HEALTH BENEFIT EXCHANGE BASICS

December 14, 2010

The Patient Protection and Affordable Care Act of 2009 ("PPACA")(Public Law 111-148) requires in Section 1311 that "Each State shall, not later than January 1, 2014, establish an American Health Benefit Exchange ("Exchange") that facilitates the purchase of qualified health plans; [and] provides for the establishment of a Small Business Health Options Program ("SHOP Exchange") that is designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in qualified health plans offered in the small group market in the State."

Establishing an Exchange

- Each state, if they choose, may establish an Exchange in the individual and small group markets by January 1, 2014. These Exchanges may be merged if the state desires.
- Each state must notify the U.S. Secretary of Health and Human Services (HHS) ("Secretary") whether it plans to operate a qualified exchange no later than January 1, 2013 so that the Secretary can begin developing a federally-run Exchange for that state. A state that elects to operate an Exchange must have the Exchange operational by January 1, 2014.
- The Secretary shall award grants to states to assist in the planning and establishment of the Exchange. These grants may not be used for operating the Exchanges. Planning grants of up to $1 million have been announced and these funds were available effective September 30, 2010. The Alabama DOI applied for and received these grant funds.

Exchange Operation

- The Exchange must be a governmental agency or nonprofit entity established by the state. A state may create multiple exchanges serving different geographic areas, combine the operations of the individual and small group exchanges, or even create regional exchanges with other states.
- The Exchange must provide for:
    - Initial open enrollment period
    - Annual open enrollment period
    - Special enrollment periods
- All plans sold through the exchange (other than dental-only plans that provide pediatric coverage) must be certified as a "Qualified Health Plan" that:
    - Provides the Essential Benefits outlined in the law
    - Is licensed and in good standing in the state
    - Agrees to offer at least one Silver and one Gold plan (see below)
    - Agrees to charge the same price inside and outside of the Exchange
- The exchange will make the following levels of coverage available:
    - Bronze (covers 60% of actuarial value of benefits)
    - Silver (covers 70% of actuarial value of benefits)
    - Gold (covers 80% of actuarial value of benefits)
    - Platinum (covers 90% of actuarial value of benefits)
    - Catastrophic (high deductible plan for the young)
- Additional costs for any benefits other than essential benefits required (mandated) by the State must be paid by the Exchange

Exchange Functions

- At a minimum, an exchange must:
  - Consult with relevant stakeholders, including consumers, those with experience facilitating coverage in qualified health plans, representatives of small businesses, state Medicaid offices and advocates for enrolling hard-to-reach populations.
  - Implement procedures for certification, recertification and decertification of health plans
  - Operate a toll-free hotline
  - Maintain an Internet website with standardized plan information
  - Assign a rating to each plan relative to each plan's quality and price
  - Utilize a standardized format for presenting options
  - Inform consumers of their eligibility for Medicaid, ALL Kids (CHIP) and other applicable state or local public health programs
  - Make available a calculator to determine the actual cost of coverage after subsidies and tax credits
  - Grant a certification attesting that the individual is not subject to the coverage mandate because –
    - There is no affordable option available, or
    - The individual is exempt from the mandate
  - Transfer to the Secretary of Treasury a list of individuals exempt from the individual mandate and employees eligible for tax credit
  - Provide to each employer the names of employees eligible for tax credit and those who ceased coverage during a plan year
  - Establish a Navigator program to conduct public education activities, distribute information concerning enrollment and the availability of tax credits, facilitate enrollment, and provide referrals to the appropriate State agencies regarding questions, grievances and complaints for any enrollee
  - Keep accurate accounting of all activities, receipts and expenditures and annually report to the Secretary and publish online an accounting of its administrative costs, including funds lost to waste, fraud and abuse
  - Require insurers to justify any premium increases prior to implementation and post all related information on their websites. Any patterns of excessive/unjustified increases or practices can result in expulsion from Exchange

Federal Regulations

- The Secretary shall establish criteria for the certification of qualified health plans. At a minimum, the criteria shall require that certified plans, at a minimum, must:
  - Meet marketing requirements and not discourage enrollment in the plan by those with significant health needs
  - Ensure a sufficient choice of providers (no requirement to contract if provider does not accept payment rates)
  - Include in the network essential community providers
  - Be accredited by an entity recognized by the Secretary
  - Implement a quality improvement strategy outlined in PPACA
  - Utilize a uniform enrollment form as required in PPACA
  - Utilize the standard format for presenting plan options
  - Provide information on quality assurance measures to enrollees and prospective enrollees on health plan performance

- The Secretary shall develop a rating system to measure quality and price – also used for Web Portal
- The Secretary shall develop an enrollee satisfaction survey system for plans with more than 500 enrollees

- The Secretary shall assist Exchanges in the development of Internet portal – and continue operation of a federal Web Portal
- The Secretary shall define the Essential Health Benefits that must be in a Qualified Health Plan

Key Issues for State Consideration When Developing an Exchange

- Governance
- Roles of Various State Agencies
- Additional Functions of the Exchange
- Additional Information for Consumers
- Regulation of the market outside of the Exchange
- Multi-State Exchange or Subsidiaries
- Mandated Benefits: The State must pay for any coverage mandates that are over and above the "essential benefits" requirement
- Funding of Operations**:** Exchange must be "self-sustaining" beginning January 1, 2015. No federal funding will be available beyond this date. The Exchange is allowed to charge assessments, user fees or otherwise generate funding to support its operation.