An Overview of General Guidance on Federally-facilitated Exchanges

Released May 16, 2012

The Center for Consumer Information and Insurance Oversight (CCIIO) released general guidance on federally-facilitated exchanges (FFE), which outlines the agency’s proposed approach for operating a federal exchange, whether in partnership with a state or on behalf of the state. The guidance reflects the Department of Health and Human Services’ (HHS) intent to work with states to preserve and build upon the traditional responsibilities of state insurance departments in regulating health insurance. HHS will also “harmonize” FFE policies with existing state programs and laws where possible.

**Partnership Model:** Rather than operate a state-based exchange, states have the option to enter into a Partnership with an FFE, in which the state assumes responsibility for plan management\(^1\), consumer assistance, or both. A state choosing to undertake plan management must do all plan management activities. A state choosing to undertake consumer assistance will conduct all in-person assistance; HHS will be responsible for web-based and hotline assistance. A state electing a State Partnership must designate the agency that will have the authority and capacity to carry out the state functions.

**Federally-facilitated Exchange:** States can elect to have HHS operate the exchange in their state. The guidance outlines the proposed HHS approach to the following exchange functions:

- **Plan management:** Some of the requirements for Qualified Health Plans (QHPs) rely on reviews and standards that state departments of insurance do not currently conduct; therefore, HHS will need to perform the review for some standards and confirm the outcome of the state’s review for others.
  - HHS expects states to play a primary role in areas of traditional state responsibility, with HHS taking responsibility for oversight in areas that fall outside the scope of states’ traditional regulatory authority, are exchange-specific or where Federal funds are involved.

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\(^1\) Plan management refers to the certification and oversight of Qualified Health Plans, including a review of network adequacy, marketing, licensure, accreditation, benefits, and actuarial value standards.
To ensure a sufficient number of plans in each exchange, HHS will certify as a QHP any plan that meets all the certification standards. In future years, HHS may consider a more selective contracting (or active purchasing) approach.

In 2012, HHS will release for public comment a model application to help issuers prepare for the QHP submission process.

In early 2013, HHS intends to release the QHP issuer application; HHS expects to certify QHPs in late summer 2013, and open enrollment for 2014 will begin October 1, 2013.

Accreditation and Quality Reporting: HHS is taking a phased approach to accreditation and quality reporting. HHS will accept existing health plan accreditation from NCQA or URAC on issuers’ commercial or Medicaid lines of business in the same state. Plans without this accreditation must schedule accreditation in the 1st year of certification as a QHP and be accredited by the 2nd year.

Eligibility for subsidies and Medicaid/CHIP: HHS will work with states to ensure coordination with state eligibility systems for Medicaid and CHIP. HHS is creating a model electronic application for potential use by all states, including where HHS operates the exchange. There will be two approaches to determining Medicaid and CHIP eligibility:

- FFE will determine Medicaid and CHIP based on the new income standard (MAGI) and electronically transmit the determination to the state agency to enroll the individuals.
- FFE will conduct an assessment of Medicaid and CHIP eligibility based on MAGI and electronically transmit all information for any potentially-eligible applicants to the state agency, which will make the final determination and notify the FFE if the agency finds the applicant ineligible.

Consumer Support, Outreach and Education: FFEs will offer a website, toll-free hotline and other in-person assistance. In addition:

- HHS will establish Navigator programs by awarding grants to eligible entities. HHS intends to award Navigator grants prior to 2014, subject to available federal funds.
- HHS will work with licensed agents and brokers to promote enrollment through exchanges. To the extent permitted by state law, HHS will allow agents and brokers to enroll individuals in a QHP as long as they ensure individuals use the
exchange internet site to verify eligibility or use the broker site if certain standards are met.

**Federally Facilitated SHOP exchange for small business:** HHS will adopt state definitions of small employer in 2014 and 2015 (e.g., 1 – 50, 2 to 50, or up to 100 employees).

- FF-SHOP will allow employers to model various choice scenarios (such as by changing employer contribution percentage) before making final selection.
- Multi-state employers will offer coverage to their employees either through the FF-SHOP serving the employer’s primary place of business or through the state-based or FF-SHOP serving each employee’s primary worksite.
- FF-SHOP will provide for premium aggregation and other office functions, such as employer billing, receipt of payments, and payment reconciliation.

**Stakeholder Input:** HHS is exploring with the National Association of Insurance Commissioners (NAIC) whether an advisory board can or should be created in states where such boards do not already exist.

**Highlights and Comments:**

- Although HHS does not intend to selectively contract with QHPs in the first year of an FFE, the guidance suggests they may review plan benefit design to ensure “meaningful difference” between plans and prevent look-alike products. This is a consumer-friendly distinction that is not required by the statute.
- Coordination with states will be essential in an FFE. HHS will have to obtain state information for a number of plan requirements, including whether the plan is in “good standing” and meets other state requirements (licensure, rate and benefit review).
- Network Adequacy: HHS is proposing that network adequacy reviews consider service area, which is a requirement not included in the statute. Of concern, though, is that most state network adequacy requirements apply only to HMOs yet all plans seeking to participate in the FFE must meet network adequacy standards.
- HHS’ intent to build on state laws, capacity and experience, and to harmonize rules and requirements where possible will help with coordination and mitigate adverse selection.
- The phased approach to accreditation and quality reporting recognizes that most states do not now apply these requirements to commercial plans.