flexibility to modify their exchanges without federal approval.** After a state receives initial federal certification, HHS should provide states with the autonomy within federal guidelines to design their exchanges in a manner that promotes choice and competition. While the proposed rule provides states flexibility in the design and implementation of exchanges, the requirement for states to obtain HHS approval for "significant changes" using a Medicaid- and CHIP-like state plan amendment process undermines this flexibility. The federal approval process could potentially stifle market competition if the HHS approval criteria are too rigid or burdensome.

Recommendation #3: Final Rules Must Provide a Complete Set of Requirements that Promote Private Market Competition and Choice

Unless complete guidance is issued early this year, states will not have enough time to build exchanges, and the result will be more states with a federal fallback exchange. As of mid-February 2012, final rules are lacking in critical areas. Although Proposed Rules, Frequently Asked Questions (FAQs), and Bulletins have been issued on some (but not all) of the major provisions of health care reform, final requirements are essential to implementation of 2014 reforms.

For example, the Centers for Medicare and Medicaid Services (CMS) recently released a draft application for state exchange certification which requires states to provide detailed information on several major functions where HHS has not issued final requirements, (e.g., eligibility and enrollment standards; web portals; Navigators; and risk adjustment). Below is a detailed list of the open issues that regulations need to address in order to be complete.

At a minimum, CCC believes that a complete set of *final requirements must*:

- **Clarify that health insurance exchanges – whether operated by a state or the federal government – will promote private market competition and choice.** Exchanges can work most effectively if they are open to all qualified health plans that seek to participate. Market-oriented exchanges—that are open to all qualified health plans—can better attract plan participation, foster private market competition to keep costs more affordable, and assure robust plan choices and options for businesses and families. We do not believe it would be appropriate or feasible for the

federally-facilitated exchange to implement selective-contracting or pursue an "active purchaser" model as this would limit choices for consumers and compromise private market competition that is necessary to assuring affordability in coverage.

- **Allow for innovative benefit designs.** Exchanges should also avoid imposing standardized benefit packages, and instead, allow a broad range of innovative plan designs — so long as they meet federal requirements for qualified health plans (including minimum standards on covered benefits, actuarial values, and limits on cost-sharing).

- **Provide additional details on the design and functions of a "federally-facilitated" exchange and partnership models.** Without critical information from HHS on the "federally-facilitated" exchange and partnership options, states are forced to make uninformed decisions between establishing their own exchange or allowing the federal government to operate an exchange. HHS should specify how the "federally-facilitated" exchange will be designed and what functions it will operate within states. Further details on the shared "partnership" approach of an exchange should also be provided to states so that they know which business systems they would be responsible for implementing and what services HHS would perform within each core business area. Further, it will be critical for HHS to identify the data it will collect from states and health plans within each business area so states can determine what the information will be used for and if it would duplicate existing state regulatory processes.

- **Address outstanding questions:** Among the issues highlighted above, the following open issues must be addressed to ensure for the effective establishment of exchanges in states:

  - **State establishment of exchanges**

    - What are the specific requirements states will have to meet to establish: (1) an individual market exchange; and (2) a SHOP exchange?
    - What will states have to do to obtain "conditional approval" of their exchange?
    - What roles and responsibilities will other agencies (IRS, Social Security Administration (SSA), Homeland Security, etc.) undertake in exchange implementation, particularly with respect to making eligibility determinations?
    - How will the process for determining eligibility for premium subsidies cost sharing reductions work? How will appeals of those determinations be adjudicated?
    - How will the initial open enrollment, annual open enrollment and special enrollment periods be defined?
    - What premium payment requirements will apply to members? What rules will apply for late payments/grace periods?
    - Will states need to establish a process for aggregating premiums from multiple sources (e.g., enrollees, employers, the federal government)?
    - What requirements will apply to the marketing of health plans offered on exchanges?
    - What outreach and education activities will states be required to perform?
    - What rules will apply to establishing call centers?
    - What kind of on-going oversight and monitoring of the exchange and its participating health plans will states be required to perform?
    - What requirements will states have to meet in establishing a cost calculator for their exchange websites?
    - What rules will states have to follow in establishing their Navigator Programs?
    - Will states allow broker and agents to directly enroll individuals in an exchange? If so, what rules will they apply to brokers and agents?
    - What kind of audit process for exchanges will states have to undertake, both at the state and federal levels?

- **Qualified Health Plans in the exchange**

  - What kind of oversight and monitoring will states have to perform with respect to QHPs – what rules will states be permitted to develop with respect to the selection, certification and recertification process for Qualified Health Plans (QHPs)?
  - What rules will states have to follow to ensure QHPs are appropriately accredited?
  - What requirements will states have to follow in reviewing QHPs' initial premiums as well as their justifications for future premium increases?
  - Will the federal government establish its own network requirements, including treatment of essential community providers, and if so, what will those requirements be?
  - How will the federal government assign ratings to QHPs offered on state exchanges?
  - How will QHP offerings be presented on state exchange websites? In what format?
  - What rules will states have to follow to ensure QHPs meet federal requirements related to products offered in and outside the exchange (e.g., ensuring that the rates for such products are pooled together)?

- **Essential Health Benefit Package**

  - What rules on cost-sharing and actuarial value will apply to QHPs?
  - With respect to the state benchmark plan approach proposed for 2014-2015:
    - What process will states have to follow in designating their benchmark plan selection?
    - How will state benefit mandates in benchmark plans be treated?
    - How will annual and lifetime limits including in state defined benchmark plans be treated?
    - Will multi-state plans be required to offer the same benchmark plan coverage as state based QHPs?
    - For state benchmark plans that include benefits that go beyond the ten Essential Health Benefit (EHB) categories, will QHPs be required to offer those additional benefits?
    - What will be the required scope of pediatric dental, vision, habilitative and mental health and substance abuse benefits?
    - What process will be used to update the essential benefits package?
  - How will essential benefits related to rules for "minimum" essential coverage?
  - How will routine costs be defined for purposes of the requirement to cover routine costs for clinical trial participants? Will the rules differentiate coverage requirements for clinical trials at different phases? (The law requires coverage of Phases 1-IV, although Phases I and II may be considered too risky for patient treatment.)
  - Required benefits for newly eligible Medicaid recipients?

- **Data reporting**

  - What data collection requirements will apply to QHPs offered by exchanges? How will QHPs submit required data, and in what form?
  - What systems will be used for collecting this data?
  - How will data be transmitted between exchanges, health plans, and the federal data services hub to ensure the right people are receiving the coverage and subsidy payments?
  - What kind of data will health plans have to report for the risk adjustment and risk corridor program for individual and SHOP exchanges?
  - What kind of data will health plans have to report for the temporary reinsurance program for the individual exchange?

- **Eligibility and enrollment**

  - What will the rules be for enrolling individuals and small employers in exchanges?
  - What enrollment transactions, specifications and timing for reporting will apply?
  - What will the uniform enrollment application look like?
  - What requirements will apply to changes to enrollments and member updates?
  - How will the enrollment reconciliation process work?
  - How will the enrollment process and payment related process be coordinated?
  - How will special enrollment periods be implemented?
  - What grace period rules will apply?
  - What other enrollment requirements will apply (e.g., with respect to ID cards, member mailings, etc.)?

- **Risk mitigation in an exchange**

  - What are the details on how the risk adjustment for individual and small group markets will work?
  - What are the details on how risk corridors for individual and small group markets will work?
  - What are the details on how the reinsurance program for individuals will work?

- **Financial management**

  - What processes will apply for transfers of funds among entities?
  - What is the financial relationship between federal and state entities?
  - What reporting requirements will apply to the exchange?

- **Consumer assistance and educational tools**

  - What requirements will states have to follow in implementing the Navigator program?
  - What responsibilities will the Call Center have to carry out?
  - How will consumers interact with the HHS Web Portal?
  - What will be the standard format required for the display of benefits and pricing of QHP offerings on the exchange website?
  - What rules will apply to agent and brokers who enroll individuals and small employers for exchange coverage?
  - What information will health plans be required to report for the transparency requirements?
    - Transparency in coverage – claims payment policies and practices, periodic financial disclosures, enrollment/disenrollment data, data on claims denial and rating practices, information on cost-sharing and payments for non-network coverage and information on enrollee rights.
    - Transparency in cost-sharing – what requirements will apply with respect to the requirement to Permit individuals to learn the amount of cost-sharing with respect to specific items or services by a participating provider upon request; at minimum, such information must be available through an Internet website.
  - What quality measures will apply to QHPs and how will these be communicated to consumers?
  - How will the provider non-discrimination rules be interpreted? For example, will QHPs continue to be able to apply the terms of their contracts, including payment terms to all providers?

- **Insurance reforms**

- Will the Open Enrollment Period (OEP) and Special Enrollment Period (SEP) provisions of the exchange establishment proposed rule apply to the market outside an exchange?
- More generally, will OEPs be allowed in the outside market or will plans be required to offer guarantee issue on a continuous basis?
- Will grace period provisions be applied to the outside market?
- How will the modified community rating requirement be interpreted? For example, will HHS allow member-level build up of rates for each family member? Will age rating be phased in? How will the area rating provision be interpreted? Will HHS accommodate service area restrictions?
- How will the prohibition on eligibility waiting periods of more than 90 days for group coverage interact with the guaranteed issue provision (effective date issue)?