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HHS issues final regulations on health insurance exchanges

Final regulations have been issued giving guidance to States as they implement Health Insurance Exchanges pursuant to the Patient Protection and Affordable Care Act. These final regulations offer states substantial discretion in the design and operation of an Exchange, and include standards for the establishment and operation of an Exchange and other rules.

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The Department of Health and Human Services ("HHS") has released final regulations implementing the Health Insurance Exchange provisions of the Patient Protection and Affordable Care Act ("ACA"). The final regulations are generally designed to offer states substantial discretion in the design and operation of an Exchange, and include standards for:

- The establishment and operation of an Exchange;
- Qualification and accreditation of health insurance plans that participate in an Exchange;
- Determinations of an individual's eligibility to enroll in Exchange health plans and in insurance affordability programs;
- Enrollment in health plans through Exchanges; and
- Employer eligibility for and participation in a Small Business Health Options Program ("SHOP".)

Background

ACA requires that State-based Exchanges be in operation beginning January 1, 2014. The Exchanges are intended to provide a competitive marketplace for individuals and small employers, who will be able to directly compare available private health insurance options on the basis of price, quality and other factors. Initially, they will be open only to individuals and small employers, but States may make their Exchanges open to large employers beginning in 2017.

The Federal government will establish and operate an Exchange in States that do not elect to establish one, or where the State Exchange will not be operable by January 1, 2014. Individuals with household incomes below 400 percent of the Federal Poverty Level ("FPL") who do not have access to affordable minimum coverage from an employer will be entitled to receive subsidized health coverage through an Exchange.

Observation: According to the Kaiser Family Foundation, as of this month, 14 States have begun to establish their Exchanges, three plan to establish one, 20 are studying their options under PPACA, 12 have had no significant Exchange activity, and two States do not plan to create an Exchange.

Final regulations on exchanges and qualified health plans

The final regulations:

- Set forth the Federal requirements that States must meet if they elect to establish and operate an Exchange;
- Outline the minimum requirements that health insurance issuers must meet to participate in an Exchange; and
- Provide basic standards that employers must meet to participate in SHOP.

Issues of interest to employers

Employers are subject to a $3,000 penalty for each employee who enrolls in an Exchange and is eligible for a premium subsidy. This penalty will be $2,000 per full-time employee (less 30) if employees are not offered healthcare coverage. Employees are not eligible for premium subsidies if they are covered by an employer plan that is affordable and provides minimum value. Rules defining "minimum value" have not yet been proposed.

Employers will be particularly interested in the provisions of the final regulations governing communications between the employer and the Exchange(s).

- Exchanges must verify the eligibility of individuals, and notify employers of employees who will receive premium subsidies.
- Employers must provide information necessary for the verification of eligibility (HHS is considering ways in which individuals could gather this information as well.) The final regulations do not provide guidance on the verification process, as these issues are still under consideration.

Small employers may enroll in SHOP to provide coverage for their employees through an Exchange.

- Eligible employers are those with up to 100 employees, although States may choose to limit access to SHOP to employers with 50 or fewer employees through 2015.
- Beginning in 2017, States may permit larger employers to participate in their Exchanges.

Observation: While the regulations define a number of terms used throughout the regulations, they do not define "minimum essential coverage" or "eligible employer sponsored plan". These critical concepts are to be defined in future Treasury guidance.

Exchange establishment and functions

General standards

To be operational on January 1, 2014, a State must receive approval or conditional approval of its Exchange blueprint from HHS by January 1, 2013. If a State chooses not to establish an Exchange or if its Exchange is not approved, HHS will establish a Federally-facilitated Exchange in that State. Information regarding the Federally-facilitated Exchange will be provided in future guidance.

An Exchange must be a governmental agency or a non-profit entity established by a State. Governing boards must include at least one consumer representative and must not have more than half of its members from health insurance issuers, agents or brokers.

The entire geographic area of the State must be in the service area of one or multiple Exchanges. States may participate in a regional Exchange that spans two or more States (whether or not contiguous), and may establish subsidiary Exchanges within the State, if each such subsidiary Exchange serves a distinct geographic area.

States that do not choose to establish an Exchange and/or do not have their Exchange blueprint approved or conditionally approved by January 1, 2013 may elect to operate an Exchange at a later date. In that case, the State must have an approved or conditionally approved Exchange blueprint at least 12 months prior to the first effective date of coverage (*e.g.*, by January 1 of the prior year). Standards for a State to elect to cease operations of its State-based Exchange and have a Federally-facilitated Exchange instead are also provided.

State Exchanges must be self-supporting by 2015. Prior to that time, States may receive Federal grants to pay for Exchange establishment.

Certification of qualified health plans

ACA requires that Exchanges implement procedures for the certification, recertification and decertification of health plans as Qualified Health Plans ("QHP"s), which are health plans that are certified to be offered through an Exchange. The regulations provide flexibility to the Exchanges to determine the number and type of health plan choices to offer, the standards for a health plan's network design and its marketing practices.

An Exchange must complete the certification of the QHPs that will be offered during an open enrollment period. The initial open enrollment period begins on October 1, 2013.

Rules for QHP issuer rate and benefit information, including rules for increases in rates, transparency in coverage, and minimum criteria for the service areas of QHPs are provided.

Special rules are provided for offering limited-scope dental plans through an Exchange. The plan must cover at least the pediatric dental essential health benefits under ACA and meet the QHP certification standards. It may be offered as a stand-alone dental plan or in conjunction with a QHP.

General functions of an exchange

An Exchange must perform certain minimum functions, including providing consumer assistance tools and programs, such as a call center and an Internet website meeting certain requirements.

An Exchange must establish a Navigator program through which it awards grants to entities or individuals to provide consumer assistance. Navigators may not be health insurance issuers or related to the insurance industry. At least one navigator entity in each Exchange must be a community and consumer-focused non-profit group. States may also choose to permit agents and brokers to assist qualified individuals, employers or employees in enrolling in QHPs as long as certain requirements are satisfied.

Standards are provided for notices to be sent by Exchanges, the payment of premiums, and health information technology. Exchanges are required to implement operational, technical, administrative and physical safeguards to protect all personally identifiable information.

Eligibility determinations for participation and affordability programs

The regulations require an Exchange to:

- Determine whether an applicant is eligible to enroll in the Exchange (*e.g.*, meets citizenship and residency requirements, etc);
- Determine eligibility for advance payments of the premium tax credit (*e.g.*, has household income under 400% of the FPL and is not eligible for minimum essential coverage through an eligible employer-sponsored plan or Medicaid, the Children's Health Insurance Program ("CHIP"), or a Basic Health Program ("BHP") operating in the Exchange area); and
- Determine whether the applicant is eligible to receive cost-sharing reductions under ACA (*e.g.*, determine household income level, etc.)

Eligibility must be redetermined annually.

If an Exchange finds that an applicant's attestation regarding enrollment in an eligible employer-sponsored plan is not reasonably compatible with other information, the Exchange must utilize data obtained through electronic data sources to verify the attestation. HHS plans to release further guidance for the States regarding using electronic data sources for this verification.

The regulations do not provide operational guidance for verifying an individual's eligibility for qualifying coverage under an employer-sponsored plan, although the preamble references potential methods for verifying this information that were discussed in the proposed regulations. These include a template that employers and employees could use to capture previously reported information, or a central database that employers would populate with plan-level and employee-level information as part of the verification process. HHS is working with the Departments of Labor and Treasury to identify a process for gathering the necessary information to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, and will issue further guidance on this topic.

An Exchange is responsible for transmitting eligibility and enrollment information to HHS that is necessary for HHS to begin, end or change advance payments of the premium tax credit or cost-sharing reductions, and to the QHP to implement the advance payments. An Exchange is also required to transmit the name and Taxpayer ID to HHS of any individual

determined to be eligible for advance payments because the individual's employer does not provide affordable minimum essential coverage that meets the minimum value requirements.

The regulations set forth procedures for sharing information between an Exchange and the agencies administering Medicaid, CHIP or a BHP in the area of the Exchange.

Enrollment in qualified health plans

Rules for the enrollment of individuals in a QHP under an Exchange and for the administration of initial and annual open enrollment periods by the Exchange are provided. The initial open enrollment period begins October 1, 2013 and ends on March 21, 2014. If a qualified individual's election of a QHP is received by December 15, 2013, coverage must be effective as of January 1, 2014. Thereafter, if an election is made during the first 15 days of a month in the open enrollment period, coverage must be effective as of the first of the following month. If an election is made during the last half of the month, coverage must be effective as of the beginning of the second following month. Earlier coverage dates are permissible. Requirements relating to termination of coverage in a QHP are also provided.

Small business health options program ("SHOP")

An Exchange must provide for the establishment of a SHOP meeting the requirements of the regulations. A SHOP is an Exchange-based marketplace for qualified small employers to purchase coverage for their employees. Under the regulations, a small employer is one with between 1 and 100 employees, but States may elect to limit participation to employers with 50 or fewer employees for 2014 and 2015. States may determine whether to open their SHOP to large employers beginning in 2017. To be qualified to participate in SHOP, an employer must make, at a minimum, all full-time employees eligible for one or more QHPs in the small group market offered through a SHOP.

Standards are provided for the establishment and functions of a SHOP, including employer choice of QHPs, payment of premiums by the employer and employees, eligibility standards and determinations, enrollment of employees into QHPs under SHOP, enrollment periods and application standards.

A separate section of the regulations governs employer interactions with the Exchanges and SHOP participation. These rules provide that only qualified employers may participate in the SHOP. A qualified employer must disseminate information to its qualified employees about enrolling in a QHP through the SHOP, submit its contributions to the QHP, and inform the SHOP of newly eligible dependents and employees and the loss of qualified employee status.

Health insurance issuer standards

Qualified health plan minimum certification standards

Under the regulations, a health insurance issuer that wishes to participate in an Exchange must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP. A QHP issuer must comply with all statutory requirements and with the processes, procedures and requirements of the Exchange. Each QHP it offers must comply with the

Exchange's benefit design standards. The issuer must:

- Be licensed and in good standing in each State in which it offers coverage;
- Implement and report on its quality improvement strategies;
- Disclose and report information on health care quality and outcomes;
- Pay any applicable user fees charged by the Exchange; and
- Comply with the risk adjustment program (under separate final regulations just issued.)

A QHP issuer in an Exchange must offer at least one QHP in the silver coverage level and at least one in the gold coverage level, as well as a child-only plan at each level. Rates and benefits must be submitted on a timely basis to the Exchange. QHP issuers must provide information required by the Exchange that is designed to achieve transparency in coverage, including claims payment policies and practices, financial disclosures and various data. Information concerning prescription drug distribution and cost reporting is required of QHPs as well.

Provider networks under QHPs must meet network adequacy standards, and must have a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access to a broad range of providers for low-income or medically underserved individuals in the service area.

Rules are provided for enrollment periods and the enrollment process, rating variations (only geographic variations) and the termination of coverage. Rules are also provided governing the segregation of funds for abortion services in accordance with ACA and State laws.

QHP issuers offering a QHP through a SHOP must satisfy additional requirements regarding premium payments and enrollment of qualified employees. Finally, there are rules for non-renewal of participation by a QHP issuer and decertification of QHPs.

For more information, please do not hesitate to contact your local PwC professional:

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