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CMS Proposed Rule on Health Benefit Exchange Implementation

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In mid-July, the U.S. Department of Health and Human Services (HHS) issued a proposed rule on the establishment of American Health Benefit Exchange (''Exchanges'') and Qualified Health Plans. These regulations largely codify Affordable Care Act (ACA) requirements, with some notable exceptions. Recognizing that the pace and politics of Exchange implementation varies from state to state, HHS departs from ACA guidance and provides states with three options for Exchange establishment: a state-run Exchange; a federally-run Exchange; or, a new ''hybrid option'' under which a state and the federal government would share operating authority.

The regulations further indicate that states may go into 2014 with a federally-run Exchange and opt to launch a state-run Exchange at a later date. The regulations and the commentary note that HHS will accommodate state flexibility beyond federal minimums and encourage states to adopt standards that reflect the demands of local markets and ensure that consumers have access to value-based coverage.

In addition to state flexibility, consistent themes throughout the draft regulation are cooperation and collaboration, between states and the federal government, state Medicaid and insurance agencies, and state agencies and Exchanges.

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Of particular note are the following provisions and related discussion in the preamble to the proposed rule:

Establishing and Operating Exchanges

Conditional Approval. In what appears to be an acknowledgement of the enormity of the task before states, the proposed rule offers States some flexibility in their implementation timeline by allowing ''conditional approval'' of state Exchanges that show progress toward, but not complete readiness for, operations by the statutory HHS approval deadline of Jan. 1, 2013. This is a departure from the expectation set by HHS to date that States must demonstrate full implementation capacity for all Exchange functions by 2013 or risk HHS intervention to establish a federal Exchange in the State.

Fluid Timelines. The draft rule presents a more fluid picture of the timeline for State election to run Exchanges than that articulated in the ACA. The rule would permit States to begin or cease Exchange operations after 2014 as long as the States work with federal officials to transition from or to the Federally-facilitated Exchange, beginning at least 12 months in advance of the change.

Conflicts of Interest. HHS weighs in on the discussion that has been ongoing in many states over Exchange governance. The proposed rules prohibit Exchange boards from having a majority of representatives with conflicts of interest, defined as representatives of insurance issuers, agents, brokers or other individuals licensed to sell health insurance. HHS invites comment on whether additional types of representatives with potential conflicts of interest should be limited in Exchange board participation.

Exchange Plan Amendments. The rules outline a potentially rigorous accountability approach by requiring that States notify HHS in writing of any substantial changes to Exchange Plans. Supporting commentary suggests that HHS is considering use of a State Plan Amendment (SPA) process similar to the process in place for Medicaid and CHIP as the vehicle for Exchange Plan changes. HHS seeks comment on this approach.

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Navigator Program. The ACA requires that Exchanges establish Navigator programs to assist individuals in accessing coverage through Exchanges; the law bars the use of federal funds to underwrite the costs of these programs. Proposed regulations describe the categories of entities that may function as navigators, obligate Exchanges to have at least two of these categories of entities service as navigators and note that if the Navigator program assists Medicaid-eligible individuals, Medicaid may underwrite a portion of the costs of the program.

Individual Premium Billing. Adding a layer of complexity in one area of Exchange functionality, the regulations offer Exchanges the option to collect premiums from individuals, but require those Exchanges that conduct premium billing also permit enrollees to pay premiums directly to QHP issuers.

Qualified Health Plans

Accreditation of QHP Issuers. The regulations make a distinction between QHPs and QHP issuer (or carriers) which will be important to states seeking to increase QHP choice and encourage Medicaid-only plans to enter the individual market. Exchanges will be able to certify a QHP—a product offered by an issuer—while the QHP issuer's accreditation is pending. Exchanges must establish timelines by which an issuer must be accredited.

Certification of QHPs. The proposed regulations address the minimum marketing and network adequacy standards that QHPs must meet in order to be certified and HHS seeks comment as to whether it should impose more expansive network or marketing requirements.

Notably, with respect to the ACA requirement that QHPs contract with ''essential community providers'' (ECPs), including Federally Qualified Health Centers (FQHCs), the regulations inject the words ''sufficient number'' of ECPs and seek public comment on how to assess whether the QHP has contracted with a sufficient number of ECPs and also what requirements should prevail with respect to QHP FQHC payment rates.

Plan Enrollment

Enrollment Periods. The proposed rule specifies time frames and parameters for initial and annual open enrollment periods. The proposed initial open enrollment period for state Exchanges is Oct. 1, 2013, through Feb. 28, 2014, to allow for sufficient outreach and education. HHS seeks comment on the appropriate time frame for annual open enrollment periods thereafter, offering Oct. 15 through Dec. 7 or Nov. 1 through Dec. 15 as alternatives. The rule also provides parameters for special enrollment periods.

Coverage Effective Dates. Coverage effective dates are the first of the month with specific exceptions for births and adoptions. This policy raises questions for maintaining continuity of coverage for individuals losing coverage at other times during the month and suggests a potential conflict, practical if not legal, with respect to Medicaid's enrollment standards which require immediate if not retroactive enrollment.

Small Business Health Options Program

SHOP Flexibility. The proposed rule provides new flexibility with respect to employer choice in the SHOP. As required by the ACA, the SHOP must allow an employer to select a tier of coverage in which all QHPs are made available to employees. The proposed rule further provides that the SHOP may permit participating employers to select one or more QHPs to offer as coverage to their employees. HHS seeks comment on this latter provision, which in statute appears to apply to large employers, but in the proposed rule has been extended to small employers.

Employer Enrollment Periods. The proposed rule delegates responsibility to the SHOP to establish a uni-

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form timeline relating to employer enrollment and employee enrollment in QHP coverage. The initial open enrollment period for SHOP must commence October 1, 2013. The proposed rule further requires the SHOP to establish a rolling enrollment process to match the enrollment process for the small group market outside of the SHOP. HHS reasons that small employers are more likely to join the SHOP with the flexibility of a rolling open enrollment period rather than a single annual open enrollment period.

Employee Enrollment Periods. The proposed rule requires the SHOP to establish annual open enrollment periods for employees which, due to the rolling enrollment process, standardize to the plan year. HHS further requires the SHOP to ensure that employees hired outside of the open enrollment period are provided with a specified time frame to seek coverage when they start their employment.

Premium Aggregation. In contrast to the flexibility offered in the individual Exchange, the proposed rule requires SHOP to perform premium payment administration duties. The statute is silent in this regard, but the discussion indicates that HHS reasons this policy to be an administrative simplification for employers.

Rate Setting. The proposed rule specifies standards for rates and rate changes. HHS requires that the SHOP confine QHP issuer rate changes to a uniform time frame that is either quarterly, monthly, or annually, with rate changes occurring during the year applying only to new coverage and annual renewals. HHS invites comment on whether it should allow more or less restrictive time frames.

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The proposed rules, available at http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17610.pdf and http://www.gpo.gov/fdsys/pkg/FR-2011-07-15/pdf/2011-17609.pdf, were published on July 15 in the *Federal Register* and HHS will accept comments on them until Sept. 28. While these regulations focus on a subset of crucial issues, they are not exhaustive. Guidance on other key provisions—such as the essential health benefits package, the Basic Health Plan, Exchange and Medicaid eligibility and enrollment and the Medicaid-Exchange interface—are anticipated later this summer or in the fall.

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