Proposed Establishment of Health Insurance Exchanges and Qualified Health Plans

Summary

Background
Among the most significant provisions in the *Patient Protection and Affordable Care Act* (ACA) are those pertaining to state health insurance exchanges, an organization or agency to facilitate the purchase of health insurance coverage in the individual and small group markets. Section 1311 outlines the general responsibilities and goals of the exchanges, while Section 1321 outlines the flexibilities granted to states in establishing and operating the exchanges.

States may establish exchanges as government agencies, as independent non-profits or as quasi-governmental agencies; states also may contract with other organizations, including state agencies, for operation of some or all exchange functions (such as enrollment or marketing). States also may establish a statewide exchange, regional exchanges or multi-state exchanges, provided each state party to an exchange passes statutes accepting the arrangement. States may choose to operate separate exchanges for the individual and small group markets, or merge the two markets into a single exchange. The US Department of Health and Human Services (HHS) must sign-off on state exchanges to ensure they meet the guidelines set forth in the ACA. Finally, states may choose to do nothing and let the federal government operate an exchange in the state. ACA requires plans offered on exchanges to begin coverage on January 1, 2014.

On Monday, July 11, HHS released two proposed rules regarding health insurance exchanges. The first proposed rule, addressed in this summary, provides guidance to states on the structure, governance and functions of health insurance exchanges serving the individual market and the small group market; the latter through the Small Business Health Options Program (SHOP). This rule also provides basic guidance on the accreditation and certification of health insurance issuers and Qualified Health Plans (QHPs).

HHS notes throughout its discussion of the proposed rule that its overall goal is to balance the competing needs of nationwide consistency and state flexibility, as states are responsible for the implementation of exchanges. In practical terms, what this means is that certain aspects referenced in the final version of this rule may not be the final policy for a particular state. Chapters may wish to engage their state's legislators and regulators on these matters.

The second rule released on July 11 regards reinsurance, risk corridors and risk adjustment arrangements for state health insurance exchanges. AAFP staff are reviewing this rule and, if necessary, will provide a separate summary of that proposal.

These proposed rules are the initial guidance to states and stakeholders regarding health insurance exchanges. Additional rulemaking is expected regarding the "essential health benefits package," actuarial values, benefit design standards, quality measurement within exchanges, eligibility standards (including premium tax credits, cost-sharing reductions and coordination with other programs, such as Medicaid and Children's Health Insurance Program), enrollment applications and procedures, and exemptions from the individual mandate. Proposed rules on these issues may be released jointly or individually. AAFP will continue to monitor these issues and will provide summaries of rules where appropriate.

HHS provided a 75-day comment period on the proposed rule. The deadline for comments is September 28, 2011. The AAFP will analyze the proposed regulations and submit a formal response to HHS.

Table of Contents

State Health Insurance Exchange Structure, Governance and Functions

Much of the proposal regarding the structure, governance and functions of state health insurance exchanges follows closely the model provided in the *Affordable Care Act*.

Structure of Exchanges

The first step for states under the ACA and the proposed rule is to make the determination as to whether or not it will create an exchange. If a state opts not to operate an exchange, HHS will then step in and operate the exchange in that state according the rules set forth in this and future proposals. The ACA provides states with several options regarding the geographic area(s) served by exchanges, as well as what entities are eligible to operate exchanges.

The entire geographic area of a state must be served by exchanges that are:

- Statewide,
- Intrastate, referred to in the proposed rule as “subsidiary” exchanges, covering specific, non-overlapping geographic areas within the state, or
- Interstate, referred to in the proposed rule as “regional” exchanges consisting of two or more states in partnership; states do not need to be contiguous to form a regional exchange.

HHS invites comment on operational and policy concerns regarding the possibility of allowing subsidiary exchanges that cross state lines. This would be a hybrid of regional and subsidiary exchanges designed to serve a population clustered around state borders.

States may form exchanges within or as:

- Existing governmental agencies,
- Independent public agencies, or
- Non-profit organizations.

Additionally states must consider whether to merge or keep separate the individual and small group markets within its exchange(s). This decision must be consistent across all subsidiary exchanges within a state, if applicable. Adding some degree of confusion to the proposed rule are the parallel tracks for the individual market exchange and the small group market exchange, referred to as the Small Business Health Options Program (SHOP). In many instances, the rule encourages consistency between the two markets; governance, discussed below, is an example. SHOP will be made available to small employers defined as those with less than 50 employees that elect to make at least all of its *full-time* employees eligible for coverage.

The ACA requires each exchange to be approved by HHS by January 1, 2013. The rule proposes that the approval process will require each state to submit a plan detailing how the exchange is prepared to operate according to the standards set forth in a final rule. HHS will draft a template outlining the required components of an Exchange Plan. While the earlier date is set by statute, HHS may issue conditional approval to accommodate states making progress in the implementation of their exchange. Exchanges must be operational on January 1, 2014. HHS will operate an exchange in states that do not meet the January 1, 2013 deadline for approval or conditional approval. States wishing to implement an exchange after the deadline must receive approval from HHS at least 12 months prior to the exchange beginning operations.

As states may wish to modify their exchanges in the future, HHS is considering using the State Plan Amendment process in place for Medicaid and the Children's Health Insurance Program (CHIP). This process requires that states notify and receive approval from HHS prior to implementing "significant changes" to an exchange. The term "significant change" has been, at times, problematic in Medicaid and may warrant attention. (See AAFP's comments on Medicaid payment transparency.) In its discussion of the rule, HHS suggests that "significant changes" could be changes to the governance structure of an exchange, changes to state laws or regulations, or to the health plan certification process, among others. The AAFP anticipates HHS to issue further guidance on this matter.

States that wish to cease exchange operations must give HHS 12 months advance notice and states must coordinate with HHS on a transition plan. The proposed rule offers no further details on the transition plan.

Administration and Governance
States may contract out some or all exchange services. These could include eligibility determination, enrollment and marketing, as examples. States may contract with entities including those with experience in the individual or small group markets or state Medicaid agencies. States may not contract with health insurance issuers for exchange functions.

HHS proposes that governing boards for exchanges that are independent state agencies or non-profit organizations must:

- Be administered under a formal, publicly-adopted operating charter or by-laws;
- Hold regular public governing board meetings that are announced in advance;
- Not have a majority of voting members representing health insurers, agents or brokers; and
- Have a majority of voting members with "relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets."

The proposed rule does not require governing boards to include voting membership specifically reserved for patients and primary care physicians. The AAFP's "Family Medicine Principles for State Health Insurance Exchanges" encourages exchange governing boards to require at least one seat for consumers and at least one for primary care physicians, in at least equal proportion to the total number of seats allotted to insurers, specialty medicine, health systems and other stakeholders. HHS does note in its discussion that these standards should be considered the minimum.

The ACA requires exchanges to consult with relevant stakeholders, specifically citing consumers, advocates for "hard to reach populations," experts on enrollment, state Medicaid agencies, and representatives of small business and the self-employed. The proposed rule expands the list of stakeholders with whom an "exchange must regularly consult on an ongoing basis," to include health care providers, public health experts, large employers, health insurers, agents and brokers, and federally-recognized Indian tribes. The rule and its discussion are silent on what constitutes regular, ongoing consultation.

Financing
States will receive assistance from the federal government for the start-up and initial operation of health insurance exchanges. However, federal support will be withdrawn on January 1, 2015, at which point the exchanges must become self-sufficient. States may assess user fees from insurers participating on the exchange or "otherwise generate funding." In its discussion, HHS suggests that other funding may include provider taxes.

Functions: General
Exchanges must certify "qualified health plans" that meet the basic requirements set forth in the essential benefits package and enroll qualified individuals, employers and employees in qualified health plans offered on the individual exchange or SHOP. Beyond this, exchanges must determine eligibility to participate in the exchange, eligibility criteria for advance payment of premium tax credits, and administer an appeals process for individual eligibility determinations. Exchanges also are responsible for processing premium payments, enforcing oversight and financial integrity requirements, providing outreach and education to consumers, and evaluating quality improvement strategies, enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures and data reporting.

HHS anticipates further rulemaking regarding quality reporting.

Functions: Consumer Assistance
Exchanges must provide consumer assistance tools, including a toll-free number and internet web site. The web site should provide standardized comparative information on each available qualified health plan, including premium and cost-sharing information, a benefits summary, enrollee satisfaction survey results, quality ratings, medical loss ratio information, transparency measures (discussed further under qualified health plans), and the plan's provider directory. The web site must also publish exchange financial information and provide applicants with information about "Navigators" (discussed below) and other consumer assistance services. Finally, the web site must allow for an eligibility determination and enrollment.

States also must provide a calculator function to help applicants determine and compare the premiums and cost sharing of qualified health plans while taking into consideration any premium tax credits and cost sharing reductions for which the applicant may be eligible.

The ACA requires states to establish "Navigator" programs to assist consumers with impartial evaluation of and enrollment in qualified health plans offered on the exchanges. Exchanges will award grants to public or private entities to become Navigators. HHS proposes entities eligible to serve as Navigators include community and consumer-focused non-profits, commercial industry organizations, chambers of commerce, unions, licensed agents and brokers, state and local agencies, Indian tribes and tribal organizations, and trade, industry and professional organizations. Entities wishing to become Navigators must meet licensing or certification standards required by the state or the exchange and demonstrate that it has, or can quickly develop, relationships with groups served by exchanges. Insurers are prohibited from becoming Navigators and any entity serving as a Navigator cannot receive grants or other funds from insurers for the duration of that entities service as a Navigator.

Functions: Individual Market Enrollment

HHS will develop a standard, streamlined enrollment application form that exchanges may use for enrollment in qualified health plans, Medicaid, CHIP and Basic Health Plans, if applicable. The single, streamlined form developed by HHS will also help exchanges determine financial assistance requirements such as advance payments of the premium tax credit and cost-sharing reductions. Exchanges also will have the option to develop their own unique single enrollment form, subject to approval by HHS. Exchanges are required to accept the form from applicants, determine eligibility and assist the applicant in the enrolling in the qualified health plan of their choice. The latter requirement includes notifying the issuer of the selected plan and transmitting necessary information on a timely basis. Additionally, exchanges must establish a process for insurers to verify and acknowledge receipt of this information. Applications may be filed through the web site, through a call center, by mail, in person by the applicant, by an authorized representative of the applicant, or by someone acting responsibly on their behalf.

HHS proposes an initial open enrollment period for the individual market exchange beginning on October 1, 2013 and extending through February 28, 2014. Those submitting applications prior to December 22, 2013 will have their coverage begin on January 1, 2014. Coverage will begin for applications received thereafter on either February 1, 2014 or March 1, 2014. HHS proposes that the annual open enrollment period in future years begin on October 15 and run through December 7. HHS further proposes that coverage in the individual market exchange will follow a benefit year structure, beginning with the calendar year on January 1.

HHS further proposes rules to establish special enrollment periods following certain "triggering events" such as:

- Loss of minimum essential coverage;
- Marriage, birth and adoption;
- Gaining status as a citizen, national or lawfully present individual;
- Unintentional, inadvertent or erroneous enrollment or non-enrollment in a qualified health plan;
- Demonstrable material violation by a qualified health plan of a provision of its contract;
- An individual gaining or losing eligibility for advance payment of premium tax credits and/or cost-sharing reductions;
- A permanent relocation; or
- Other exceptional services as a state or exchange may define.

Certain terms, such as "substantially violated a material provision," are undefined.

The rule proposes a 60-day time limit from the date of the triggering event for the special enrollment period. Further, the rule states that loss of coverage does not include loss due to failure to pay premiums or certain rescissions. Finally, the rule proposes that enrollees may switch coverage levels (for example, from a "Silver" level plan to "Gold"), except at such times as the individual may gain or lose eligibility for advance payment of premium tax credits and/or cost-sharing reductions. HHS suggests in its discussion that additional exceptions, using the example of an enrollee becoming pregnant, may be necessary.

HHS also proposes several causes for termination of enrollment, which exchanges are required to track. Enrollees may terminate their coverage at any time "with appropriate notice," however this phrase is not defined. Exchanges also may terminate an enrollee's coverage in a QHP. These include the enrollee no longer being eligible for a QHP through an exchange (for example, qualifying for Medicaid), becoming eligible for other minimum essential coverage (for example, through a large group plan), failing to pay premiums for the QHP, having coverage rescinded, or the changing to a different QHP during an open or special enrollment period. The proposal also includes termination due to the decertification or termination of the QHP.

The agency proposes termination dates for each possible cause. For enrollee-initiated terminations of coverage, a "reasonable time" standard is proposed. If reasonable notice is given, coverage is terminated on the date requested by the enrollee. If a reasonable amount of time is not given by the enrollee, the last day of coverage will be the first day after a reasonable amount of time has passed. HHS does not define or provide guidance on this standard in its discussion.

Exchange- and QHP-initiated terminations of coverage carry different effective dates. For those enrollees moving to a different QHP or to other minimum essential coverage, there will be no gaps in coverage; current coverage will end the day before new coverage begins. For all other causes, coverage will end roughly one month, on either the 14th or final day of the month, following initiation of termination.

Functions: Small Group Market

Many of the exchange functions discussed regarding the individual market are cross-walked to the proposed rules for the small group market exchange, known under the ACA as the Small Business Health Options Program (SHOP). A key difference is the selection of QHPs under SHOP. Whereas individual market exchanges allow consumers to select from the panoply of options, SHOP applies a first filter of employer choice prior to allowing individual employees to select a plan. Employers will define their contribution towards employee premiums at initial enrollment and renewal and then select from several options of coverage.

HHS proposes several options for employers participating in SHOP to offer coverage to their employees. They may:

- Make all QHPs at a coverage level available (all "Silver" plans, for example),
- Allow employees to choose any QHP at any level,
- Select specific levels from which employees may choose (only "Bronze" and "Silver" level plans, for example),
- Select specific QHPs from different levels (QHP A1 from the "Platinum," QHP B2 from "Gold," etc.), or
- Select a single QHP to make available to all employees.

Further, in exchanges that merge the SHOP and individual markets into a single risk pool, employers may select any QHP. In separate SHOP and individual markets, however, only those QHPs participating in SHOP may be chosen.

HHS notes that providing this level of flexibility raises the possibility of risk selection and questions whether minimum participation rate standards should be established for SHOP. Such standards possibly could apply at the insurer or QHP level. However, HHS welcomes comment on whether doing so is desirable in the first place and, if so, how to calculate the minimum participation rate, what such a rate should be and whether it should be established in future regulations.

The rule proposes that a SHOP assist employers by providing a single monthly bill listing all premiums owed. These bills may include both the employer and employee amounts owed. The SHOP is permitted through the rule to collect all premiums owed and distribute the appropriate payment amounts to each insurer.

Unlike the individual market exchanges, whose QHPs will offer coverage on a benefit year standard beginning on January 1, SHOPs will offer small businesses rolling enrollment in QHPs operating on a 12-month plan year standard. Plan years may begin on any day. The proposal requires SHOPs to establish a uniform time at which they may alter rates for QHPs; these times may be monthly, quarterly or annually. An insurer may not change an employer's rate(s) during its plan year, however.

Small employers, defined as those with 100 or fewer employees, may participate in the SHOP, irrespective of the work site of the employee. States retain the option of limiting participation to employers with 50 or fewer employees for plan years beginning prior to January 1, 2016. Employers wishing to participate in a SHOP must offer QHP coverage to at least all full time employees. As with the individual market, HHS will develop single, streamlined application forms for qualified employers and employees; likewise, an exchange may develop its own forms, pending approval by HHS.

HHS proposes several rules additional rules regarding employees, such as allowing new employees to enroll in a QHP through the SHOP, that non-lawfully present individuals are not eligible for SHOP coverage after they achieve legal status, and that small employers will be held harmless if they grow beyond the 50 or 100 employee maximum.

If an employer chooses to cease participating in a SHOP, the SHOP bears responsibility for ensuring that QHP coverage is terminated for each participating employee. A SHOP further bears responsibility for notifying each employee that their coverage will be ending. HHS is considering whether this notification should include information for the employee of his/her eligibility for a special enrollment period in the individual market exchange, as well as their possibly qualifying for advance payment of premium tax credits, cost-sharing reductions or eligibility for Medicaid, CHIP or a Basic Health Plan.

Consumer Interest Determinations

HHS proposes to provide exchanges with discretion on how to determine whether offering health plans is in the interest of individuals and employers. At its root, this is one of the core questions states must address in establishing an exchange. HHS proposes that states/exchanges may:

- Choose to utilize an "any qualified plan" strategy for certifying QHPs, wherein an exchange would certify all health plans as QHPs solely on the basis that such plans meet and agree to comply with the minimum certification requirements.
- Undertake an "active purchaser" strategy of competitive bidding or selective contracting processes, and limit QHP participation to only those plans that ranked highest in terms of certain exchange criteria.
- Choose to negotiate with health insurance issuers on a case-by-case basis. Under this strategy, the exchange would request a health insurance issuer, upon meeting the minimum certification standards, to amend one or more specific health plan offerings to further the interest of qualified individuals and qualified employers served by the exchange.

HHS suggests in its discussion that the "interest" determination may vary based upon a number of factors, including the size and risk profile of the exchange's potential enrollees, concentration of the health insurance market in the area served by the exchange, and the applicable state insurance rules.

The ACA places three statutory prohibitions on exchange conduct, though, related to "interest" determinations. Exchanges may not exclude QHPs on the basis that:

- The plan is a fee-for-service plan;
- The plan imposes premium price controls; or
- The health plan provides treatments necessary to prevent patients' deaths in circumstances the exchange determines are inappropriate or too costly.

Certification of Qualified Health Plans

Exchanges bear responsibility for certification of insurance products as "qualified health plans." Maintaining its goal of providing a minimum level of nationwide consistency, while allowing flexibility for states and exchanges to respond to local market conditions, HHS proposes general processes for the certification, recertification and decertification of QHPs. The rule proposes that QHPs pass through two filters for certification:

1) The QHP demonstrates compliance with minimum certification requirements (discussed below).
2) The exchange determines that the making the QHP available is in the interest of consumers (discussed above).

Minimum certification requirements are broken down into several categories, including QHP issuer participation standards, rate and benefit information, transparency, marketing, network adequacy and essential community provider participation, treatment of "direct primary care medical homes," service area and adherence to enrollment and termination guidelines.

While they are not included in the minimum requirements, HHS notes that the proposal sets a floor and suggests, but does not limit, other measures an exchange may consider, including: reasonableness of the estimated costs supporting the calculation of the health plan's premium and cost-sharing levels; past performance of the health insurance issuer; quality improvement activities; enhancements of provider networks including the availability of network providers to new patients; and premium rate increases from years preceding the Exchange operation and proposed rate increases.

QHP Issuer Participation Standards
HHS proposes several QHP issuer participation standards, including issuer requirements, offering requirements and state requirements. Issue requirements include ongoing demonstration of compliance with exchange processes and procedures, compliance with benefit design standards, licensed and in good standing with the state, paying applicable user fees, complying with the exchange's risk adjustment program and implementing and reporting on enrollee satisfaction, as well as quality improvement strategy or strategies. HHS will address quality improvement in a forthcoming rule.

Offering requirements are defined by the ACA. These include offering at least one silver level and one gold level QHP, a child-only plan offered at the same level of each QHP offered, and consistent premium rates (discussed below). The state requirements dictate that issuers participating in the state must adhere to the laws and regulations of the state and exchange.

Rate and Benefit Information
HHS proposes to align QHP rate and benefit information certification with existing and developing state premium rate review programs. QHPs must set rates for the entire benefit or plan year, whichever is applicable, and submit rates to the exchange for review. Rate changes must be accompanied by a justification to the exchange and be "prominently posted" on the issuer's web site ("prominently posted" is undefined). HHS proposes to allow certain rating variations, though. These include geographic rating areas and family size; the ACA provided two additional categories: age and tobacco use. HHS proposes that QHPs must offer coverage using some combination of four rating categories: individuals, two-adult families, one-adult families with one or more children, and all other families. Additionally, HHS is considering whether to require QHPs to cover an enrollee's tax household. They believe this standard would ease administration of the premium tax credit program, particularly for families filing with non-spousal adult dependents.

Transparency
The rule proposes that QHP issuers must provide coverage transparency information to the exchange, HHS, the state insurance commissioner and the public. The notices must be written in plain language and disclose, at a minimum, claims payment policies and practices, periodic financial disclosures, enrollment and disenrollment data, claims denial data, rating practice data, information on out-of-network payments and cost-sharing, and information on enrollee rights. HHS also proposes that a QHP must make information available via a web site regarding an enrollee's cost sharing for specific items and services provided by a participating provider.

Network Adequacy
HHS's proposal leaves determination of network adequacy, in large part, to the states or exchanges. QHPs must include essential community providers, abide by network adequacy standards established by the exchange and make their provider directory available online to applicants and enrollees. The rule proposes that a QHP include a "sufficient number" of essential community providers in its network. HHS considered requiring QHPs to offer contracts to all essential community providers, but opted not to do so in the proposed rule. HHS fears that such a requirement may inhibit attempts to use network design to incentivize higher quality, cost effective care by tiering networks and driving volume towards providers that meet certain quality and value goals. HHS is considering creating an exemption for integrated delivery network health plans wishing to participate as QHPs, as these would not necessarily contract with essential community providers.

HHS also is considering adding additional requirements for QHPs to demonstrate adequacy of provider networks. These requirements, based upon the National Association of Insurance Commissioners' "Managed Care Plan Network Adequacy Model Act," include:

- Sufficient numbers and types of providers to assure that services are accessible without unreasonable delay;
- Arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients;
- An ongoing monitoring process to ensure sufficiency of the network for enrollees; and

- A process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.

HHS, in its discussion of network adequacy, notes recognition of the ACA's focus on primary care, as well as the challenge of the primary care physician workforce crisis. However, HHS's encouragement of states, exchanges and insurers to, "consider broadly defining the types of providers that furnish primary care services (e.g., nurse practitioners)," is a potential scope of practice concern to the AAFP and primary care medicine.

Direct Primary Care Medical Homes
The ACA permits QHPs to offer coverage through a "qualified direct primary care medical home plan." HHS provides little guidance on this provision in the proposed regulative, save that the QHP meets all requirements that are otherwise applicable and the services covered are coordinated with the QHP issuer. HHS, in its discussion, notes that it interprets the phrase "direct primary care medical home" to mean an arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services. HHS notes it based its interpretation on a model operating in Washington state. HHS generally considers primary care services to be routine health services, including screening, assessment, diagnosis and treatment for the promotion of health, and detection and management of disease or injury. HHS considered, but declined, to allow through the proposal that individuals could purchase a direct primary care medical home plan and separately acquire wrap-around coverage. This course was rejected as administratively burdensome and that it would require exchanges to accredit or certify providers as direct care primary care medical homes. HHS specifically requests comment on what standards HHS should establish under this section of the rule.

Adherence to Enrollment and Termination Guidelines
HHS proposes that QHP issuers must enroll qualified individuals in QHPs offered on the exchanges during the initial and annual open enrollment periods, as well as during special enrollment periods, using enrollment information provided by the exchange in an electronic format. QHPs must adhere to the enrollment and termination of enrollment rules discussed above. While QHPs may terminate coverage for non-payment of premiums, enrollees will receive a grace period of three months. HHS proposes that, during the grace period, the QHP is required to pay all appropriate claims submitted on behalf of the enrollee.

Service Areas
HHS proposes that exchanges determine a process to establish or evaluate the service areas of QHP's. The agency believes this would help exchanges determine service areas for plans to cover, permit plans to propose coverage of certain service areas, or negotiate with issuers over service areas during the certification process. Specifically, HHS proposes that an exchange must ensure that the service area of a QHP covers at least a county, or a group of counties if the exchange designates such a group, unless the QHP issuer demonstrates that serving a partial county is necessary, nondiscriminatory, and in the interest of qualified individuals and employers. Additionally, the exchange must ensure that QHP service areas be established without regard to racial, ethnic, language and health status factors to guard against redlining and other practices that would specifically exclude high-utilizing or high-cost populations.

Non-Renewal and Decertification of QHPs
HHS proposes that QHP issuers that wish to discontinue a QHP in the exchange must notify the exchange prior to the beginning of the QHP's recertification process. Additionally, the QHP must fulfill its obligation to cover benefits for each enrollee through the end of the benefit or plan, whichever is applicable; fulfill data reporting obligations from the last plan or benefit year; provide written notice to enrollees; and, follow the exchanges coverage termination guidelines. HHS proposes that if a QHP is decertified by the exchange, it may not terminate coverage until enrollees have been notified and received an opportunity to enroll in other coverage. The proposed rule is silent on the issuance of notifications of non-renewal or decertification to participating providers.

Accreditation of Insurers (QHP Issuers)
Exchanges are required to accredit insurers wishing to offer qualified health plans. QHP issuers must be accredited based upon local performance of its QHPs by an entity recognized by HHS. HHS does not suggest

any specific entities and seeks comment on the standards by which HHS should recognize accrediting bodies; the agency hints it may use the process employed by HHS for Medicare Advantage plans as a model. The ACA lists nine criteria that must be used in the accreditation process:

- Clinical quality measures, such as the Healthcare Effectiveness Data and Information
- Set;
- Patient experience ratings on a standardized CAHPS survey;
- Consumer access;
- Utilization management;
- Quality assurance;
- Provider credentialing;
- Complaints and appeals;
- Network adequacy and access; and
- Patient information programs.

Prescription Drug Cost Reporting

HHS proposes to codify the ACA's requirement that QHPs provide information to HHS on the distribution of prescription drugs, pharmacy benefit management activities, the collection of rebates and other funds in conducting these activities, and costs incurred to provide the drugs. Specifically, the agency proposes that the QHP issuer must provide the following information:

- The percentage of all prescriptions that were provided under the contract through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, that is paid by the QHP issuer or pharmacy benefit manager (PBM) under the contract;
- The aggregate amount, and the type of rebates, discounts, or price concessions, with certain exceptions, that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed; and
- The aggregate amount of the difference between the amount the QHP issuer pays the PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

Unanswered Questions

What may be most surprising about the proposed rule is how unsurprising much of it is. The proposal, overall, provides states and exchanges with wide latitude to form, operate and respond to changing local market conditions.

Utah, however, may face one hurdle placed by the proposal: existing exchanges must have to be in operation prior to Jan. 1, 2010 and must insure an equal or greater percentage of its population than projected to be covered under ACA in 2016. HHS estimates nationwide coverage at 93.6%, while the Congressional Budget Office estimates nationwide coverage at 95%. Currently, less than 1% of Utah's population receives coverage through their exchange, operating close to the "any willing plan" model. In 2010, the Utah Department of Health estimated that 10.6% of the population was uninsured.

Most pertinent to family physicians, though, may be that the proposal aims to level the playing field between consumers and insurers. The proposal is silent, though, on leveling the playing field between physicians and insurers. Further, HHS' encouragement of states, exchanges and insurers to use nurse practitioners as primary care providers in lieu of physicians could put family physicians at a disadvantage when negotiating or renegotiating contracts with insurers, particularly in light of the proposed network adequacy standards.

Further Information
For additional background information, please review AAFP's

- Family Medicine Principles for State Health Insurance Exchanges
- Background Information: State Health Insurance Exchanges
- Health Insurance Exchanges: Variation in State Efforts

Materials on exchanges prepared by other organizations include:

- States Should Structure Insurance Exchanges to Minimize Adverse Selection, Center on Budget and Policy Priorities
- Multi-state Health Insurance Exchanges, Urban Institute
- State Implementation of National Health Reform: Harnessing Federal Resources to Meet State Policy Goals, Academy Health
- Health Reform Across the States: Increased Insurance Coverage and Federal Spending on the Exchanges and Medicaid, Robert Wood Johnson Foundation
- Explaining Health Care Reform: What Are Health Insurance Exchanges?, Kaiser Family Foundation
- Health Insurance Exchanges: Implementation and Data Considerations for States and Existing Models for Comparison, Robert Wood Johnson Foundation
- Health Insurance Exchanges: Key Issues for State Implementation, Academy Health
- The Massachusetts and Utah Health Insurance Exchanges: Lessons Learned, Georgetown University Health Policy Institute
- Health Insurance Exchanges – How Economic and Financial Modeling Can Support State Implementation, SHADAC
- A Guide To Health Insurance Exchanges, *Kaiser Health News*
- Health Insurance Exchanges, HHS.gov

News articles outlining state exchanges and proposed regulations:

- "After Much Scrutiny, HHS Releases Health Insurance Exchange Rules" *Kaiser Health News*
- "Obama Administration Rolls Out Standards for Health Insurance Marketplaces" *New York Times*
- "'Flexibility' may help states meet key part of health-care law" *Washington Post*
- "States grapple with health insurance exchanges" *Washington Post*
- "States slow to adopt health-care transition" *Washington Post*