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MEMORANDUM

August 31, 2011

TO: Members of the Legislative Health Benefit Exchange Implementation Review Committee

FROM: Christie Lee, Research Associate, 303-866-2756
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SUBJECT: Proposed Health and Human Services Rules Regarding Affordable Health Exchanges

This memorandum responds to your request for information on rules regarding Affordable Health Exchanges proposed by the federal Department of Health and Human Services (HHS). Specifically, you asked for information regarding the specific areas in which Colorado has flexibility in establishing its Health Benefit Exchange (exchange). You also asked for a comparison of the proposed HHS rules and Senate Bill 11-200 concerning Colorado's exchange.

Background

The Affordable Care Act (ACA) requires each state to have an operational exchange by 2014. The exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors.

In July 2011, the HHS proposed rules regarding the establishment of exchanges and qualified health plans (QHPs). HHS is seeking public comment on these proposed rules and may modify them based on the feedback it receives. Comments must be received by 5:00 p.m. (Eastern Standard Time) on September 28, 2011. Table 1, which is appended, summarizes the proposed rules, along with an explanation of the specific topics on which HHS is seeking comment (Attachment A). The table also compares the requirements in the proposed federal rules to those in Senate Bill 11-200.

Statutory Requirements

The ACA requires state exchanges, at a minimum, to:

- implement procedures for certification, recertification, and decertification of health plans as QHPs;

- operate a toll-free hotline to respond to requests for assistance;
- maintain a website that provides standardized comparative information on QHPs;
- assign a price and quality rating to each QHP;
- present health benefit plan options in a standardized format;
- inform individuals of eligibility requirements for Medicaid, the Children's Health Insurance Program (known in Colorado as the Children's Basic Health Plan or CHP+), and any other applicable state or local public program;
- establish and make available electronically a calculator to determine the actual cost of coverage after taking into account any premium tax credits and cost sharing reductions;
- grant a certification that an individual is exempt from the requirement to maintain health insurance coverage because:
  - there is no affordable QHP available through the exchange, or the individual's employer, covering the individual; or
  - the requirements for any other exemption from the individual responsibility requirement or penalty are met;
- provide information to the Secretary of the Treasury on:
  - individuals who are exempt from the requirement to maintain health insurance coverage;
  - individuals who are determined to be eligible for the premium tax credit because:
    - the employer does not provide minimum essential health coverage; or
    - the employer provides the minimum essential health coverage but it is determined to either be unaffordable to the employee or does not provide the required minimum actuarial value; and
  - individuals who notify the exchange that they have changed employers and individuals who cease coverage under a QHP during a plan year;
- establish a Navigator program that provides grants to entities assisting consumers;
- present enrollee satisfaction survey results;
- provide for initial open enrollment, annual open enrollment, and special enrollment periods;
- consult with stakeholders; and
- publish data on the exchange's administrative costs.

Exchanges must ensure that QHPs offered through the exchange:

- provide information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers;
- consider plan patterns and practices with respect to past premium increases and submission of plan justifications for current premium increases;
- disclose certain plan data, including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out-of-network coverage, and other information identified by HHS;
- provide timely information to consumers requesting their amount of cost sharing for specific services from specified providers;
- provide information to participants in group health plans; and
- provide information on plan quality improvement activities.

State Flexibility

The proposed rules allow each state to choose how it structures and governs its exchange. A state can choose to establish the exchange as a nonprofit entity, as an independent public agency, or as part of an existing state agency. States can also decide whether to establish one or more state or regional exchanges, merge the state's exchange with other state exchanges, or choose not to create an exchange and have the federal government set up the exchange for them. Through the adoption of Senate Bill 11-200, Colorado created a nonprofit unincorporated public entity at the state level known as the Colorado Health Benefit Exchange.

States can also decide a number of other factors relating to QHPs, enrollment, and the Small Business Health Options Programs (SHOPs), as explained in the following paragraphs.

Qualified health plans. The state exchanges are required to offer certified QHPs. In order for a plan to be certified, it must meet minimum standards as outlined in the proposed rules and in the ACA. The proposed rules give states flexibility in establishing standards for health plans offered in their exchanges. For example, the proposed rules give exchanges flexibility in:

- the number and type of health plan choices offered that meet the standards;
- setting marketing and network adequacy standards for health plans; and
- stabilizing premiums for health plans through temporary reinsurance and risk corridor programs, and a permanent risk adjustment program.

Enrollment. States have latitude regarding the design of websites, call centers, and in-person offices to help people enroll in coverage. State exchanges can design their own application process, as long as it meets certain requirements, or use the standard application developed by the HHS. States also must award grants to certain entities to serve as navigators to assist individuals through the process of enrolling in a health plan through the exchange, but have flexibility over the specific organizations that will serve as navigators.

Small Business Health Options Program. States must also establish a Small Business Health Options Program (SHOP). A SHOP is a health insurance exchange specific to small employers. States can decide how the SHOP is structured. Specifically, states have flexibility with regard to the size of small businesses that can participate in SHOP (up to 50 employees instead of 100 employees until 2016). Starting in 2017, states may allow businesses with more than 100 employees to buy large group coverage through the SHOP. SHOPs may be structured to allow an employer to select a specific level of coverage in which all health plans within that level are made available to the qualified employees of the employer, or, as an alternative, to allow the employer to make one or more plans available to employees.