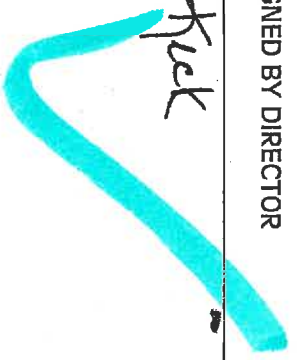


**DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR**

ACTION REFERRAL

TO <i>Singleton</i>	DATE <i>10-26-11</i>
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DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER <i>100183</i>	<input type="checkbox"/> Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR <i>cc: Mr. Kuck</i> 	<input type="checkbox"/> Prepare reply for appropriate signature DATE DUE _____ <input type="checkbox"/> FOIA DATE DUE _____ <input checked="" type="checkbox"/> Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

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Department of Health & Human Services
OFFICE OF THE DIRECTOR

October 19, 2011

Anthony E. Keck, Director
Department of Health and Human Services
P. O. Box 8206
Columbia, SC 29202-8206

Dear Tony:

This letter responds to your request for a description of the flexibility accorded State Health Insurance Exchanges under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. 111-148.

Section 1321 of the ACA, entitled "State Flexibility in Operation and Enforcement of Exchanges and Related Requirements," provides for the development of state-based "Affordable Insurance Exchanges" intended to serve as competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. Section 1321 essentially gives States three choices: (1) to establish and operate an Exchange that meets federal minimum requirements; (2) to establish and operate an Exchange that includes additional functions specified by the State; and (3) to have the federal government establish and operate the Exchange within that State. ACA § 1321(b)(1), (b)(2), (c).

The U.S. Department of Health & Human Services (HHS) issued Initial Guidance to States regarding the Exchanges on November 18, 2010. Two sets of proposed rules were published in the Federal Register this summer to implement various components of the Exchange. *See* 76 Fed Reg. 41866 (July 15, 2011); 76 Fed. Reg. 51202 (August 17, 2011). Comments on both sets of rules are due October 31, 2011.

The statute, and the implementing regulations that have been proposed to date, set forth numerous federal requirements that a State Exchange must satisfy in order to be certified by HHS. (The premium tax credits and reduced cost-sharing are available only for coverage purchased through a certified Exchange. If a state exchange is not certified, then HHS will operate a federally-facilitated Exchange in that state.) We briefly list those minimum requirements here. Among other things, an Exchange must:

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- Certify that health plans are “qualified” to participate on Exchange, by evaluating for compliance with federal and state standards on the following (proposed 45 C.F.R. § 155.1000):
 - scope of benefits and benefit structure, including cost sharing (proposed 45 C.F.R. §156.200)
 - rating variations (proposed 45 C.F.R. §156.255)
 - risk adjustment (proposed 45 C.F.R. §155.105)
 - provider network (proposed 45 C.F.R. §156.230)
 - health care quality (proposed 45 C.F.R. §155.105)
 - “transparency” in plan documents and notices (proposed 45 C.F.R. §156.220)
 - segregation of federal funds for plans that cover abortion services (proposed 45 C.F.R. §156.280)
 - licensing (proposed 45 C.F.R. §156.200)
- Consumer Assistance
 - maintain a web site that standardizes comparative information on each available health plan (including price, benefits, quality ratings, enrollee satisfaction, etc.) (proposed 45 C.F.R. §155.205)
 - operate a toll-free call center (proposed 45 C.F.R. §155.205)
 - establish and make available a “calculator” to facilitate comparison of available plans (proposed 45 C.F.R. §155.205)
 - provide general consumer assistance functions (proposed 45 C.F.R. §155.205)
 - conduct outreach and education activities (proposed 45 C.F.R. §155.205)
 - contract with “Navigators” who will conduct outreach and facilitate enrollment (proposed 45 C.F.R. §155.210)

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- Eligibility
 - collect applications from individuals, both on-line and on paper (proposed 45 C.F.R. Subpart E)
 - collect applications from employers and employees (for SHOP), both on-line and on paper (proposed 45 C.F.R. §155.710)
 - determine who is eligible for federal premium tax credits, cost-sharing reductions, Medicaid, and CHIP (proposed 45 C.F.R. §§155.310, 155.345), including requirement to verify information provided through trusted data sources (proposed 45 C.F.R. §§155.315, 155.320)
 - determine eligibility of employers and qualifying employees for SHOP (proposed 45 C.F.R. §155.710)
 - apply special eligibility standards to Indians (45 C.F.R. §155.350)
 - establish an appeals process for eligibility determinations (proposed 45 C.F.R. §155.355)
 - issue certificates for individuals who are exempt from the individual mandate (45 C.F.R. §155.200)
- Enrollment
 - conduct annual open enrollment and provide for special enrollment periods in specified circumstances (proposed 45 C.F.R. §§155.410, 155.420)
 - conduct “rolling” enrollment for employers/employees using the SHOP (proposed §155.725)
 - notify individuals and employers regarding time period for re-enrollment (proposed 45 C.F.R. §§155.410, 155.725)
 - enroll individuals who are eligible for coverage in the plan they select, and communicate with the health plans, HHS, and Treasury regarding enrollment (proposed 45 C.F.R. §155.400)

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- enroll individuals who are eligible for Medicaid (through electronic transmission of information to Medicaid), and refer individuals who may be eligible under specific Medicaid categories to Medicaid for further evaluation (proposed §155.345)
- monitor and submit reports regarding termination of coverage (proposed 45 C.F.R. §155.430)
- Billing and handling of premium payments
 - for the SHOP, provide an employer with “aggregate billing” and accept payments for distribution to health plans (proposed 45 C.F.R. §155.240)
 - coordinate with the U.S. Department of Treasury regarding payment of an individual’s advance premium tax credit to his or her health plan (proposed 45 C.F.R. §§155.105, 155.340)
 - establish a process to facilitate through electronic means the collection and payment of premiums (proposed 45 C.F.R. §155.240)
- Quality activities
 - evaluate quality improvement strategies (proposed 45 C.F.R. §155.200)
 - conduct enrollee satisfaction surveys (proposed 45 C.F.R. §155.200)
 - conduct assessment and ratings of health care quality and outcomes (proposed 45 C.F.R. §155.200)
 - monitor information disclosures (proposed 45 C.F.R. §155.200)
 - report data (proposed 45 C.F.R. §155.200)
 - regularly consult with stakeholders (proposed 45 C.F.R. §155.130)
- Oversight and financial integrity
 - keep an accurate accounting of all activities, receipts, and expenditures and annually submit a report on same to the federal government (proposed 45 C.F.R. §155.200)

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- Collect user fees or impose statewide assessments, or otherwise implement and supervise a means of being “self-sustaining” beginning in 2015 (proposed 45 C.F.R. §155.160)

The federal statute and rules thus set forth *minimum* requirements regarding the types of plans that can be included on the Exchange, the benefits the plans must offer, the cost-sharing structure of the plans, how plans communicate with consumers, when and how consumers may enroll, who is eligible for tax credits and cost-sharing reductions, how eligibility will be determined, who can assist consumers in enrolling, risk adjustment and reinsurance among plans, and the monitoring of quality of the plans.

The rules permit, and even encourage, that a State may want to *add* to these minimum requirements; however, there is not currently a process by which a State can have a certified Exchange that *subtracts* from these minimum requirements. Section 1332 of the ACA does provide for “waiver[s] for state innovation” that would permit a State to apply for approval from the Secretary of HHS (and/or the Secretary of the Treasury Department) to depart from various requirements of the ACA, including the rules relating to Exchanges, the individual mandate, the employer penalty, and the advanced premium tax credit. A proposed rule for the application, review, and reporting process for waivers for State innovation was published in the Federal Register on March 14, 2011 (76 Fed. Reg. 13553). However, the statute currently provides that waivers are available beginning only in January 1, 2017. Thus, they are not a vehicle for flexibility prior to 2017.

Because the federal requirements are quite extensive and prescriptive, the flexibility accorded to State Health Insurance Exchanges, while still important, is fairly constrained. In addition to the ability to decide whether to add any additional requirements to the federal minimum, a State has the flexibility to do the following:

- Determine how an Exchange will be structured and governed (i.e., within a state agency, as an independent state agency, or as a non-profit). ACA § 1311(d)(1). If the Exchange is governed by a Board, however, the proposed federal rules have requirements regarding conflicts of interest, qualifications of Board members, and Board composition. Proposed 45 C.F.R. §155.110(c).
- Decide how it will select the plans to be offered through the Exchange -- i.e., whether it will be an active purchaser that selects plans for inclusion on the Exchange, or whether it will be an open marketplace for all plans that meet the requirements for a qualified health plan. ACA §1311.
- Determine whether to require qualified health plans to provide benefits in addition to the “essential health benefits.” ACA § 1311(d)(3).
- Form a regional Exchange with other States or set up different Exchanges in different parts of the State. ACA §1311(f).

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- Operate a unified Exchange for individuals and small businesses or two separate Exchanges.
- Decide whether to merge the risk pools for rating the individual and small group markets. ACA §1312(c).
- Decide whether to allow agents and brokers to assist individuals and employers enroll in plans through the Exchange. ACA §1312(e).
- Until 2016, decide whether small employers should be defined as those employing 50 or fewer employees. In 2016, small employers are defined as those employing 100 or fewer employees. ACA §§ 1312(f)(2)(A); 1304(b)(2)-(3). Beginning in 2017, a State has flexibility as to whether to allow large employers to purchase through the Exchange.
- Establish how an Exchange will be financed, through user fees or otherwise. ACA §1311(d)(5)(A).
- Decide whether to offer administrative services to qualified employers in addition to aggregate premium billing and whether to allow qualified employers to have more choices regarding the qualified health plans available to their employees. ACA requires exchanges to allow qualified employers to offer their employees all qualified health plans available at a specified level. ACA §1312(a)(2); Proposed 45 C.F.R. §705(b)(2).

In sum, the principle flexibility accorded to State Exchanges is not *what* they will be doing, but *how* they will be doing it. Moreover, some of these decisions (i.e., whether or not to merge risk pools) can be made by the State as a matter of state insurance market regulation, without setting up an Exchange. Finally, to the extent that the statute and proposed rules give States certain flexibility over the Exchange, it is not clear the extent to which the decisions made by the State will be subject to federal oversight and/or negotiation. The proposed rules envision that a State will have to file an “Exchange State Plan” (similar to a Medicaid State plan) in which it sets forth how its Exchange will operate. The Plan must be federally approved in order for the Exchange to be certified. HHS has not released the components that must be included in a plan, and there is no experience that would enable a State to predict the extent to which some of its decision will be subject to federal review.

I did want to draw your attention to an option that is not provided for in the ACA, but which HHS has advanced in recent weeks, and which may provide States another avenue for flexibility. HHS is proposing the idea of “Partnership” Exchanges where both HHS and States take on various functions; overall, however, HHS would be responsible and accountable for ensuring the Exchange meets all of the standards. Under this model, States can choose to operate “plan management” functions and/or some consumer services. Plan management functions include (but are not limited to) plan selection, collection and analysis of plan rate and benefit package information; and plan monitoring, oversight, data collection and analysis for quality.

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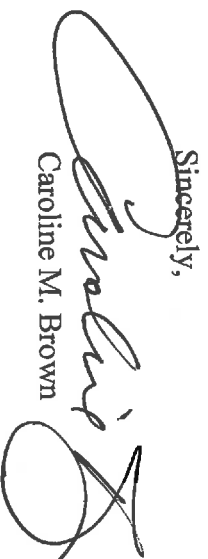
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Under the proposed option for plan management, the State would help select plans to be offered on the Exchange. A State could also choose to take on certain consumer assistance functions, including in-person assistance; management of the Navigator program; and outreach and education. HHS would be responsible for call center operations; website management; and written correspondence with consumers to support eligibility and enrollment. Under the Partnership model, Exchange functions other than selected consumer assistance or plan management functions would be performed by HHS. States entering into a Partnership would agree to ensure insurance department, Medicaid, and CHIP cooperation to coordinate business processes, systems, data/information, and enforcement.

I would be happy to provide greater detail on any of the above. Please let me know if you have any questions.

Sincerely,

A handwritten signature in black ink, appearing to read "Caroline M. Brown". The signature is fluid and cursive, with a long horizontal stroke extending to the right.

Caroline M. Brown