

State Consultation on the Development of a Federal Exchange

The Affordable Care Act (ACA) directs the Secretary of Health and Human Services (HHS) to facilitate the establishment of an Exchange in any state that does not achieve certification by January 1, 2013. HHS has published a draft application for that certification form under the Paperwork Reduction Act.

We wish to emphasize to our partners in HHS that it is equally important for states to understand the nature of the federal alternative that will be facilitated if they do not seek certification. In fact, due to the complex nature of the policy decision process at the state level, states need this information much sooner than the January 1, 2013 deadline required of states requesting certification.

We request the following information from HHS no later than June 1, 2012 in order for us to make an informed decision about the direction we should pursue. This deadline is necessary to allow states that are considering deferring some (or all) functions of the exchange to HHS to understand how those processes would work in the context of a state exchange. This information request is based on the certification form proposed by HHS for states. It seems reasonable that HHS be able to provide the same type of information to states as the states would be required to provide to HHS.

GENERAL REQUIREMENTS – For each of the following planning and operational areas, please provide a detailed description of the plans for proposed federal exchanges that includes, at a minimum, a comprehensive implementation plan along with business process models, key milestones, high-level timelines, and detailed progress reports showing current achievement of the milestones. The responses should also outline how the implementation plan would be adapted for different states, and what the costs to each state would be to accommodate the federal exchange.

If HHS plans to contract out any of the functions described below to any entities (including state agencies as well as private entities) please provide a description that includes any current or future agreements with eligible entities that will carry out responsibilities of the exchange, procedures in place to ensure program integrity and prevention of fraud, waste and abuse, and how the exchange plans to ensure that the entities will carry out contracted responsibilities of the exchange in compliance with state and federal requirements. The description should also include the name of the contractors, contact points, evidence of contractor qualifications and an assessment of the conflict of interest of each contractor.

PART 1. ENABLING AUTHORITY AND GOVERNANCE

- I. **Enabling Authority:** Please explain your authority to establish a federal exchange in any particular state, identifying any limitations or provisions. This explanation should include:
 - a. A copy of current law and/or regulation that clearly indicates the legal authority under which a federal exchange would be established, and
 - b. A written legal opinion from the Office of the Attorney General or a declaration from a federal court certifying that the federal government is authorized to establish an exchange under federal law, and detailing the authority of the federal government in all operational aspects of the exchange, including, but not limited to the authority to

administer premium tax credits, collect and disburse fees and payments, and require states to participate or cooperate.

- c. Please note that proposed or pending legislation or regulations will not be sufficient to establish the nature and authority of the federal government to establish and operate an exchange. To the extent that any law or regulation is not clear on its face that the federal government has authority to establish or operate any function of the exchange, the written legal opinion described in (b) above must be provided.
- II. **Governance:** HHS should outline their plans for governance of any federal exchange established in a state.
 - a. Governing Body: HHS should submit the rules or regulations under which they plan to structure the governing body for federal exchanges, including:
 - i. A description of the entity that will be running the exchange and the overseeing governing body, including rationale for selecting this governance model
 - ii. A description of the organizational structure of the exchange, including providing an organizational chart and resumes on executive leadership
 - b. Board Membership: If HHS plans to involve non-governmental stakeholders, please include:
 - i. A description of the overall board composition, rationale for this structure, and how members are selected
 - ii. A conflict of interest policy and procedure for preventing or mitigating conflicts of interest, including an explanation if any conflicts are known to exist
- III. **Non-interference with State Standards** – Please provide an attestation that the federal exchange will not establish standards that conflict with those promulgated by state legislatures or agencies that are responsible for maintaining a solvent and regulated insurance market related to the exchange.

PART 2: FUNCTIONS OF THE FEDERAL EXCHANGE

- I. **Consumer Functions:** It is assumed that the federal exchanges will provide functions similar to those that are required of state exchanges. Please describe in detail plans to address the following consumer needs in each state that will have a federal exchange.
 - a. Outreach and Education: Please provide a description of the HHS plan to consult with relevant stakeholders, including consumers, individuals and entities with experience in facilitating enrollment in health plans, representatives of small businesses and self-employed individuals, State Medicaid offices, and advocates for enrolling hard to reach populations. As part of this description, please include a description of:
 - i. The approach to identify and consult with state-level stakeholders
 - ii. The approach to providing outreach and educational materials to the public about the exchange
 - iii. The approach to establishing relationships and working with partners (including insurers, agents and brokers) to connect with hard-to-reach populations

- iv. Evidence of consultation with state-level stakeholders to date, and plans for future engagement of stakeholders at the state level
 - v. How HHS has considered (or will consider) the comments submitted by state-level stakeholders in designing a federal exchange for that state
- b. Call Center: Please provide a description of the approach to develop state-oriented call-center operations, including:
 - i. A description of the approach to ensure sufficient consumer outreach, interpretation services, and overall consumer experience
 - ii. A description of the call center functionality and how it will interface with existing state call centers
- c. Insurance portal: A federal exchange will need to provide a website through which enrollees and prospective enrollees of Qualified Health Plans can get comparative information. Please provide a description of the HHS plan for this portal that details:
 - i. How it will support the consumer experience (including the interface with the call center, navigators, and agents/brokers)
 - ii. How it will display accurate pricing information for QHPs, including what comparative information will be displayed, and a description of any features to simplify and support the consumer decision process
 - iii. How the portal will calculate premiums, the second lower cost silver plan, and facilitate premium aggregation
 - iv. How the portal will show consumers if a particular professional or facility is in the network of each plan
 - v. How the portal will obtain and display relevant quality information about insurers
 - vi. How the portal will support a seamless experience for those seeking eligibility or enrollment in various public or private programs or markets
 - vii. The functionality and technology behind the electronic calculator and method to determine the actual expected out-of-pocket cost of coverage taking into account premium tax credits, cost sharing, cost-sharing reductions, and other relevant information for predicting the consumer's expected cost for each plan
- d. Navigators: Please provide a detailed description of the proposed federal exchange's Navigator program, including the types of entities that will be eligible to serve as Navigators and how the program will minimize conflicts of interest and ensure that Navigators possess the level of expertise required to perform any functions delegated to them.
 - i. Please provide a strategy for funding the Navigator grants along with documentation that HHS has the legal authority to collect and disburse funds in that program
- e. Agents/brokers: Please provide a detailed summary of how the federal exchange will
 - i. Engage agents/brokers in the design and function of the exchange
 - ii. Determine appropriate compensation for the services agents/brokers provide to the exchange

- iii. Protect the role of agents/brokers from intrusion by non-licensed entities and prevent duplication of effort or service overlap by Navigators

II. **Eligibility:** Please provide a detailed description of:

- a. The eligibility determination and redetermination process, including business process models
- b. Evidence of capacity, including adequate staffing, to accept and process applications through multiple channels, including in-person, online, mail, and phone, and to conduct verifications. Please describe the anticipated number of exchange employees providing these functions that will reside and work in the state and a detailed plan for geographic coverage
- c. Relevant notices and plan-related documents
- d. Evidence that agreements and processes are in place to share information with the Internal Revenue Service and other required federal agencies.
- e. How the federal exchange will determine in real time whether an individual's employer does not provide minimum essential coverage (MEC) or provides MEC that is unaffordable or does not meet the minimum value requirement

III. **Exemptions from the Individual Mandate:** Please provide a detailed description of:

- a. The process for determining that an individual is exempt from the individual mandate, including the business process model
- b. Evidence of capacity, including adequate staffing, to accept and process applications for exemption through various channels required in statute

IV. **Certification of QHPs and Plan Management:** Please provide a detailed description of:

- a. How HHS will define the QHPs for each state that is considering a federal exchange, including:
 - i. Will the exchange actively negotiate rates and limit entry?
 - ii. How will the federal exchange determine the maximum number of insurers and QHPs plans that will be allowed on the federal exchange?
 - iii. Any requirements above and beyond those in statute that will be placed on insurers offering QHPs in the federal exchange
 - iv. Will plans be required to demonstrate financial advantage over their competitors to be included?
- b. The specific criteria for QHPs in each state covered by a federal exchange
- c. How the certification process will work, including the business process model
- d. How HHS will verify that an issuer is licensed and in good standing with the appropriate state authority and the cost to the state to comply with that process
- e. The specific approach to certification, recertification, and decertification of QHPs, including:
 - i. What the standards and implications of these actions are
 - ii. The division of responsibilities between HHS and the state Department of Insurance
 - iii. Additional certification standards above the federal minimum that will be required in each state

- iv. The approach (if any) to achieving plan alignment between the exchange and Medicaid
 - v. The frequency and burden to insurers of recertification and the approach to annual plan renewal
 - f. Ongoing oversight and monitoring of QHPs, including specific performance measures, tracking and resolving complaints, and compliance with certification requirements
 - g. The proposed approach to rate analysis and benefit package review and how to populate the rating engine and calculator functions of the exchange
 - h. How the exchange plans to collect, analyze, and publish quality data for QHPs
 - i. How the exchange plans to engage insurers in these processes
- V. **Financial Management:** Please provide a detailed description of plans, policies, and procedures related to:
- a. The Risk Adjustment and Reinsurance programs and how those would be implemented in a state with a federal exchange
 - b. HHS' plan to keep an accurate accounting of all activities, receipts, and expenditures in a federal exchange, including:
 - i. The mechanism for handling and processing payments or funds
 - ii. The additional cost burden on the insurance market of these activities
- VI. **Enrollment:** The federal exchange must allow an individual to enroll in any qualified plan available to that individual. Please describe in detail:
- a. The business process model for QHP enrollment
 - b. Evidence of capacity to accept and process QHP applications
 - c. Evidence of existing functionality for plan comparison that allows individuals to receive an eligibility determination, compare and select plans, and be enrolled in the plan of their choice
 - d. A description of all notices that the exchange will provide to individuals enrolling in QHPs
- VII. **The SHOP Program:** Please provide a detailed description of the SHOP program component of a federal exchange, including:
- a. Whether the governance, plan certification and management, enrollment, call center and other functions of the SHOP exchange will be handled separately from the insurance portal described above, and if so, a detailed description of the differences
 - b. An action plan for outreach and education efforts in the small business community
 - c. How the SHOP exchange will interface and work with brokers/agents
 - d. Any limitations placed on employers, including potential requirements for employers to limit employee choice or structure defined contribution in a particular way
 - e. What tools and functionality to benefit employers and employees will be built into the SHOP exchange
 - f. Any option for traditional group plans to be offered to employers
 - g. How the exchange will correctly display information when employees have choices available to them, such as family tiers, dependent coverage, and opting out of coverage

- h. How the exchange plans to provide transparent information to the employer about the true cost of coverage, including separating out the cost of administering the exchange from premiums
 - i. A comprehensive description of the proposed roles of brokers, agents, and navigators in the SHOP exchange, including:
 - i. An analysis of the proposal vis-à-vis existing state regulation of sales activities and roles
 - ii. The method by which brokers, agents, and Navigators will be compensated
 - j. How HHS will decide whether to include business with 51 to 100 employees in the SHOP exchange in any given state
 - k. How the SHOP exchange will determine employer eligibility and what to do when an eligible employer becomes ineligible mid-plan-year
 - l. The enrollment process and timeframes, including rolling enrollments, special enrollment periods, etc.
 - m. How the SHOP exchange will handle premium aggregation, including the process for handling shortages or non-payment, reconciling accounts, etc.
 - n. How the SHOP exchange will mitigate the incentive for employees to migrate to the non-group programs of the exchange
- VIII. **Reporting:** Please provide a description of how the federal exchange will satisfy the reporting requirements of the ACA, including:
- a. Reporting to the Secretary of the Treasury required lists of individuals such as those exempt from the individual mandate or who are eligible for premium tax credits or cost-sharing reductions
 - b. A comprehensive process for reporting to employers information on employees whose enrollment could trigger penalties for the employer
 - c. Publication of the cost burden of the federal exchange including the cost of licensing, regulatory fees, payments required by the exchange, administrative costs, and losses due to fraud, waste, and abuse
- IX. **Funding:** Please provide a detailed plan for how the federal exchanges will be self-sustaining by the deadlines in statute. Please include in that plan a detailed list of all entities that will be expected to pay for the operational and other costs of the federal exchange and an estimate of the economic incidence of those costs.
- X. **Program Integration:** Please provide a detailed plan for program integration that includes:
- a. A detailed plan for transitioning the PCIP and state high risk pool enrollees into the private and public plans as of January 1, 2014 through a federal exchange
 - b. A detailed description of every interface and necessary coordination with Medicaid (Title XIX) or CHIP (Title XXI) eligible persons in the state
 - c. Proposed requirements on state programs to provide information or services to facilitate that integration and the consequences for failure to comply
 - d. Evidence of successful collaboration with state agencies administering Medicaid, CHIP, and BHP (of applicable), including:
 - i. Any MOUs or contracts developed with each agency

- ii. Descriptions of roles and responsibilities of the federal exchange, state Department of Insurance, and other agencies related to QHPs
 - iii. Descriptions of roles and responsibilities of the federal exchange and state agencies that administer Medicaid, CHIP, and BHP, related to eligibility determinations, income verifications, and enrollment processes
 - iv. A statement from each affected state agency indicating their level of satisfaction with the existing cooperative relationship with HHS
- XI. **Oversight and Monitoring:** Please provide a description of the policies and procedures (to date) for oversight and monitoring of the federal exchange, including procedures to prevent fraud, waste, and abuse
- XII. **Adjudication of Appeals of Eligibility Determination:** Please describe the procedures by which the Secretary or other federal officers hears and makes decisions with respect to appeals of any determination. Please provide a description of the process for adjudicating eligibility appeals, including timelines, deadlines, notice requirements and the process for coordinating with the State Medicaid agency. This description should also include evidence of existing capacity to accept and process appeals and evidence of a firewall or absence of conflict of interest between the entity performing appeals and the entity providing eligibility determinations.

PART 3: FEDERAL TRANSPARENCY AND OPERATIONAL READINESS

States that elect to utilize federal grant funding to implement and operate a state-based exchange are required to adhere to specific requirements and pass CMS Gate Reviews. CMS should be held to the same standards as states in the process of developing a federal exchange.

Please identify the federal entity that will be tasked with this oversight and how states will be included in this process.

Please demonstrate operational ability to meet the requirements outlined in Parts 1 & 2 by demonstrating to states that the federal exchange has the ability to meet the requirements of the Gate Review process.