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10 Things Providers Should Know About the Health Insurance Exchange Final Rule

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On March 12, 2012, the U.S. Department of Health and Human Services (''HHS'') released its final rule (''Final Rule'') implementing the new Affordable Health Insurance Exchanges (''Exchanges'') authorized under the Patient Protection and Affordable Care Act (''PPACA'').[1] These Exchanges are intended to establish and operate a ''one-stop marketplace'' in each state for individuals and small employers to obtain health insurance. According to HHS, these Exchanges will offer Americans ''competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs, and the Exchanges will give individuals and small businesses the same purchasing power as big businesses.''[2]

Overview

The Final Rule does the following:

- incorporates public comments received by HHS on two previously published proposed rules on Exchange eligibility and establishment (''Proposed Rules'')[3];
- establishes minimum federal standards for states wishing to create an Exchange, including standards for determining enrollment eligibility for individuals and employers;
- outlines the minimum federal standards for health insurance issuers to participate in an Exchange by offering qualified health plans (''QHPs''); and
- establishes minimum standards for the operation of a Small Business Health Options Program (''SHOP''), a one-stop health coverage marketplace serving small employers and their employees.[4]

The Final Rule does not address all of the statutorily required aspects of the Exchanges.[5] Therefore, be prepared to follow developments as HHS releases additional guidance and rulemaking.

[1] Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18,310 (March 27, 2012).

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[2] 77 Fed. Reg. 18,311.

[3] Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866 (proposed July 15, 2011); Exchange Functions in the Individual Market, 77 Fed. Reg. 51,202 (proposed Aug. 17, 2011).

[4] 77 Fed. Reg. 18,311.

[5] *Id.*

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An Exchange may be established by a state as a state agency or as an independent nonprofit entity. The Exchange will provide several key functions, which include:

- evaluating and certifying QHPs to be offered by health insurance issuers in the Exchange;
- operating a website for consumers to make cost and quality comparisons between QHPs;
- determining those consumers' eligibility for a QHP or public coverage;
- determining consumers' eligibility for any federal premium tax credits or cost-sharing reductions; and
- facilitating enrollment in a QHP.

HHS emphasizes that the Final Rule provides states with ''substantial flexibility'' in determining how to perform these key functions.[6]

While states, health insurance issuers, and related vendors pour over all of the details of the Final Rule, we thought it would be helpful to highlight 10 issues related to these Exchanges that would be of particular interest to health care providers.

1. Providers Should Closely Follow Exchange Developments

QHPs will include new health plan products in a state. The Exchanges also may be the means by which Medicaid-eligible individuals enroll in Medicaid. Consequently, providers may want to follow closely the development of Exchange policy in their states.

Indeed, the new consumer federal insurance subsidies and other health reform policies may drive a significant portion of the current population of insured individuals into the QHPs operating in the Exchanges. PPACA established federal health insurance premium tax credits and cost-sharing subsidies to increase the affordability of mandatory coverage for qualified individuals.[7] However, these federal credits and subsidies are restricted to enrollees of QHPs offered through the Exchanges.

Also, while health insurance issuers may offer separate health plan products outside of an Exchange, they are prohibited from offering rates for those health plan products that are lower than those offered within an Exchange.[8] Therefore, this regulatory structure creates incentives for consumers looking for affordability and value for their dollar to review health insurance coverage from among the QHPs offered in an Exchange before deciding where and which health plan to purchase.

Accordingly, if a significant proportion of their patient populations are going to be covered by QHPs, providers may want to follow the many ongoing legal and policy variables that are arising as states and the federal government establish these Exchanges.

2. Key Developments Occurring at State and Federal Levels

It is impossible to stay informed on the emerging nature of the Exchanges without following developments at ***both*** the federal and state levels.

The first step is following the decision of your own state as to whether it intends to establish its own Exchange. The Final Rule clearly leaves it to the states to decide whether to establish and run their own Exchange and seek federal approval for that Exchange.[9] At least 17 states and the District of Columbia are developing exchanges, and others are likely waiting on a decision by the Supreme Court of the United States on the constitutionality of PPACA.[10] Interestingly, the 17 states include only three of the six states that possess approximately 50 percent of the uninsured population: California, Illinois, and New York. The other three states with a significant amount of the uninsured population are Florida, Georgia, and Texas.

The standards included in the Final Rule for the general functions of an Exchange are only a federal floor. States are free to require additional functions.[11] Thus, providers are encouraged to follow the actions by their state legislature, governor, health agencies, or governing boards in setting any additional standards for their state's Exchange.

If a state chooses not to establish its own Exchange or fails to develop it by the statutory deadline, then a federally facilitated Exchange (''FFE'') established by HHS will operate in that state.[12] FFE requirements on functions, eligibility, and certification standards for QHPs and the SHOP mirror those for the state-facilitated Exchanges.[13] It is not clear at this time whether there will be one set of FFE standards or separate standards for each state hosting an FFE. Consequently, providers should follow the emerging process for establishing the standards for the federal Exchanges.

The Final Rule provides for a ''State Partnership'' Exchange in which HHS delegates to a state certain management or coordination functions under an FFE, such as coordination with the state's insurance, Medicaid,

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[6] *Affordable Insurance Exchanges: Choices, Competition and Clout for States*, HHS Fact Sheet, March 12, 2012, http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011a.html.

[7] Patient Protection and Affordable Care Act of 2010, Pub. L. 111-148 § § 1401, 1402.

[8] *Id.* at § 1301(a)(1); 45 C.F.R. § 156.255(b) (2012).

[9] 45 C.F.R. § § 155.100, 155.105.

[10] The 17 states are California, Colorado, Connecticut, Delaware, Hawaii, Illinois, Maryland, Massachusetts, Mississippi, Nevada, New York, Oregon, Rhode Island, Utah, Virginia, Washington, and West Virginia. *State Action Toward Creating Health Insurance Exchanges, as of April 13, 2012,* KAISER FAMILY FOUNDATION (May 14, 2012, 11:40 AM), http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17.

[11] 77 Fed. Reg. 18,324.

[12] 45 C.F.R. § 155.105(f).

[13] *Id.*

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and CHIP agencies.[14] In the preamble to the Final Rule, HHS notes the concern of some commenters for the risk of fragmented Exchange services under a Partnership model and the need to ensure that one entity is solely accountable for the Exchange's performance. HHS has committed to provide further information on this approach in future guidance.[15]

3. States Face a Deadline to Establish Federally Approved Exchanges

A state's plan to operate its own Exchange must be approved by HHS *no later than January 1, 2013*, as being ready to meet the October 1, 2013, open enrollment date, and offer QHPs on January 1, 2014. By November 16, 2012, states are required to submit Exchange Blueprints that outline the core functions about how these federal minimum Exchange standards in the Final Rule are met. Then, HHS will conduct a readiness assessment.[16] If a state's plan for operating its own Exchange does not receive approval from HHS by January 1, 2013, HHS will establish and operate an FFE in that state.

Many public commenters to the Proposed Rules considered the 2013 deadline as difficult to achieve for many states so they proposed waivers or asked for other flexibility in obtaining HHS approval. In the preamble to the Final Rule, HHS responded that it believes that HHS lacks statutory authority to change the deadline. The preamble to the Final Rule offers the possibility of a state receiving ''conditional approval'' before January 1, 2013, upon a determination by HHS that the state's Exchange will be operational by January 1, 2014.[17] HHS recently provided additional details on the conditional approval process in guidance.[18] Also, the Final Rule permits states that are not ready for approval for 2014 to apply to operate their Exchange in 2015 or later.[19]

4. Stakeholder Participation Will Impact Exchange Development

The Exchanges are required to consult with stakeholders on a regular basis.[20] The required categories for stakeholders are provided in the Final Rule: agents and brokers, health insurance issuers, large employers, health care providers, public health experts, federally recognized tribes located in the Exchange's geographic area, state Medicaid and CHIP agencies, small businesses and self-employed individuals, advocates for enrolling hard-to-reach populations,[21] those experienced in facilitating enrollment in health coverage, and educated health care consumers who are enrollees in QHPs.[22]

The text of the Final Rule also requires that the Exchanges ''regularly consult on an *ongoing basis*'' with the stakeholders.[23] The preamble to the Final Rule further states that the consultation is to ''add perspective to the *development* of an Exchange.''[24] It is unclear how formalized the process needs to be and when and how the FFEs will commence state stakeholder consultation.[25] Much discretion is left to the Exchanges. The bottom line is that providers are explicitly named as stakeholders and should take advantage of these opportunities to shape the development of these Exchanges.

5. QHPs a Work in Progress: Provider Reimbursement Rates, Network Adequacy, Other QHP Requirements

***Overview*—**A QHP is a health plan product that is certified to participate in an Exchange, thereby making certain enrollees of that health insurance product eligible for federal subsidies. A QHP meets all of the benefit design standards established in PPACA and required by the Final Rule, including the essential health benefits; cost-sharing limitations; and a bronze, silver, gold, or platinum level of coverage.[26] A QHP issuer also must submit a ''justification for a rate increase'' to the Exchange prior to the implementation of the increase.[27]

***Network Adequacy Standards*—**QHPs are required to include for all of its enrollees a network of providers of adequate number, type, and geographic distribution to assure that all covered benefits will be accessible without unreasonable delay, including the essential community providers that serve primarily low-income and medically underserved populations.[28] Each QHP's provider directory is required to be available online through the Exchange or sent to a potential enrollee in hard copy upon request. Also, each provider directory must identify which providers are not accepting new patients.[29]

States establishing an Exchange may create more specific standards to evaluate the extent to which the QHP applicant is satisfying these network adequacy requirements. The Final Rule declines to mandate inclusion of specified provider types but instead encourages states to consider needed provider classes specific to that state's population.

For example, the Final Rule mentions the need for adequate mental health and substance abuse services that historically may have been difficult for low-income or underserved populations to access. Demand for these services is likely to increase following expanded coverage. The Final Rule ''urge[s] States to consider lo-

[14] 77 Fed. Reg. 18,325.
[15] *Id.* at 18,326.
[16] 45 C.F.R. § 155.105(c).
[17] 77 Fed. Reg. 18,316.
[18] Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, General Guidance on Federally-facilitated Exchanges (2012), 4-5. http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.
[19] 45 C.F.R. § 155.106.
[20] 45 C.F.R. § 155.130.
[21] This includes individuals with substance abuse or mental health disorders.
[22] This is defined as one who is knowledgeable about the health care system and experienced in making informed health or medical decisions. 77 Fed. Reg. 18,320.
[23] 45 C.F.R. § 155.130 (emphasis added).
[24] 77 Fed. Reg. 18,320 (emphasis added).
[25] HHS has announced the dates of four regional implementation forums for the 2012 summer. *Affordable Insurance Exchanges: Updates and Upcoming Implementation Forums*, HHS Fact Sheet, May 16, 2012, http://cciio.cms.gov/resources/factsheets/affordable_insurance_exchanges.html.
[26] 45 C.F.R. § 156.200(b)(3).
[27] *Id.* at § 156.210(c).
[28] *Id.* at § § 156.230, 156.235.
[29] *Id.*

cal demographics, among other elements, when developing network adequacy standards,'' as the Exchanges are free to require specific provider types in the network adequacy standards if deemed necessary.

Limited Enrollment Period—Providers should be aware of a new standard enrollment period and appreciate how this time period will likely affect the timing for the negotiation of provider agreements with health insurance issuers. The Final Rule establishes an initial open enrollment period of October 1, 2013, through March 31, 2014.[30] For benefit years in 2015 or later, the annual open enrollment period will extend from October 15 to December 7 of the previous year,[31] with special enrollment periods for triggering events. Consequently, provider contracts will need to be finalized well before these enrollment periods.

Provider Reimbursement Rates— The Final Rule does not regulate the rates between QHPs and providers as a formal Exchange function. Also, the Final Rule does not explicitly prohibit states from setting QHP standards for provider reimbursement. In fact, the Final Rule requires that QHP issuers comply with any additional requirements imposed by the state beyond those of the federal floor. Consequently, providers may face proposals in their states to control health care costs by regulating provider reimbursement in some manner.[32]

Marketing Opportunity—Up to now, many consumers have purchased health insurance coverage in the individual market through a broker or agent to whom they may have directed questions about specific provider availability and covered services. The entire eligible individual market population will soon have the opportunity to select coverage through an Exchange's website, or other coordinated consumer-friendly tool, in which all QHPs will be evaluated head to head. QHP marketing material may have a significant effect on consumer choices. This presents an opportunity for providers that affiliate now with QHPs to achieve a level of marketing and exposure in the marketplace that may be greater than previously known. An affiliation with a well-respected provider could be an important deciding factor for many consumers selecting a QHP.

6. Eligibility Assessments Determine Whether Individuals Qualify for QHPs and Credits or Subsidies

Qualified individuals are those prospective consumers who have been determined to be eligible to enroll in a QHP through an Exchange. [33] The Exchange makes this determination based on information submitted by the consumer that establishes citizenship, residency, and non-incarceration status.[34] It is during this eligibility assessment that the Exchange also will determine eligibility for Medicaid, Children's Health Insurance Program (''CHIP''), or the Basic Health Program (''BHP''), and eligibility for, and amount of, any advance payments of premium tax credits or cost-sharing reductions.[35] Eligibility of qualified enrollees must be redetermined on an annual basis.[36]

After public comment on the Proposed Rules, HHS revised the residency requirement to match the Medicaid ''intent to reside'' standard wherein an individual will be deemed to reside in a state if he or she is at least 21 years of age and has entered the service area with a job commitment or to seek employment (whether or not currently employed).[37]

7. The ''No-Wrong Door'' Concept is Essential

The stated goal of HHS is to establish sufficient coordination between all of the potential access points for eligible individuals so that consumers face ''no wrong door'' in seeking health insurance coverage.

Ideally, one submission of material as part of one enrollment process will be sufficient to obtain the appropriate coverage. In this regard, the Final Rule requires the Exchanges to establish agreements with state Medicaid, CHIP, and BHP administering agencies so that each has the capacity to assess prospective applicants for eligibility in any of the other programs. Based on the information provided by an applicant, an Exchange must assess whether he or she is eligible for state programs.[38] To the extent that the Exchange determines that an applicant is eligible for state programs, such as Medicaid or CHIP, then the Exchange must notify the state Medicaid agency or CHIP agency *and* transmit all information from the records of the Exchange to the relevant state agency. Conversely, Medicaid, CHIP, and BHP agencies must establish procedures to identify Exchange-eligible individuals among applicants.

Nothing in the Final Rule specifies a type of Medicaid product to be delivered through the Exchange. However, as the Exchange will become the marketplace for at least the lower-income populations, states may be more motivated to establish Medicaid managed care plans for the newly Medicaid eligible populations in order to ease any potential movement between plans if an applicant's eligibility changes.

8. Navigators Will Be on Front Line of Enrollment

The Final Rule requires the Exchanges to establish ''Navigators'' that are defined as community-based organizations specializing in consumer outreach that will educate prospective applicants about an Exchange and assist them in selecting a QHP that best meets their needs. Specifically, a Navigator is required to maintain expertise in Exchange eligibility and enrollment; raise public awareness of the Exchange; provide culturally and linguistically, accurate and impartial guidance to individuals in the selection of a QHP; and appropriately

[30] 45 C.F.R. § 155.410(b).
[31] *Id.* at § 155.410(e).
[32] For example, in order to have more affordable premiums, the Massachusetts Legislature may develop a proposal to impose a ''global payment system'' for private providers and issuers. Sarah Kliff, *Massachusetts Payment-Reform Bill Would Overhaul How Health-care Providers Are Paid*, WASH. POST, Apr. 30, 2012, http://www.washingtonpost.com/business/economy/massachusetts-payment-reform-bill-would-overhaul-how-health-care-providers-are-paid/2012/04/30/gIQAsahnsT_story.html.
[33] *Id.* at § 155.20.
[34] *Id.* at § 155.305(a).
[35] *Id.* at § 155.305 (c)-(g).
[36] *Id.* at § 155.335(a).
[37] 77 Fed. Reg. 18,351; *see also* 45 C.F.R. § 155.305(a)(3)(i)(B).
[38] 45 C.F.R. § 155.310.

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direct applicant questions or grievances concerning their health plans.[39]

The Exchange will set standards for those entities that wish to apply for grants to become Navigators. Categories of likely applicants for Navigator grants include ''consumer-focused non-profit groups,'' trade and industry associations, chambers of commerce, unions, licensed agents or brokers, commercialized fishing, ranching and farming organizations, resource partners of the Small Business Administration, Indian tribes, state or local human service agencies, and others. An Exchange must require that a Navigator have expertise in reaching out to ''underserved and vulnerable populations'' and other populations likely to be eligible for QHP enrollment.[40] The Exchange must develop conflict-of-interest standards that, at a minimum, will bar health insurers, their subsidiaries, and associations from participating as Navigators.[41]

Many of the previously uninsured will likely be selecting an Exchange QHP through the assistance of a Navigator. Providers should consider their relationships with these organizations that form the pool of likely Navigators. Some providers might wish to consider establishing Navigators themselves. However, providers need to closely follow the development of any additional conflict-of-interest standards adopted at the state level. Agents and brokers also may be involved in the enrollment of applicants in Exchange-offered products under certain circumstances.[42]

9. Small Business Health Options Program

Each Exchange must establish a SHOP for the Exchange to offer small employers a portal through which to select and offer health coverage to their employees and their dependents. A SHOP must conduct the same Exchange functions related to facilitating the comparison of, selection of, and enrollment into QHPs, as is the case for the individual market.[43] The same certification standards apply for becoming a QHP in a SHOP.

A SHOP allows a qualified employer to select a level of coverage, and then all QHPs of that level are made available to the employees of that qualified employer.[44] The term ''qualified employers'' is defined as those small employers having employed between one and 100 employees in the previous year.[45] For plan years before 2016, states have the option of narrowing the qualified employer definition to employers with no more than 50 employees.[46] Also in 2017, a state may elect to expand a SHOP to the large group market. QHPs in a SHOP are restricted to making any rate changes at uniform intervals (such as annually, quarterly, or monthly) to be decided by the state.[47]

10. More Details to Follow from HHS

Several of the Final Rule's provisions on eligibility determinations and the administration of advance payments of the premium tax credit, along with provisions on the role of agents and brokers in assisting qualified individuals to enroll in a QHP, have been published on an interim final basis. This means that such provisions could yet be altered based on comments received by HHS.

HHS also has not yet formalized its recommended approach for states to define essential health benefits (''EHB'') as a component of QHP benefit design standards under Section 1302 of PPACA. The EHB bulletin issued by HHS in 2011 only described the regulatory approach that HHS ''plans to propose.''[48]

Furthermore, HHS has stated that separate federal rulemaking is forthcoming to address standards for issuing certificates of exemption from the individual responsibility policy under section 1411(a)(4), defining actuarial value and other benefit design standards as well as quality standards for the Exchanges and QHPs.[49] Finally, HHS recently provided guidance on the conditional Exchange approval process, but more could follow.[50]

Conclusion

With little more than seven months before the state Exchanges must be certified and, with additional guidance from HHS due at any time, providers are encouraged to follow state and federal developments closely. Where possible, providers should consider participating in the planning process already underway in their state if they have not already done so.

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[39] *Id.* at § 155.210(e).
[40] *Id.* at § 155.210.
[41] *Id.* at § 155.210(d).
[42] *Id.* at § 155.220.
[43] *Id.* at § 155.705 (a).
[44] *Id.* at § 155.705(b).
[45] *Id.* at § 155.20.
[46] *Id.*
[47] 45 C.F.R. § 155.705(b).
[48] *Essential Health Benefits Bulletin*, Center for Consumer Information and Insurance Oversight, December 16, 2011.
[49] 77 Fed. Reg. 18,312.
[50] *See supra* note 18.