Affordable Insurance Exchanges: Coming to a State Near You

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One of the critical aspects of the Patient Protection and Affordable Care Act ("ACA") is the establishment of the Affordable Insurance Exchanges (the Patient Protection and Affordable Care Act). These Exchanges are intended to provide both individuals and small businesses with access to health insurance coverage through a competitive marketplace allowing for the direct comparison of prices, quality and other factors. Thus, consumers theoretically should be able to obtain, through competition, the highest quality of coverage at the lowest price. Pursuant to the ACA, the Exchanges are required to be established within each state no later than January 1, 2014.[1] The decisions made between now and then by each state will have a significant impact upon how health insurance is made available and who controls the marketplace in the future.

How Do the Exchanges Function?

Prior to their establishment, states must first choose between a series of options for the design and operation of their particular Exchange. The options include a State-based Exchange, run by the state, or a Federally-facilitated Exchange, established and operated by the Secretary of the United States Department of Health and Human Services ("HHS"). Within the Federally-facilitated Exchange option, states may elect to pursue a State Partnership Exchange where the state administers and operates certain limited activities associated with the management plan and consumer assistance.[2]

Whether operating a State-based Exchange or a State Partnership Exchange, a state must go through a formal approval process, which consists of the submission of the Exchange Blueprint, consisting of a declaration letter and an Exchange application.[3] The original dates set for submission of the declaration letter and exchange application were November 16, 2012 (30 days prior to the required approval date of January 1st) and December 14, 2012 (10 days prior to the required approval date of January 1st), respectively.[4] However, on November 15, 2012, pursuant to a request by Governors Bob McDonnell and Bobby Jindal, HHS agreed to permit all states to file both the declaration letter and exchange application together on December 14, 2012. States were also permitted until February 15, 2013 to request to operate a State Partnership Exchange.[5]

Approval by HHS will be based upon the state's ability to demonstrate that it can satisfactorily perform all required Exchange activities. However, HHS appears to have recognized that during the initial year of implementation, states will be in various stages of development when the Exchange Blueprints are submitted and thus will utilize conditional approvals for instances where the Exchanges have not been fully established at the time of the Exchange Blueprint submission. All that is required is a demonstration by the state that significant progress has been made toward meeting the Exchange requirements and that the Exchange will be operational for the initial enrollment period beginning October 1, 2013.[6]

Regardless of the Exchange model selected, all States are required by federal law to be ready to enroll consumers into coverage on October 1, 2013 and fully operational by January 1, 2014. It remains to be seen whether the States or the federal government will be able to meet these fast-approaching deadlines.

1. State-based Exchanges

As the name suggests, State-based Exchanges offer the most control by the state as it controls and operates all Exchange activities. These activities include contracting with health plans, providing consumer outreach and education, building the necessary information technology infrastructure and enrolling the individual citizens of the state into some form of coverage. However, as mentioned above, for those states that elect to operate a State-based Exchange, they must first submit an Exchange Blueprint for approval by the federal government. The Exchange Blueprint outlines how the Exchange "meets, or will meet, all legal and operational requirements associated with the model [the state] chooses to pursue."[7] To be approved, the state's Exchange Blueprint must meet a myriad of federal regulations governing the standards required of all Exchanges.[8] Thus, while this Exchange model does offer the greatest control by the state, it is still subject to a significant amount of uniformity and control by the federal government as required by federal law. In fact, a person could fill an entire textbook attempting to identify and discuss all of the standards and regulations already promulgated and adopted by the federal government to govern the standards for Exchanges. The following is a sampling of requirements to provide some context of the types of issues the federal government has placed an emphasis upon in shaping the uniformity all Exchanges must possess:

(1) Exchanges must service the entire geographic area of the state unless special circumstances are demonstrated to warrant multiple distinguished Exchanges[9]

(2) Exchanges may only offer health plans that "have in effect certification issued or are recognized as plans deemed certified . . . as a [qualified health plan ("QHP")]"[10]

(3) Exchanges must provide consumer assistance tools including toll-free call centers, an up-to-date website and both outreach and education activities[11]

(4) Exchanges must have in place security and privacy standards for any personally identifiable information collected to determine eligibility for a particular QHP[12]

(5) Exchanges must have standards in place to identify eligibility of applicants to enroll in particular QHPs where they meet a limited regulatory defined set of standards of citizenship, residency and lack of incarceration[13]

Thus, while State-based Exchanges are state controlled and operated, they are still subject to a significant amount of federal control and oversight. States are required to obtain approval of their Exchange models from HHS no later than January 1, 2013.[14]

2. Federally-facilitated Exchanges

For those states without an approved Exchange on January 1, 2013, the regulations require HHS to establish and operate a Federally-facilitated Exchange within those states.[15] Under such a model, HHS operates the Exchange. Though it is yet unknown exactly how the Federally-facilitated Exchanges will operate, CMS released a memo in May 2012 providing some guidance and offering an insight into at least the initial policy decisions.[16] Therein, HHS articulates four "guiding principles" for Federally-facilitated Exchanges based upon comments received at the time the proposed rules were being adopted. They are as follows:

1) *Commitment to consumers:* Our goal is to ensure that consumers in all 50 States and the District of Columbia have access to high-quality, affordable health coverage options through a State-based Exchange, Partnership Exchange, or FFE. We will continuously seek to improve policies and processes in each Exchange in pursuit of a positive and seamless consumer experience.

2) *Market parity:* HHS will work to harmonize market requirements inside and outside of an FFE to promote the competitiveness of each FFE, minimize administrative burden for issuers, and ensure consumer protections.

3) *Leveraging the traditional State role:* HHS recognizes the significant experience and the traditional role of States in many core areas of FFE operations. We will seek to capitalize on existing State policies, capabilities, and infrastructure that can also assist in implementing some of the components of an FFE.

4) *Engagement with States and other stakeholders:* HHS will seek input from a variety of stakeholders to support and inform decision-making. We will communicate our progress regularly so that affected parties understand how each FFE is developing and have adequate time to prepare for successful participation.

In applying these "guiding principles," HHS has indicated it will adopt a clearinghouse type model and contract, at least initially, with all health plans that meet all certification standards as a QHP. This will be reassessed once the Exchanges are operational and HHS has additional time to review and assess its certification process. The Exchange will also, among numerous other functions, take responsibility for determining eligibility for individuals' premium tax credit and cost-sharing reductions.[17]

While the Federally-facilitated Exchanges will be largely operated by HHS, HHS has advised that it "intends to work in collaboration with States, where appropriate, to ensure

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the best, most effective experience for the State and its residents."[18] Additionally, even if states do not choose to enter into a partnership type roll, states may nevertheless elect to run reinsurance programs or coordinate with the Center for Medicaid and CHIP Services ("CMCS") on Medicaid and CHIP eligibility. Finally, it must be emphasized that even in a state where a Federally-facilitated Exchange is implemented, insurers and health plans must meet not only the federal requirements, but also the already existing state laws governing insurers and health plans.[19]

3. State Partnership Exchanges

The third option falls in the middle of these two extremes whereby the state operates a State Partnership Exchange. Under this model, HHS administers and operates the majority of the aspects of the Exchange while the state maintains primary responsibility for select activities. Those activities may include: (1) plan management – conducting all analysis and reviews necessary for QHP certification, collect and transmit data to HHS and manage the certified QHPs and (2) consumer assistance – providing in-person assistance to consumers about filing, coverage options, reporting and enrollment.[20] This allows states to maintain some involvement while not shouldering the brunt of the operational and financial burden.

What Have States Decided to Do?

As of December 17, 2012, 19 states, along with the District of Columbia,[21] have declared their intention set up a State-based Exchange.[22] All of these states, except Minnesota, have established the legal authority for their exchanges. A majority have passed legislation while six, Kentucky, Minnesota, Mississippi, New Mexico, New York and Rhode Island, are utilizing non-legislative mechanisms such as executive order to establish their Exchange.[23] In all, these states account for approximately 115 million people, of which 9.8 million are presently uninsured and potentially eligible for tax credits.[24]

Back in the fall of 2010, to assist in establishing State-based Exchanges, HHS provided states with funding of up to $1 million each for planning grants. In 2011, states were able to begin applying for level one and level two establishment grants. Level one grants are to provide additional funding as states developed their various policies and operational elements for the Exchanges while level two are intended as multi-year awards to carry a state from now through the end of 2014 and are given only where significant implementation progress has been demonstrated.[25] Through these establishment grants, states have received as little as $3.4 million (Delaware) and as much as $196 million (California) to establish their Exchanges.[26] In all, as of November 2012, approximately $2 billion has been distributed to the states through the various available grants.[27]

In most instances, the structure and governance of the State-based Exchanges have begun to take shape. The three structures most commonly utilized are: (1) a quasi-governmental structure (e.g. California, Massachusetts, Connecticut); (2) oversight through an existing state agency (e.g. New York, Rhode Island, Vermont); and (3) creation of a non-profit corporation (e.g. Hawaii and Mississippi).[28] In almost all circumstances, and regardless of the Exchanges' structure, an independent Board of Directors will govern with the number and composition of the board varying among the states.[29] Over half of these states have also specified the relationship they will have with the QHPs. Some have chosen a clearinghouse model whereby the Exchange will contract with all QHPs that meet the minimum standards required (as discussed above).[30] Other states have chosen to be an active purchaser and only selectively contract with specific QHPs.[31] Selective contracting is a strategy to try and improve plan quality, better coordinate health care services and attempt to negotiate better plan pricing by restricting the QHPs allowed to be offered in a particular state.[32]

Conversely, 32 states have declined State-based Exchanges (New Jersey being among them) with only seven of those states declaring their intent to pursue a State Partnership Exchange.[33] Approximately 197 million people reside in these 32 states, of which about 18.3 million are uninsured and potentially could qualify for tax credit subsidies.[34] Thus, unless these states change their positions, the federal government will be responsible for operating the Exchanges for approximately two-thirds of the population and uninsured.

Several of the governors for these states have expressed their disappointment with the way in which HHS has rolled out the Exchanges and their regulations. On December 12, 2012, Governor Tom Corbett of Pennsylvania announced in a letter to Secretary Kathleen Sebelius that his state would not be establishing a State-based Exchange due to HHS' failure to provide enough detail about the operation of the proposed Exchange.[35] Governor Corbett also expressed concern that state authority to run the Exchange is "illusory" given the fact that even though after 2015 the state will be solely responsible for the cost of the exchange, it will "have no authority to govern the program."[36]

Governor Bob McDonnell of Virginia also recently informed HHS that Virginia would not be creating a State-based Exchange.[37] Governor McDonnell expressed similar frustration over the federal governments unwillingness to provide sufficient information for Virginia to determine whether it would have enough control over its own Exchange if implemented.[38] Despite pushes from both his own advisory counsel

and health insurers located in Virginia to support a State-based Exchange, Governor McDonnell rejected the plan claiming in a statement that "despite repeated requests for information, we have not had any clear direction or answers from Washington until recent days, and we cannot conclude, as we review those materials, that we would have the control and flexibility needed to efficiently and effectively run our own state exchange."[39] Governor McDonnell warned, "If Virginians are faced with running a costly, heavily regulated bureaucratic exchange without clear direction from Washington, then it is in the best interest of our taxpayers to let Washington manage an exchange at this time."[40]

What Path Has New Jersey Chosen for Its Exchange?

Here in New Jersey, Governor Chris Christie has grappled with similar tough decisions in the face of pressure from those in the State legislature to adopt a State-based Exchange. On December 6, 2012, Governor Christie vetoed a bill (S2135 – New Jersey Health Benefit Exchange Act) approved by the Democrat controlled Legislature that would have established a State-based Exchange.[41] This was the second time Governor Christie vetoed such a bill with the first bill (A2171 – New Jersey Health Benefit Exchange Act) reaching his desk back in May 2012, prior to the United States Supreme Court's decision about the constitutionality of the ACA.[42]

In his veto, Governor Christie expressed concern that despite the deadline to declare New Jersey's intentions, the state still awaited substantial federal guidance on how each of the three Exchange models would function.[43] Of primary concern to the governor in the veto was the unknown cost. For example, Governor Christie raised the question of "whether the federal government intends to share user-fee revenue with the states in a Partnership Exchange."[44] Further, Governor Christie called it "irresponsible" were he to agree to a State-base Exchange when "the total price for such a program has never been quantified, and is likely to be onerous."[45] The Governor summed up his position by stating, "In short, I will not ask New Jerseyans to commit today to a state-based exchange when the federal government cannot tell us what it will cost, how that cost compares to our other options, and how much control they will give the states over this state-financed option."[46]

On February 15, 2013, Governor Christie confirmed that he would leave the operation of New Jersey's Exchange to the federal government. While Governor Christie closed the door to a State-based Exchange in 2014, he did leave open the possibility of a state operated Exchange in future years if the federal government better outlines and explains the requirements and characteristics of the Exchange to better allow New Jersey to assess its cost and benefit to the state.[47]

Conclusion

While this is not what many supporters of the ACA envisioned when the law was passed and $2 billion was pumped into various federal grants to encourage State-based Exchanges, HHS remains confident that the Exchanges will be in place and all consumers will have access by January 1, 2013.[48] It is yet to be determined whether the federal government will be able to shoulder the financial burden of operating the Exchanges on its own over the long-term or convince more states to establish their own State-based Exchanges. What is certain is that regardless of the model implemented in each state, the federal government is shaping a very specific and tailored health insurance delivery system that will significantly change the way in which health insurance is bought and sold in this country.

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Footnotes

[1]42 U.S.C. 18031(b)(1)

[2]Center for Consumer Information and Insurance Oversight ("CCIIO"), Center for Medicare & Medicaid Services ("CMS"). "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges." November 9, 2012. http://cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf. p 1

[3]Ibid. at p 4

[4]Ibid.

[5]Sebelius, Kathleen. Correspondence from the Secretary of Health and Human Services. November 15, 2012.

[6]CCIIO, CMS, "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges." November 9, 2012. http://cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf. p4-5

[7]CCIIO, CMS. "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges." November 9, 2012. http://cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf. p 1

[8]Ibid.

[9]45 C.F.R. 155.105(b)

[10]45 C.F.R. 155.1000

[11]45 C.F.R. 155.205

[12]45 C.F.R. 155.260

[13]45 C.F.R. 155.305

[14]45 C.F.R. 155.105(a)

[15]45 C.F.R. 155.105(f)

[16]CCIIO, CMS. "General Guidance on Federally-Facilitated Exchanges." May 16, 2012. http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf.

[17]The Kaiser Family Foundation. "Establishing Health Insurance Exchanges: An Overview of State Efforts." November 2012. http://www.kff.org/healthreform/upload/8213-2.pdf. p 2

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[18]CCIIO, CMS. "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges." November 9, 2012. http://cciio.cms.gov/resources/files/hie-blueprint-11092012.pdf. p 3

[19]CCIIO, CMS. "General Guidance on Federally-Facilitated Exchanges." May 16, 2012. http://cciio.cms.gov/resources/files/FFE_Guidance_FINAL_VERSION_051612.pdf. p 9

[20]Ibid.

[21]NY, VT, MA, RI, CT, MD, MS, KY, MN, CO, MN, UT, WA, OR, ID, NV, CA, HI

[22]Center on Budget and Policy Priorities. "Status of State Health Insurance Exchange Implementation." December 17, 2012. http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf. p 1

[23]Ibid.

[24]Radnofsky, Louise. "U.S. Faces Big Insurance-Exchange Burden." WSJ. December 14, 2012. http://online.wsj.com/article/SB10001424127887324296604578179731269549130.html

[25]Ibid. at p 5

[26]Ibid.

[27]Radnofsky, Louise. "U.S. Faces Big Insurance-Exchange Burden." WSJ. December 14, 2012. http://online.wsj.com/article/SB10001424127887324296604578179731269549130.html

[28]The Kaiser Family Foundation. "Establishing Health Insurance Exchanges: An Overview of State Efforts." November 2012. http://www.kff.org/healthreform/upload/8213-2.pdf. p 3

[29]Ibid.

[30]Ibid.

[31]Ibid.

[32]Ibid.

[33]Federally-facilitated Exchange - ME, NH, PA, NJ, OH, IN, WI, VA, TN, SC, GA, FL, AL, LA, TX, OK, KS, MO, NE, SD, ND, MT, WY, AZ, AK. State Partnership Exchange – AK, DE, IL, IA, MI, NC, WV

[34]Radnofsky, Louise. "U.S. Faces Big Insurance-Exchange Burden." WSJ. December 14, 2012. http://online.wsj.com/article/SB10001424127887324296604578179731269549130.html

[35]George, John. "Pa. Rejects Running Own Health Insurance Exchange Under Affordable Care Act." Philadelphia Business Journal. December 12, 2012. http://www.bizjournals.com/philadelphia/news/2012/12/12/pa-rejects-running-own-health.html

[36]Ibid.

[37]Sluss, Michael. "Governor Says 'No' to State Health Insurance Exchange." December 15, 2012. http://www.roanoke.com/politics/wb/317987

[38]Ibid.

[39]Ibid.

[40]Ibid.

[41]Veto of Governor Chris Christie to Senate Bill 2135. December 6, 2012. http://blogs.app.com/ capitolquickies/files/2012/12/S-2135-AV.pdf

[42]Veto of Governor Chris Christie to Assembly Bill 2171. http://www.njleg.state.nj.us/2012/ Bills/A2500/2171_V1.HTM

[43]Veto of Governor Chris Christie to Senate Bill 2135. December 6, 2012. http://blogs.app.com/ capitolquickies/files/2012/12/S-2135-AV.pdf

[44]Ibid.

[45]Ibid.

[46]Ibid.

[47]Ibid.

[48]Radnofsky, Louise. "U.S. Faces Big Insurance-Exchange Burden." WSJ. December 14, 2012. http://online.wsj.com/article/SB10001424127887324296604578179731269549130.html