

State Decisions: Federally Facilitated Exchange (FFE) States

This document is intended to outline varied approaches and considerations for FFE states, as they move forward in the new operating environment. There is a wide range of regulatory functions, from more traditional state functions, like confirming licensure, solvency and good standing, to new functions the state will have to undertake, like evaluating whether products meet essential health benefits (EHBs) and federal rating pool requirements. It is important, as states consider how to handle the many issues presenting themselves as a result of the federal Affordable Care Act (ACA), that states retain regulatory authority over plans sold in their state. The federal government should not take over roles traditionally held by the state Insurance Departments. Additionally, states may consider the effect of imposing additional requirements beyond those set by the ACA.

Data coordination

Will the state confirm insurer licensure, solvency, and good standing?

In order to certify a plan as a qualified health plan (QHP), an FFE must verify that it is offered by a QHP issuer that is licensed, solvent, and in good standing with the state. This could be done in several ways:

- The state could verify licensure, solvency, and good standing for the FFE, perhaps in the same manner as is done for certification of Medicare Advantage plans.
- The FFE could accept documentation or attestations from the company.
- The FFE could require the submission of financial reports to verify solvency.

States may want to consider to what extent they wish to participate in this process. Some considerations may include:

- Administrative burden on the Department of Insurance.
- Administrative burden on the carrier.
- Potential for miscommunication or fraud.
- Potential for federal government to perform its own solvency review for QHP certification purposes.

Will the state confirm producer licensure and appointment?

An FFE will permit agents and brokers (including web-based brokers) to enroll individuals, employers, and employees in a QHP through an Exchange. Individual producers would use either the issuer's portal to the FFE or the consumer-facing website. Subject to the requirements of 45 CFR §155.220, producers selling nongroup coverage on the FFE will be required to register with the FFE, sign an agreement to abide by privacy and security requirements, and complete training in the range of QHP options and other insurance affordability programs. HHS is recommending, but not requiring, that producers selling small group coverage through the FF-SHOP undergo the same training and registration requirements as those selling nongroup coverage. All sales in the FF-SHOP involving an agent would utilize the consumer-facing website. If an agent or broker violates the terms of the agreement, CMS may suspend or terminate agent or broker access to the exchange; CMS intends to notify the state when this occurs and refer any market conduct issues to the state for follow-up and remediation. Web brokers would redirect consumers to the FFE for eligibility determinations, and then would allow them to compare and shop for plans on the web broker's site using an application programming interface.

States may want to consider:

- The content of FFE producer training programs and the extent to which the state wishes to make additional training a condition of licensure.
- Whether existing state processes and standards related to producers (such as licensure requirements, appointments with issuers, and compensation) need to be updated in light of market changes.
- Potential conflicts between standards contained in the FFE producer agreement and state requirements.
- Administrative burdens on the Department of Insurance, producers, and carriers.
- The importance to consumers of ensuring that agents and brokers are providing good-quality, reliable

information that is in the consumer's best interest; that personal and sensitive information is kept private and secure; and that agents and brokers that violate requirements or do not meet standards will face recourse.

- Extent to which a state wants to ensure consumers have resources available to find an agent that meets their needs; close in proximity, appointed with a company the consumer prefers or appointed with all carriers in the exchange, etc. Maybe this is a search tool on the department's website.
- Whether to allow continuing education credit for FFE training.

Rates and forms

Will the state inform the FFE of state rate and form review outcomes?

While the FFE will be able to make QHP certification decisions based upon standards contained in the final Exchange rule and upon other standards developed by the FFE, all QHPs sold on the Exchange must also meet all requirements of state law and regulation that do not prevent the application of the federal law, including rate and form approval requirements. These requirements will apply to all plans in the state, whether sold through Exchanges or outside of them. In addition, the Exchange must receive and disclose justifications for all QHP premium increases. Initially, HHS has said that it will not place additional certification requirements on QHPs in an FFE, though it could still exclude plans sold by issuers that have a history of requesting premium increases that have been found unreasonable under the rate review process established by the ACA. In addition, it could also decline to recertify a QHP based upon a pattern of premium increases. As part of its certification process, an FFE will want to ensure that a potential QHP has met all requirements of state law and that its forms and rates have been not been denied by the state.

States may want to consider:

- Whether and how to provide this verification.
- Administrative burdens on Departments of Insurance and on carriers.
- Potential for additional federal reviews of QHP forms to assess compliance with state law.
- The outstanding uncertainty regarding outside exchange product approval when a state is not assuming enforcement authority for ACA-related provisions.

While the federal government has no such authority for rate and form approval, it can impose significant fines after the fact upon issuers whose plans are not in compliance with federal law.

For additional information on rate and form review considerations, see the NAIC's Exchange plan management white papers on rate review and form review.

Will the state review forms for federal law requirements?

Many of the market reforms in the ACA will be primarily enforced through the form review process. These requirements will apply to all plans in the state, whether sold through Exchanges or outside of them. 45 CFR §150.101(2) indicates that states have primary enforcement authority with respect to the requirements of title XXVII of the PHS Act that apply to health insurance issuers offering coverage in the group or individual health insurance market. If CMS determines that a state is not substantially enforcing title XXVII of the PHS Act, CMS would enforce them. In addition, if states do not review policy forms for compliance with federal law requirements, HHS may do so as part of its general enforcement processes.

States may want to consider:

- Entering into a collaborative enforcement arrangement with HHS to clarify the role of the state insurance department.
- Potential for federal involvement in form review.
- Administrative burden on the Department of Insurance.
- Administrative burden on carriers submitting forms for review to both states and HHS.
- The importance to consumers of ensuring that products offered in the state's insurance markets meet all necessary requirements.
- The outstanding uncertainty regarding outside exchange product approval when a state is not assuming

enforcement authority for ACA-related provisions.

While the federal government has no authority for rate and form approval, it can impose significant fines after the fact upon issuers whose plans are not in compliance with federal law.

For additional information on form review considerations, see the NAIC's Exchange plan management white paper on form review.

Will the state review plans for compliance with actuarial value requirements?

All non-grandfathered, individual and small group plans, inside and outside of Exchanges, must meet requirements to provide the appropriate actuarial value for the four metal tiers (60%, 70%, 80% and 90%). In addition, silver plans sold on the Exchange must be accompanied by variants with reduced cost sharing levels for those with household incomes below 250% of FPL and for Native Americans.

States may want to consider:

- Whether to review all non-grandfathered individual and small group plans for compliance with actuarial value requirements.
- If reviewing plans, whether to use the default data set incorporated into the federal AV calculator or, beginning in 2015, whether to substitute its own claims data to be used in calculating AV.
- Potential federal review of plans inside and outside of the Exchange for compliance with AV requirements.
- Administrative burden on Department of Insurance. While the AV calculator will streamline review of plans, particularly if it can be accessed through SERFF (which will integrate the federal AV calculator), some aspects of plan design, such as tiered networks and value-based insurance design (to the extent permitted under state law), may not fit neatly into the actuarial value calculator and may require a more labor-intensive review.

For more detail on enforcement of AV requirements, see page 5 of the NAIC's Exchange plan management white paper on form review and page 10 of the NAIC's Exchange plan management white paper on rate review.

Network adequacy

Will the state provide information about network adequacy reviews to FFE?

An FFE must ensure that a QHP offers a sufficient choice of providers and provides information to enrollees and prospective enrollees on the availability of in-and out-of-network providers. The final Exchange rule gives Exchanges broad leeway to develop standards that suit individual state markets and does not set additional standards. The March 1, 2013 HHS draft letter to Issuers on FFE and SPE indicates the following: (1) For the 2014 coverage year, when CMS is evaluating applications for QHP certification, CMS will rely on state analyses and recommendation when the state has the authority and means to assess issuer network adequacy; (2) In states without sufficient network adequacy review, CMS will accept an issuer's accreditation from an HHS-recognized accrediting entity; (3) Unaccredited issuers will be required to submit an access plan as part of the QHP application. The letter also indicates that CMS will monitor network adequacy, for example, via complaint tracking or gathering network data from any QHP issuer at any time to determine whether the QHP's network(s) continues to meet these certification standards.

States may want to consider:

- Whether to attempt to meet federal standards and review network adequacy of QHPs.
 - Whether to apply these standards outside the Exchange as well.
 - Potential federal review of plan network adequacy.
- The ramifications of these decisions on the insurance marketplace, including the potential for adverse selection resulting from different standards inside and outside the Exchange.
- Whether to apply the same standards to PPO plans as to HMO plans.
- Administrative burdens for Department of Insurance and carriers (*Note: The SERFF system has been modified to collect various elements of network adequacy data – states will be able to capture as much or as little information as is desired*).
- The importance to consumers of ensuring that provider networks are adequate.

For additional detail of network adequacy requirements in Exchanges, see the NAIC's Exchange plan management white paper on network adequacy.

Will the state review networks for presence of essential community providers?

The ACA and the final Exchange rule require QHPs to include essential community providers (ECPs), who serve primarily low-income, medically underserved populations, in their networks. They are required to reimburse these providers at predominating rates, but no lower than Medicaid reimbursement rates. Verifying the presence of these providers in networks is a new element of the network adequacy review process that has not traditionally been performed by states. The March 1, 2013 HHS draft letter to Issuers on FFEs and SPEs indicates that CMS will determine requirements for inclusion of ECPs in provider networks to be met if either the safe harbor standard or minimum expectation standard is met. The Safe Harbor Standard is described as the issuer application demonstrating that at least 20% of available ECPs in the plan's service area participate in the issuer's provider network(s). Additionally, the issuer offers contracts during the coverage year to: (1) All available Indian providers in the service area, using the model QHP Addendum for Indian providers developed by CMS; and (2) At least one ECP in each ECP category in each county in the service area, where an ECP in the category is available.

The Minimum Expectation standard is described as the issuer application demonstrating that at least 10% of available ECPs in the plan's service area participate in the issuer's provider network(s). Such applications will be determined to meet the regulatory standard, provided the issuer includes as part of its application a narrative justification describing how the issuer's provider network(s), as currently designed and after taking into account new 2014 enrollment, provides an adequate level of service for low-income and medically underserved enrollees.

States may want to consider:

- Whether to verify QHP compliance with this requirement during any network adequacy review.
- The potential for federal involvement in network adequacy review if the state does not undertake it.
- Any additional administrative burden on the Department of Insurance and carriers (*Note: states engaging in network adequacy reviews may consider incorporating this data into that review*).
- The importance to individuals and families of ensuring that there is adequate access to essential community providers.

Marketing

Will the state coordinate application of state marketing rules to QHPs in the Exchange?

The final Exchange regulation requires QHPs to comply with any applicable state laws and regulations regarding marketing. In its general guidance on FFEs, HHS has suggested that it will accept carrier attestations of compliance with state marketing requirements. There may, however, be times when the FFE will want to verify these attestations either by seeking confirmation by the state or by directly examining the marketing of the QHP.

States may want to consider:

- Whether and how to share state marketing standards with the FFE.
- What role to play in ensuring that the marketing materials consumers in the state receive are accurate, reliable, and meet all necessary state requirements, and also that marketing used by issuers are appropriate and meet all state requirements.
- Potential for duplicative examinations if the state does not coordinate with FFE.
- Impact of federal marketing examinations upon state oversight and upon issuers of QHP plans, including impact of any monetary penalties levied by the FFE.

Market Reform and Plan Management Activities

Will the state enter into a Marketplace Plan Management arrangement?

HHS is allowing interested states to attest that they will perform all the plan management activities listed in Section 4.0 of the Blueprint in time for the 2013 QHP selection process. Interested states are required to submit a letter from their

Governor or Insurance Commissioner attesting that the state will: (1) have the legal authority and operational capacity to conduct the plan management activities required to support certification of QHPs, as described in 45 CFR §155.1010(a); (2) collect and analyze information on plan rates, covered benefits, and cost-sharing requirements pursuant to 45 CFR 155.1020; (3) help ensure ongoing plan compliance and resolve consumer complaints described in 45 CFR 155.1010(a)(2); (4) provide issuer technical assistance as needed; (5) help manage decertification of issuers and associated appeals in compliance with 45 CFR §155.1080; and (6) participate in a one-day review of its operational plans and capacity to perform these functions.

Interested states may want to reach out to their state officer to understand whether there are any current deadlines to pursuing this opportunity.

States may want to consider:

- Whether the state wants to support plan management functions for the FFE.
- How information will be shared between the state insurance department and the FFE.
- Whether the state has the resources to take on additional plan management activities and if not, understand the extent to which federal funds are available to support these activities.
 - In a Feb. 20, 2013 FAQ document, HHS indicated that a state is eligible to apply for an Exchange Establishment Grant, consistent with the guidance set forth in the Funding Opportunity Announcement, to fund these activities. If a state does apply, it is agreeing to participate in the review, reporting, and technical assistance programs associated with oversight of these Establishment Grants and to ensure appropriate use of grant funds and effective performance of the required plan management activities.
 - HHS has also provided feedback to states indicating they may use remaining planning grant funds to support plan management functions in a “Partner/Not a Partner” option.

How will the state handle consumer complaints?

The handling of consumer complaints will likely depend on the level of coordination between the federal government, states and exchanges. Exchanges, including FFEs, are statutorily required to have a call center available to consumers with questions related to applying for insurance affordability programs or commercial insurance through the exchange. CMS has indicated that complaints received by an FFE may be forwarded within CMS to a tracking system, or another process could be worked out with states.

States may want to consider:

- Whether and how to coordinate consumer complaints pertaining to market reforms and/or the Exchange.
 - Determine when the state’s role ends and the federal government’s role begins.
 - Sharing some complaints with the FFE prior to resolution may raise confidentiality concerns.
 - How will complaints and the results of examinations be communicated.

Will the state institute enrollment requirements or other measures to address adverse selection in the individual market outside the Exchange?

The ACA and subsequent regulations provide for initial and annual open enrollment periods that are consistent across Exchanges and outside insurance markets in order to help protect against adverse selection with the implementation of guaranteed issue, adjusted community rating, prohibition of preexisting condition exclusions, and other market reforms in 2014. They also provide for special enrollment periods (many of which apply to both the Exchange and the outside market) to permit consumers to enroll in coverage outside of the regular open enrollment periods if they meet certain conditions.

The HHS final Health Insurance Market Rules, at 45 CFR §147.104, require issuers to accept every employer and individual in the state that applies for coverage, subject to certain exceptions. These exceptions allow issuers to restrict enrollment in coverage: (1) to open and special enrollment periods; (2) to employers with eligible individuals who live, work or reside in the service area of a network plan; (3) in certain situations involving limited network capacity and limited financial capacity. However, in the group market, an issuer must allow an employer to purchase health insurance coverage for a group health plan at any point during the year. A health insurance issuer may limit the availability of

coverage in the small group market to an annual enrollment period that begins November 15 and extends through December 15 of each year for a plan sponsor that is unable to comply with a material plan provision relating to employer contribution or group participation rules.

States may want to consider:

- Whether to permit carriers to enroll individuals outside of open and special enrollment periods.
- Whether additional measures to address adverse selection would be necessary if enrollment outside of open enrollment periods is allowed.
- Whether the state has a process in place to effectively monitor insurer solvency during a condensed time period of high enrollment (initial and annual open enrollment periods).
- Whether the state has the tools it needs to allow a plan to stop enrolling in a guaranteed issue environment if solvency issues arise.

Essential Health Benefits

In final regulations issued in February 2013, HHS set forth the criteria for the selection of a state EHB benchmark plan. States may designate an essential health benefits benchmark plan selected from one of four options and supplemented to include benefits in each of ten statutorily-prescribed categories. If a state does not designate a benchmark plan, HHS will use the largest plan by enrollment in the state's small group market. The state will be required to defray the cost of any state-mandated benefits enacted after Dec. 31, 2011 that are not included in the benchmark plan for all individuals enrolling in a QHP. State mandates enacted prior to Dec. 31, 2011 are deemed to be part of a state's benchmark plan for purposes of determining whether reimbursement will be required. The regulation includes a list of EHB benchmark plans for each state and additional documentation about each benchmark plan is available on the NAIC website.

States may want to consider:

- EHB packages must comply with nondiscrimination requirements.
- It is still unknown how the states will "pay" for the cost of mandated benefits not included in the EHB. However, for years 2014 and 2015 states are required to make payments either to the individual enrollee or to the issuer on behalf of the enrollee, to defray the cost of additional benefits.
- How best to balance cost and comprehensiveness of the benefit package to suit the needs of state residents.
- How to best minimize the chance that the state will have to pay for the cost of state mandates in coverage sold through the Exchange.
- The Administrative burden associated with determining whether a specific health plan's benefit package is "substantially equal" to the selected EHB benchmark; this is a separate issue as to whether a benefit substitution within a category is actuarially equivalent.
- Whether the state will define habilitative services.
 - The final HHS Essential Health Benefits regulation provides that, if the EHB benchmark plan does not include coverage for habilitative services, a state may determine which services are included in that category. If there is no state definition, issuers may provide habilitative services at parity with rehabilitative services or decide which habilitative services to cover and report that coverage to HHS.
- Plans, including those offered in the large group market, cannot impose annual or lifetime dollar limits on EHBs.
 - Will benefit substitutions, as described in the final EHB regulation, be used to substitute annual and lifetime dollar limits in the large group market?

Will the state restrict actuarially equivalent benefit substitutions?

Final HHS regulations on essential health benefits permit plans to make actuarially equivalent substitutions of benefits within benefit categories (except for prescription drugs). These regulations, also clarify that states retain the authority to restrict or prohibit these substitutions. In addition, final OPM rules for the Multi-State Plan (MSP) Program provide that if a state restricts substitutions of essential benefits or requires standardized benefit packages, MSPs must use the state benchmark plan and comply with standardization requirements.

States may want to consider:

- The cost and additional resources needed to verify actuarial equivalence.
- The impact of restricting or prohibiting substitutions on consumer choices and on health plan innovation.
- The impact of restricting or prohibiting substitutions on the ease of plan comparisons by consumers.
- The impact of allowing benefit substitutions on regional insurers if multi-state insurers take advantage of this flexibility.

Will the state require meaningful difference between plans outside of Exchange?

HHS has indicated that it will review QHPs sold on an FFE by the same issuer for “meaningful difference” to ensure that a manageable number of distinct plan options are offered. The draft March 1, 2013 annual letter to issuers on FFE and SPE indicates that CMS will conduct a benefit package review for all QHPs offered by an issuer. The goal of this review is to identify QHPs that are not meaningfully different from other QHPs offered by the same issuer and with the same plan characteristics. As explained in the draft letter, CMS expects its review to consist of two parts: (1) Whether the health plan’s benefit package and plan costs are substantially different from other potential Exchange plan offerings in that state from that issuer. CMS will take into account the extent to which each potential QHP is substantially different from other QHPs of its plan type with respect to key characteristics such as metal level, service areas covered, provider networks, premiums, cost sharing, benefits offered, or formulary structure; and (2) Whether consumers would likely be able to distinguish the particular plan from other QHP offerings from the same issuer in a given service area. States could extend the meaningful difference requirement to the individual and small group markets outside the Exchange if they wished.

States may want to consider:

- The impact of meaningful difference requirements on consumer choice.
 - Extending the meaningful difference standards to the outside market could stifle market innovation; thereby limiting plan options available to meet consumer needs.
- The impact of meaningful difference requirements on consumer decision-making.
- Administrative burden on the Department of Insurance of reviewing plans for meaningful difference.

Will the state enact and enforce federal rating rules?

The ACA imposes new adjusted community rating requirements and a requirement that all of a carrier’s enrollees in the individual market be considered part of a single risk pool and that all enrollees in the small group markets be considered to be part of a second single risk pool unless a state opts to merge the individual and small group markets, in which case all non-grandfathered plans’ risk would be merged. Final HHS Market Rules Regulations further require that rates for plans in a single risk pool vary only based on (1) whether the plan covers an individual or family, (2) rating area, (3) age, except that the rate may not vary by more than 3:1, and (4) tobacco use, except that the rate may not vary by more than 1.5:1. If states do not enforce these requirements, HHS would step in to do so, reviewing rates and forms for evidence of compliance. These regulations also clarify that non-grandfathered student health insurance coverage is not subject to the single risk pool requirement but is subject to the premium rating requirements listed above. The preamble to the regulation notes that the premium rate charged by an issuer offering student health insurance coverage may be based on school-specific group community rate if, consistent with section 2701 of the PHS Act, the issuer offers the coverage without rating for age or tobacco use.

States may want to consider:

- Potential for federal involvement in rate and form review.
- Loss of state authority and its impact on the rate and form review process.

Will the state specify age bands?

The ACA limits the variation of premiums for adults due to age to 3:1 and requires HHS, in consultation with the NAIC, to specify permissible age bands for the variation of premiums. In its final Market Rules Regulations, HHS requires issuers in the individual and small group markets to use a single age band for individuals between 0-20 years of age, one-year age bands for individuals between 21-63 years of age, and a single age band for individuals 63 and older. It also has proposed a uniform age curve for the individual and small group markets that would apply unless a state proposes a

different uniform age curve.

States may want to consider:

- Potential for federal involvement in the rate review process and the impact of the federal age curve upon state regulatory authority.
- Whether bands set by the state would be more suitable to the state's marketplace than the default federal age curve.
- Additional administrative burden on Department of Insurance.

Will the state specify geographic variation and rating areas?

Final HHS Market Rules Regulations, and subsequent guidance, provide that a state's rating areas must be based on the following geographic divisions: counties, three-digit zip codes, or MSAs and non-MSAs. HHS has clarified that they will accept any one or combination of allowable geographic divisions. State specific geographic rating areas will be presumed adequate if they meet either of the following conditions: (1) As of Jan. 1, 2013, the state had established by law, rule, regulation, bulletin, or other executive action, uniform geographic rating areas for the entire state; or (2) After Jan. 1, 2013, the state establishes for the entire state no more geographic rating areas than the number of MSAs in the state plus one. Under these standards, geographic rating areas may be noncontiguous, but the area encompassed by the geographic rating area must be separate and distinct from areas encompassed by other geographic rating areas. States have the option to seek approval from HHS for a greater number of rating areas as long as the areas are based on counties, three-digit zip codes, or MSAs and non-MSAs. If a state does not establish rating areas or a state's rating areas are determined to be inadequate, the default will be one rating area for each MSA in the state and one rating area for all other non-MSA portions of the state, as defined by the Office of Management and Budget. Future HHS guidance will be issued that will establish a process and timeline for states to update their rating areas.

States may want to consider:

- Current requirements and practices in the state for variation of premiums based upon geography.
- Impact on rating areas on premiums in the state.
- Additional administrative burdens on Department of Insurance and carriers.

Will the state enforce requirement that issuers sell coverage at the same rate inside and outside of the Exchange?

The ACA requires that a QHP be sold for the same premium regardless of whether it is sold through the exchange, directly from the insurer, or through an agent or broker. The preamble to the final Exchange rule specifies that in enforcing this provision, states should consider plans that are "substantially the same" to be the same plan

States may want to consider:

- How to determine whether two plans are "substantially the same."
- Additional administrative burden on the Department of Insurance.

Will the state license CO-OP plans?

CO-OPs must be licensed by the state and must meet all requirements of state law (except for those provisions of state law that operate to exclude CO-OP loan recipients due to their being new carriers or due to other characteristics that are inherent to the design of CO-OPs).

States may want to consider:

- Whether refusal to license a CO-OP for reasons that are inherent to the design of a CO-OP would risk preemption and the resulting impact on state regulatory authority.
- Additional administrative burden on Department of Insurance.

How will the state license Multi-State Plan (MSP) issuers and coordinate with OPM on enforcement?

Multi-State Plans (MSPs) will be offered in the Exchanges in all states, plus the District of Columbia and are “deemed certified” to be offered on an Exchange pursuant to a contract with OPM under Section 1334 of the ACA. The ACA requires that the issuer of a MSP be licensed in every state in which it operates. The final OPM regulation on the establishment of the MSP Program provides that an MSP issuer must offer coverage in at least 60% of states in the first year; 70% of states in the second year; 85% of states in the third year and all states by the fourth year. It also provides that an issuer need not offer coverage in all service areas of a state. OPM encourages statewide coverage if the issuer has the capacity to offer it, and an issuer that does not offer coverage in all service areas of a state must submit to OPM a plan for expanding to the entire state. The final regulation requires MSP issuers to offer a uniform benefits package within a state that is substantially equal to the EHB benchmark plan in each state in which it operates or one of the OPM-selected EHB benchmark plans (the 3 largest FEHBP plans). If an MSP issuer selects one of the OPM-selected EHB benchmark plans, it must (1) supplement the entire category of benefits from the largest Federal Employee Dental and Vision Insurance Program (FEDVIP) dental or vision plan options if the benchmark plan chosen lacks pediatric oral services or pediatric vision services; (2) comply with standards for habilitative services and services as defined by each state (if there is a state definition); ; (3) include, for each state, any state-required benefits enacted before Dec. 31, 2011, that are included in the state's EHB-benchmark plan, or specific to the market in which the plan is offered; if the state has not defined such category, if any OPM-selected EHB-benchmark plan lacks coverage of habilitative services and devices, OPM may determine what habilitative services and devices are to be included in that EHB-benchmark plan and (4) comply with any state standards relating to substitution of benchmark benefits or standard benefit designs. If a state requires mandated benefits beyond the EHB benchmark package to be sold to MSP enrollees, it must assume the cost of those additional benefits.

States may want to consider:

- Whether to grant licenses to issuers that intend to offer policies that do not comply with state law.
- Working closely with OPM to achieve early resolution of any potential conflicts regarding the applicability of state laws to MSP issuers.

Reinsurance

Will the state require reinsurance contributions in excess of the national contribution rate?

The transitional reinsurance program will operate from 2014-2016 and will provide a total of \$20 billion in payments to non-grandfathered individual market plans paid for with assessments on all fully-insured and self-insured health insurance plans. The final Benefit and Payment Parameters Regulation for 2014 provides that a state may elect to operate its own reinsurance program. Regardless of whether a state's reinsurance program is operated by HHS or the state, HHS will collect all reinsurance contributions from all contributing entities. The final rule establishes a methodology for calculating the national contribution rate that will apply to all contributing entities in all states. A state that operates its own reinsurance program may elect to collect more than the national contribution rate to provide funding for (1) administrative expenses of the reinsurance entity, or (2) additional reinsurance payments.

States may want to consider:

- Impact of federal payment parameters on health insurance marketplace.
- Temporary nature of the program.
- Administrative burden on Department of Insurance or other state agency or nonprofit administering the program.

Will the state end its high risk pool?

The HHS final Market Rules Regulation indicates states will continue to have the discretion to determine whether each state continues to have a high risk pool in order to ease the transition of enrollees to other products, consistent with the Feb. 1, 2013 minimum essential coverage proposed rule, which proposed to designate state high risk pools as minimum essential coverage for a period of time to be determined by the Secretary. People enrolled in a state high-risk pool will be able to enroll in coverage in the individual insurance market on a guaranteed issue basis and to receive subsidized coverage through the exchange if they are otherwise eligible.

States may want to consider:

- The number of people in the state high risk pool, the conditions of coverage in the pool, and enrollees' incomes (to evaluate whether a majority of that population would benefit from subsidies offered through the exchange); and be concentrated in the exchange market.
- If most of the high risk pool members are expected to seek coverage through the exchange, states may want to consider the number of insurers available in that market to take on and share the risk this population may bring to the exchange market.
- How the state's high risk pool is funded and whether insurers would be assessed twice (once to support the state high risk pool and again to support the federal reinsurance program, which will send their fees out of state). Whether the federal reinsurance and risk adjustment programs are expected to sufficiently compensate insurers taking on a disproportionate amount of risk, as a result of the end of the state's high risk pool.

Consumer Education and Outreach

Navigators and Application Counselors

When provisions of the ACA take effect in 2014, education and outreach to consumers will be important to ensure that individuals are aware of the requirement to obtain health insurance coverage and of other changes taking place in the marketplace. The law creates a new navigator program that uses grants awarded by Exchanges to fund individuals and organizations to provide information to consumers regarding coverage options and the availability of subsidies. Their role is not to be confused with licensed agents and brokers, who are the only professionals who may (1) recommend a particular health plan or insurer to consumers and (2) offer advice about which health plan is better or worse for a particular individual or employer. In an FFE, HHS will be selecting and providing some oversight of navigators. Final HHS Exchange regulations require Navigators to meet any licensing, certification, and other standards established at the state level, provided that such standards do not prevent the application of Title I of the ACA. Proposed HHS regulations also create application counselors to do the following: provide information about insurance affordability programs and coverage options; assist individuals and employees to apply for coverage in a QHP through the Exchange and for insurance affordability programs; and help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs. The NPRM requires application counselors to be certified by the exchange. Training is a requirement for certification. There is no federal funding to support the work of application counselors.

States may want to consider:

- The extent to which they would like to assist the FFE's outreach and education efforts.
- The extent to which they may make recommendations and suggestions regarding Navigator selection.
- Whether and how to license, certify, and/or regulate Navigators and Application Counselors.
- Administrative functions of the department in establishing licensing or certification of Navigators and Application Counselors.
- The need to ensure that Navigator and Application Counselors are impartial assisters.
- A state pursuing licensure or certification of Navigators will need to consider:
 - Whether to require state-specific training and the specifics of that requirement, (i.e. subject areas, number of training hours required, whether passage of an examination is required, etc.).
 - Whether to require that Navigators refer consumers to licensed agents when consumers want services only a licensed agent is authorized to provide.
 - The importance to consumers of ensuring that Navigators and Application Counselors take measures to ensure that personal and sensitive information is kept private and secure; and that Navigators and Application Counselors that violate requirements or do not meet standards will face recourse.
 - How to ensure consumers are protected from harm by the actions of a Navigator or Navigator entity; an example has been suggested that would require a Navigator or Navigator entity to furnish a bond in a specific amount or otherwise show evidence of financial responsibility capable of protecting all persons against the wrongful acts, misrepresentations, errors, omissions or negligence of the navigator.
 - The extent to which a state imposes conflict of interest provisions and safeguards to ensure navigators or application counselors working in medical facilities, like hospitals, are not steering consumers into health plans that benefit medical facilities or the providers working in them.

- Whether state licensure or certification requirements would unnecessarily duplicate requirements already imposed on navigators by the federally facilitated exchange.
- Whether any state licensure or certification requirements (such as financial responsibility requirements) could have the effect of unnecessarily impeding a sufficient amount of Navigators and other assisters from serving the state’s residents.
- The extent to which the conduct of navigators will be monitored and regulated if states establish no regulatory regime for navigators and the impact this could have on consumers.
- The extent to which a state wants to ensure consumers have resources available to find an agent that meets their needs; close in proximity, appointed with a company the consumer prefers or appointed with all carriers in the exchange, etc. Maybe this is search tool on the department’s website.
- The extent to which the state wishes to make existing state stakeholder outreach groups available to the FFE for consultation.
- Whether there will be a sufficient amount of Navigators and other consumer assisters in the state, so that individuals and families will have sufficient access to impartial information to help with the eligibility and enrollment process.

Will the State Insurance Department work with the Tribes or will HHS be the primary contact?

The Exchange Final Rule includes several provisions specific to the tribes in the areas of tribal consultation, premium payment, essential community providers, third party payer, navigators, network adequacy, definition of Native American and verification of Native American Status.

States may want to consider:

- Whether it will participate in HHS outreach to the tribes.
- Whether to develop a relationship with the tribes, if one does not already exist, to ensure HHS is being responsive to feedback offered by the tribes.

Future decisions

Will the state transition to partnership or SBE?

The final Exchange regulation provides for states to move from a federally facilitated Exchange model to a state-based Exchange, and vice-versa. In order to begin operating a state-based Exchange after 2014, the state must have an approved or conditionally approved Exchange blueprint and operational readiness assessment at least 12 months before the Exchange’s first effective date of coverage and develop a transition plan with HHS. Exchange establishment grant funds may be used to pay for this transition prior to 2015. After 2015, however, federal funds would not be available for transition costs.

States may want to consider:

- Transition and operational costs, which, particularly in smaller states may be greater than the costs of an FFE.
- State control over standards applied to QHPs and enforcement of those standards.
- Impact of the transition process on consumers, health plans, and state agencies.

Will the state seek a state innovation waiver?

The ACA permits states to apply for state innovation waivers that would allow states to implement alternative means towards achieving the same policy goals as the ACA, including waivers of the individual and employer mandates, health insurance exchanges, premium subsidies, and cost-sharing reductions. These waivers would go into effect in 2017.

States may want to consider:

- Whether a state innovation waiver would help the state meet the goals of the ACA in a way that is better suited to what is required under the ACA.
- How funds that would have been used for subsidies could be better used by the state to expand coverage in the state.

Medicaid

Will the state accept federal Medicaid eligibility determinations rather than reserving the right to make final determinations based upon federal eligibility assessments?

The final Exchange rule permits states to decide whether it will accept, as final, eligibility determinations performed by the Exchange or whether the state Medicaid program will receive “eligibility assessments” from the Exchange, but will make final determinations itself. Every state where there is an FFE will have to support coordination between the Medicaid program and the FFE and otherwise comply with new rules related to income-based eligibility and application, renewal and verification procedures.

States may want to consider whether:

- Federal Medicaid determinations could reduce workload on state Medicaid agency.

Will the state expand the Medicaid program, and how far?

The Supreme Court decision, which upheld the individual mandate, prohibited the federal government from conditioning continued funding for the state’s existing Medicaid program upon expansion of the program to 133% of the federal poverty level (FPL). States therefore have the option to expand or not expand their programs. There is no time limit on the ability of states to pursue this option. It is still unclear whether a state will be permitted to expand their programs to a level below 133% of FPL. Many other questions regarding the expansion of Medicaid are also still unresolved.

States may want to consider:

- The cost of the state’s share of expanding Medicaid.
- Whether it makes sense to expand Medicaid to a level below 133% of FPL, such as 100%, which is the level above which individuals are eligible for Exchange subsidies.
 - Enhanced federal funds cannot be used to expand Medicaid coverage to a level below 133% of FPL.
- What additional obligations and/or cost-savings the state might incur by expanding Medicaid.
- The impact of the decision to expand or not expand Medicaid upon premiums in the individual market.