



**American Hospital
Association**

Implementing State Health Insurance Exchanges: A Checklist of Hospital-Related Considerations

States have a significant role to play in the implementation of the *Affordable Care Act's* (ACA)¹ health insurance market reforms. A key component of the new insurance market is the establishment and operation of an American Health Benefit Exchange for individuals and a small business health options program (SHOP) Exchange for small business groups (together referred to as the "Exchanges") in each state. The goals of Exchanges are to reduce the number of individuals without health insurance coverage and to provide a state-level market mechanism to improve access and coverage for individuals and small groups. While the effective date for Exchanges is Jan. 1, 2014, states will engage in planning and implementation between 2010 and 2014 to meet their statutory obligations by Jan. 1, 2014.² If the Secretary of the U.S. Department of Health and Human Services (HHS) determines that a state has not made sufficient progress toward implementation of an Exchange, or if the state decides not to operate an Exchange, the federal government will contract with a nonprofit entity to operate an Exchange in that state.

State governments and key stakeholder groups are discussing if and how the Exchanges will operate in their respective states. HHS will issue regulations and guidance documents³ that establish standards for the operation of the Exchanges that will include: establishing certification criteria and marketing requirements for qualified health plans (QHP); defining the essential benefit package; ensuring that QHPs are accredited on clinical quality and other measures; developing a system that will rate QHPs relative to quality and price; and determining the initial open and special enrollment periods.

Summarized below are analyses of some of the issues that states have to address in establishing and implementing an Exchange, and a checklist of considerations that state hospital associations may want to use as they engage in discussion about an Exchange in their state.

¹ *The Patient Protection and Affordable Care Act*, as amended by the *Health Care and Education Reconciliation Act*, is referred to as the *Affordable Care Act* (ACA).

² By Jan. 2013, the HHS Secretary will determine whether a state is capable to establish an Exchange by Jan. 1, 2014.

³ In Nov. 2010, the Office of Consumer Information and Insurance Oversight (OCIIO) (recently transferred to the Centers for Medicare and Medicaid Services (CMS) as the Center for Consumer Support and Insurance Oversight) of HHS issued a Guidance document on the Exchange that foreshadows what HHS will address in regulations in 2011.

Overview

Exchanges play a pivotal role in the states' implementation and regulation of insurance market reforms and coverage expansions. Each state will decide how to implement the ACA requirements and the nature and functions of their Exchange(s). In most cases, states will need to enact legislation to authorize and guide these functions, opening the door for broader state-initiated changes. Below are threshold questions that each state will likely address based, in part, on state politics, stakeholder input and federal requirements.

- Will the state establish an Exchange?
- If the state chooses to establish an Exchange, will it be a state agency, a quasi-government entity or an independent nonprofit entity? Will the state look to neighboring states to establish a regional Exchange?
- Will there be separate Exchanges – one for the individual market and another for the small group market, or will they be merged?
- How will the Exchange be governed, and who will be eligible to serve on the board/committees?
- What functions will the Exchange perform and will it adopt a more limited or a more aggressive approach to market reform and oversight?
 - Will it assume an aggressive posture on its functions, e.g., actively negotiate with plans and select the “best plans” for the Exchange?
 - Will it adopt a more passive role, e.g., will the Exchange include all plans that meet minimum requirements?
- What is the relationship to other state agencies?

The states will need flexibility to establish Exchanges that reflects each of their unique circumstances, political environment and challenges. State hospital associations will want to engage in the discussion regarding the governance, functions and infrastructure of their Exchanges. While providers are not specifically identified as stakeholders in Exchange governance, hospitals need to be recognized as important stakeholders in their establishment and governance.

Issue: Governance

For those states that choose to establish and operate an Exchange, the ACA provides three options: (1) a new or existing state agency; (2) a quasi-governmental entity; or (3) an independent nonprofit entity. Each has advantages and disadvantages that need to be evaluated.

Option 1: Leveraging a new or existing state agency.

Advantages:

- Ensures coordination with other state agencies to avoid redundancy.
- Improves accountability to state government.
- Ensures that the state has a stake in its success.

Disadvantages:

- Makes it difficult for the Exchange to be nimble in its hiring of the technical expertise needed to operate and perform its functions because of civil service requirements.
- Limits the Exchange's flexibility in contracting because of state procurement practices.
- Risks that an existing agency's mission and policies will impede the Exchange's operation, e.g., the Medicaid agency may shift its existing policies and functions into the Exchange to subsidize some Medicaid costs with Exchange funds.
- Opens the door to expanding the Exchange under state authority to include other functions (such as provider rate review) that could divert attention from the primary goal of creating a competitive health insurance market for individuals and small businesses.
- Potentially changes the image of the Exchange from a private insurance market to a public program.
- Politicizes the Exchange's governance and operations.
- Creates significant expense for small states.

Option 2: An independent public entity or quasi-government agency (a middle ground between an existing government agency and an independent nonprofit organization, such as an authority that has an appointed board of commissioners responsible for decision-making and day-to-day operations).

Advantages:

- Balances the need for public accountability and support with the challenge to secure consumer and business support for the expansion of coverage. For example, composition of the governing body could include a mixture of state agency representatives (Medicaid and insurance department) and private stakeholders (employers, business leaders, consumers and providers).
- Might avoid some of the administrative requirements that limit an existing state agency from operating effectively, such as civil service requirements and procurement rules, if state enabling statute exempts the exchange from those rules.
- Avoids the political entanglements involved in a state-operated entity and would not be dependent on state appropriations (depending on the state's legislation).

Disadvantages:

- Runs the risk that public participation may outweigh other stakeholders and could freeze out valuable input from employers, business, consumers and providers.
- Opens the door to expanding the Exchange under state authority to include a number of other functions (such as provider rate review) that could divert attention from the primary goal of creating a competitive health insurance market for individuals and small businesses.

Option 3: A nonprofit entity.

Advantages:

- Avoids government oversight.
- Provides greater flexibility in decision-making.
- Avoids the administrative rules of the state government, including civil service and procurement rules and practices.
- Reduces the likelihood that the Exchange's operations will be politicized.
- Reduces interference from state government in how the Exchange makes and implements decisions and addresses problems.

Disadvantages:

- Increases the potential for loss of public accountability and input on proposed policies and rules.
- Reduces the likelihood of coordination and non-duplication of efforts between the Exchange and state agency operations.
- Reduces the financial viability of the Exchange after federal startup funds end.

State Hospital Association Checklist of Issues to Consider and Address

- ✓ Engage in the process that the state uses to establish an Exchange to ensure that the risks associated with each option are considered and addressed.
- ✓ Ensure that the rules governing the membership, appointment process, powers, duties and responsibilities of any board or committee of the Exchange are transparent and inclusive.
- ✓ Ensure that the Exchange permits providers to participate actively in the decision-making process. At a minimum there should be a board-level provider advisory body.
- ✓ Watch for ways that the Exchange can extract funding from providers, including provider-based health plans, because funding may become a challenge, particularly in the early years when individual and small employer participation is low.
- ✓ Ensure that hospital data reporting standards and requirements are consistent.

Issue: Functions of the Exchange

The ACA specifies that the functions of Exchanges be carried out either directly or through a contractor (discussed below). In defining the authority and duties of an Exchange, each state must incorporate the federally required Exchange functions and oversight responsibilities in authorizing legislation or other governing documents.

The most significant core requirement is the certification, recertification and decertification of QHPs that will be offered in each Exchange. The HHS Secretary will develop regulatory certification standards in the following five areas: marketing; network adequacy; accreditation for performance measures; quality improvement and reporting; and uniform enrollment procedures.

Each Exchange must ensure health plan compliance with the regulatory standards established by the Secretary and a number of the standards are particularly important to providers, including:

- Network adequacy.
- Justification for premium increases.
- Collection and evaluation of QHPs' data regarding claims payment policies and practices, denied claims, rating practices, cost sharing and payment with respect to out-of-network coverage, and enrollment/disenrollment.

There are a number of other core functions that each Exchange must perform to ensure adequate quality, access and coverage, including:

- Assessing QHP quality improvement programs.
- Providing a toll-free telephone hotline for consumers.
- Maintaining an internet website for consumers to obtain standardized comparative information regarding QHPs.
- Rating the QHPs offered in the Exchange and determining the actuarial levels of coverage for QHPs as prescribed by the ACA.
- Using a standardized format for presenting health benefit options, including uniform explanations of coverage.

The ACA specifically requires each Exchange to consult with certain stakeholders. The list of stakeholders mentioned in the Exchange provisions of ACA includes the following:

- Educated health care consumers enrolled in QHPs.
- Individuals and entities with experience in facilitating enrollment in QHPs.
- Representatives of small businesses and self-employed individuals.
- Medicaid state agency.
- Advocates for enrolling hard to reach populations.

Providers, including state hospital associations, must ensure that the Exchanges look to hospitals and health systems as important stakeholders in expanding coverage and access, and ensuring quality.

The discussion surrounding the Exchange functions also may extend to a broader range of issues than what is required by the ACA. State governments may consider whether the Exchanges will limit the number of plans offered or permit most state-licensed plans to participate in the Exchanges. This decision could have significant effects for health care providers. For example, a decision to limit plans to those with large minimum enrollee populations could exclude many provider-based health plans. It also would further consolidate an already heavily consolidated insurance market. If an Exchange is given the authority to negotiate plan rates, it will create winners and losers and the decisions could limit access to certain providers, especially academic medical centers and safety-net providers. Regulating plan rates also could stimulate a push to regulate provider rates.

Finally, the HHS Secretary will award grants to states to enable the state or the Exchanges to establish or operate Navigator programs. The grant would enable the state or its Exchange to contract with

private and public entities to perform the functions of the Navigator, that include: conducting public education, providing enrollment assistance, making referrals to state agencies for any enrollee grievance or complaint, answering enrollees' questions regarding their health plan coverage, and providing information that is culturally and linguistically appropriate.

State Hospital Association Checklist of Issues to Consider and Address

- ✓ Encourage the Exchange to be aggressive in applying the certification standards to the QHPs.
- ✓ Engage in the decisions regarding QHP certification standards. All standards will apply to provider-sponsored QHPs.
- ✓ Encourage the Exchange to require plans to provide sufficient data to demonstrate that the provider network is geographically accessible and actually available to patients.
- ✓ Encourage the Exchange to adopt certification standards that reward the qualified plans that collaborate with providers to use innovative approaches to delivery and payment.
- ✓ Engage with the Exchange to develop criteria that the Exchange will use to evaluate innovative delivery and payment models.
- ✓ Ensure that the Exchange conducts oversight of QHPs, particularly with regard to network adequacy, patient access, claims processing and quality improvement activities. Pay particular attention to qualified plans that push more administrative functions down on the providers as a way to reduce their administrative costs.
- ✓ Consider suggesting that the Exchange use a provider survey instrument that probes some of the qualified plan practices and requirements and their impact on providers and enrollees.
- ✓ Ensure each QHP is using language services, community outreach and cultural competency training by incorporating those requirements into the quality rating criteria for QHPs.
- ✓ Ensure that the Exchange includes hospitals in the discussion of administrative simplification activities.
- ✓ Ensure that the Exchange solicits and uses provider input regarding QHP behavior, implementation of administrative simplification and regulatory functions.
- ✓ Ensure that the Exchange requires that QHPs include safety-net providers in their networks.
- ✓ Ensure that risk adjustment adequately protects safety-net plans and safety-net providers from high costs and adverse selection.
- ✓ Encourage the Exchange to incorporate provider input into the certification and recertification process, including surveys that report on various aspects of QHP operations and behavior.
- ✓ Identify any existing organizations that already provide outreach and perform educational and enrollment functions that might participate as Navigators. For example, the State Health Insurance Program (SHIP) that assists Medicare beneficiaries in selecting coverage options could be expanded to assist a broader range of consumers.
- ✓ Work with the Exchange to minimize disruption in eligibility and enrollment between the private plans and public programs.
- ✓ Consider encouraging the Exchange to use a single point of contact for eligibility and enrollment for the Exchange and governmental programs.
- ✓ Solicit and incorporate hospital input in the development of the enrollment process, including forms. Incorporate providers into the enrollment process to ensure that the process is seamless, efficient and timely. The Exchange should be consulting with relevant stakeholders, including hospitals and consumers in enrolling hard-to-reach populations.

Issue: Contracting With State Agencies and Vendors

The ACA gives the Exchanges the discretion to contract with entities, including state agencies and private vendors, to perform certain functions. Some states may want to leverage their Exchange funding and ability to get up and running by identifying those functions (such as network adequacy and quality monitoring) that are performed effectively by existing state agencies or private vendors. For example, in some states the regulation of health plans currently is split between the Insurance Department and the Department of Health. An Exchange may want to continue relying on those agencies or vendors for the following reasons:

- The health department may have a technically knowledgeable staff capable of evaluating health plan quality, network adequacy and access. Some states may rely in part on private accreditation, such as the National Committee on Quality Assurance (NCQA). In other states the Quality Improvement Organizations (QIOs) may be an option.
- The Insurance Department has expertise regarding health plan solvency standards and technical expertise regarding insurance market conduct.

State Hospital Association Checklist of Issues to Consider and Address

- ✓ Identify, for contracting purposes, any functions performed by existing state agencies or private vendors/entities where those agencies/vendors are highly effective.
- ✓ Ensure that Exchange contracting decisions are based on the technical expertise, efficiency and timeliness of the entity. The contracts should incorporate safeguards, including termination and penalties, if the entity fails to perform effectively.
- ✓ Ensure that the Exchange adopts an effective oversight mechanism over the performance of contracting entities.