General Guidance on Federally-facilitated Exchanges

Center for Consumer Information and Insurance Oversight

Centers for Medicare & Medicaid Services

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Contents

General Guidance on Federally-facilitated Exchanges

This document outlines the Department of Health and Human Services' (HHS) approach to implementing a Federally-facilitated Exchange (FFE) in any State where a State-based Exchange is not operating. In addition to describing our high-level operational approach, we discuss:

1. How States can partner with HHS to implement selected functions in an FFE,
2. Key policies organized by Exchange function, and
3. How HHS will consult with a variety of stakeholders to implement an FFE.

Subsequent guidance documents will include additional policy and operational details intended to inform State decision-making and preparation for Exchange participation, roles and responsibilities, and potential areas of collaboration.

I. Background

The Affordable Care Act (P.L. 111-148 and 111-152) allows each State the opportunity to establish an Affordable Insurance Exchange ("Exchange") to help individuals and small employers purchase affordable health insurance coverage. Exchanges will allow individuals and eligible employers to compare and select from qualified health plans (QHPs) for their families and their employees that meet benefit design, consumer protection, and other standards. Exchanges will increase access to coverage by providing a single point of access for individual consumers to receive eligibility determinations for enrollment in the Exchange and for insurance affordability programs, and select a QHP that best meets their needs. By permitting consumers and employers to easily compare health plans, Exchanges will increase competition among issuers and improve the affordability of coverage. Exchanges are integral to the Affordable Care Act's goals of prohibiting discrimination against people with pre-existing conditions and insuring all Americans.

Coverage through the Exchange will begin in every State on January 1, 2014, with enrollment beginning October 1, 2013. Recognizing that not all States may elect to establish a State-based Exchange by this statutory deadline, the Affordable Care Act directs the Secretary of HHS to establish and operate an FFE in any State that does not elect to do so, or will not have an operable Exchange for the 2014 coverage year, as determined by January 1, 2013. As discussed in the Exchange final rule[1] and described more fully in this guidance, States will have the option to enter into a Partnership with an FFE. Under a State Partnership model, a State may administer plan management functions, in-person consumer assistance functions, or both. In non-Partnership FFE States, FFEs will perform these functions.

[1] The final rule was published at 77 Fed. Reg. 18310 (March 27, 2012) (to be codified at 45 C.F.R. parts 155, 156 and 157).

To the greatest extent possible, HHS intends to work with States to preserve the traditional responsibilities of State insurance departments when establishing an FFE. Additionally, HHS will seek to harmonize FFE policies with existing State programs and laws wherever possible.

In States where an FFE operates without a State Partnership, HHS will carry out all Exchange functions, including consulting with stakeholders and participating in formal consultation with Indian tribes; certifying, recertifying, and decertifying QHPs; determining individuals' eligibility for enrollment in a QHP through the Exchange and for insurance affordability programs; and supporting consumers, issuers, and other stakeholders through technical assistance and enrollment facilitation resources. HHS will administer these functions consistent with the Exchange final rule, which established minimum Federal standards for major Exchange business areas while leaving much flexibility and discretion to Exchanges to design processes and procedures that reflect local market dynamics.

This guidance describes the general approach regarding how HHS will interpret and implement this regulatory flexibility in operating an FFE. We focus on issues related to plan management, eligibility and enrollment of individuals, and key features of the Federally-facilitated Small Business Health Options Program (FF-SHOP). We are committed to seeking ongoing input on FFE policy and operations from interested stakeholders, including States, issuers, and consumers.

HHS has articulated four "guiding principles" for FFEs, based on comments received on the Exchange establishment and eligibility proposed rules and other input from stakeholders:

1) *Commitment to consumers:* Our goal is to ensure that consumers in all 50 States and the District of Columbia have access to high-quality, affordable health coverage options through a State-based Exchange, Partnership Exchange, or FFE. We will continuously seek to improve policies and processes in each Exchange in pursuit of a positive and seamless consumer experience.

2) *Market parity:* HHS will work to harmonize market requirements inside and outside of an FFE to promote the competitiveness of each FFE, minimize administrative burden for issuers, and ensure consumer protections.

3) *Leveraging the traditional State role:* HHS recognizes the significant experience and the traditional role of States in many core areas of FFE operations. We will seek to capitalize on existing State policies, capabilities, and infrastructure that can also assist in implementing some of the components of an FFE.

4) *Engagement with States and other stakeholders:* HHS will seek input from a variety of stakeholders to support and inform decision-making. We will communicate our progress regularly so that affected parties understand how each FFE is developing and have adequate time to prepare for successful participation.

II. State Partnership in a Federally-facilitated Exchange

As outlined in the preamble to the Exchange final rule, States will have the option to enter into a Partnership with an FFE to support administration and operation of selected functions. Specifically, a State Partner may assume primary responsibility for the plan management function, in-person consumer assistance functions (including oversight and management of Exchange Navigators), or both. These options are separate and distinct from the options available to States for conducting eligibility determinations as outlined in 45 CFR 155.302 and discussed in greater detail in the eligibility and enrollment portion of this guidance document.

To ensure operational efficiency, the State Partner in plan management will conduct all plan management activities. This includes conducting all analyses and reviews necessary to support QHP certification. In addition, the State Partner will collect and transmit necessary data to HHS in a specific format, and manage certified QHPs.

In a State Partnership in consumer assistance, the State Partner will administer, oversee, and support in-person application assistance and other in-person assistance to consumers, including a Navigator Program, to assist consumers in understanding, comparing, and enrolling in coverage, among other functions. Other in-person assistance may include supporting consumers in filing an application, obtaining an eligibility determination or reporting a change in status, comparing coverage options, and selecting and enrolling in a QHP. We note that HHS will be responsible for certain centralized functions, such as management of the Web site and consumer hotline, in States where a consumer assistance Partnership is operating.

The following chart provides additional detail on the specific functions that fall under the plan management and consumer assistance Partnership options.

Chart 1: Summary of State Partner Functions in Plan Management, Consumer Assistance

Partnership Model	Overview of State Functions
Plan Management	• Develop and implement processes and standards for QHP certification, recertification, and decertification within FFE parameters • Conduct QHP certification review including: o Licensure and good standing o Service area o Network adequacy o Essential community providers o Marketing oversight o Accreditation, on the timeline to be established in future rulemaking o Essential health benefits standards o Actuarial value standards, including variations for cost-sharing reductions, as well as cost-sharing limits o Discriminatory benefit design o Benefits for meaningful difference o Rates (new and increases), including compliance with market rating reforms • Perform QHP issuer account management • Perform QHP oversight and monitoring, including marketing • Collect necessary data from issuers • Verify accreditation status and data if any accreditation data will be displayed on the Internet portal • Collect and display quality data (in future rulemaking) • Coordinate with HHS on quality rating and enrollee satisfaction survey (in future rulemaking)
Consumer Assistance	• Support, administer, and oversee Navigator program • Provide other in-person assistance to help consumers, including: o Filing an application o Receiving an eligibility determination o Reporting changes during the coverage year o Renewing coverage o Comparing and selecting a coverage option o Enrolling in a QHP

States can choose to be responsible for the day-to-day management of the plan management and/or consumer assistance functions under these Partnership options; however, HHS, by law, retains authority over each FFE. Specifically, as HHS is responsible for Exchange implementation, we will approve State Partners to perform plan management or consumer assistance functions, and retain authority over inherently governmental functions (certification of specific QHPs, selection of Navigators, etc.) carried out by the State Partner on an ongoing basis. HHS will enter into agreements with State Partners to establish and memorialize roles and

responsibilities, and outline specific workflows, deliverables, review standards, and timeframes. State Partners may elect to use the Federal plan management system to carry out plan management activities.

A State electing a State Partnership must designate the appropriate agency that has the authority and capacity to carry out the relevant functions. We encourage States considering a State Partnership to engage in technical assistance and consultation with HHS as soon as possible to ensure the successful operations of the Partnership. States may use grant funding available under section 1311 of the Affordable Care Act for the development, refinement, and testing of functions under a State Partnership model.

Consistent with the flexibility for States choosing to operate a State-based Exchange (including conditional approval and extensions of grant funding availability), HHS designed these Partnership options particularly to leverage traditional State roles, as well as help States that want to transition to a State-based Exchange. We strongly encourage States that are not considering a State-based Exchange to consider the Partnership options. The State Partnership model enables States and HHS to work together to operate an Exchange in an effective and seamless way for QHP issuers, consumers, small businesses, and others.[2]

III. Approach to Key Exchange Functions in a Federally-facilitated Exchange

The remainder of this guidance describes how an FFE will implement major business functions where there is no State Partnership.

The policy objectives of the FFE include, but are not limited to, offering a positive consumer experience, creating an attractive and viable market for issuers, working quickly and effectively with States, and reducing administrative and operational burdens on all Exchange participants. As HHS pursues these objectives, we are mindful of our ultimate responsibility to construct a functional, operationally sound Exchange that provides excellent service to customers. HHS also has a responsibility to develop safeguards and processes to protect and oversee public dollars spent for advance payments of the premium tax credit (APTC) and cost-sharing reductions (CSR).

HHS is developing a unified FFE administrative infrastructure supporting all FFEs that can address a wide range of State needs. As described at the end of this document, HHS will look to States, consumers, issuers, health care providers, employers, and other local stakeholders to provide input on the development of an FFE in each State where an FFE operates.

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[2] In light of public comments received on the final Medicaid and Exchange eligibility regulations, we intend to propose a regulation for further comment to consider amending the final rules regarding Medicaid eligibility determinations made by Exchanges. In particular we will seek further comment regarding ways States can ensure a coordinated system when engaging non-profits and private contractors in the process of making Medicaid eligibility evaluations, while having government agencies make eligibility determinations. We believe this potential change is consistent with current State practices and plans and will seek input in the rule making process.

Plan Management in a Federally-facilitated Exchange

The plan management function includes all aspects of QHP certification, monitoring, oversight, and management. This guidance focuses primarily on the QHP certification process.[3]

QHP Certification Process

An FFE's role and authority are limited to the certification and management of participating QHPs, and do not extend beyond the Exchange or affect otherwise applicable State law governing which health insurance products may be sold in the individual and small group markets. Several QHP certification standards rely on reviews that State departments of insurance (DOI) do not currently conduct. Therefore, HHS will evaluate each potential QHP against all applicable certification standards, either by confirming the outcome of a State's review (as in the case of licensure) or by performing the review. FFEs will consider completed State work to support this evaluation where possible.

To ensure a robust QHP market in each State where an FFE operates, and to promote consumer choice among QHPs, at least in the first year HHS intends to certify as a QHP any health plan that meets all certification standards. In future years, HHS will analyze the QHP certification process and may identify improvements or changes to this process.

Chart 2: High-level Overview of QHP Certification Process

QHP Certification Process	
Issuer-level Review (Vehicle: QHP Issuer Application)	
QHP Certification Standard	*High-level Summary of FFE Activity*
Licensure and good standing	Confirm State licensure and compliance with State solvency and other related requirements.
Network adequacy	In States meeting minimum Federal standards, verify State review. Otherwise, review network adequacy data submitted in QHP Issuer Application.
Essential community providers (ECPs)	Collect information on inclusion of ECPs in provider networks and review for sufficiency.
Accreditation	Confirm accreditation status, depending on certification year (as described in future rulemaking).

[3] We note that, for references throughout this section to "health plans," "qualified health plans," health insurance issuers" and "qualified health plan issuers," the definitions of these respective terms established in the Exchange final rule apply. 77 Fed. Reg., at 18445 (to be codified at 45 CFR 155.20). We recognize that States frequently collect health plan information at the "product" level, and we intend to include a definition of product in forthcoming guidance to ensure clear communications between the FFE and State DOIs on this topic.

Program attestations	Ensure submission of required attestations (for example, attestation of compliance with marketing standards).
Plan-level Review (Vehicle: Rate and Benefit Data Submission) (Note: States continue to perform their traditional regulatory role)	
QHP Certification Standard	*High-level Summary of FFE Activity*
Essential health benefits	Confirm coverage of essential health benefits.
Actuarial value standards, including variations for cost-sharing reductions	Confirm actuarial value levels of potential QHPs, including compliance with standards related to cost-sharing reductions, cost-sharing limits, and variations to cost-sharing structures.
Discriminatory benefit design	Conduct plan-level analysis (such as outlier analysis) targeting areas where discrimination would most likely occur.
Meaningful difference	Conduct review for meaningful difference across QHPs offered by the same issuer to ensure that a manageable number of distinct plan options are offered.
Service area	Confirm that service area is at least one county or that smaller service area is necessary, nondiscriminatory, and in the interest of consumers.
Rates (new and increases)	Review new rates and rate increase justifications for reasonableness, including confirmation of compliance with market rating reforms.

States will continue to perform their traditional regulatory role for issuers and health plans, and an issuer that wishes to offer QHPs through an FFE must meet both applicable State laws and requirements and QHP certification standards. Recognizing this, each FFE intends to complete all reviews and analyses in advance of the final QHP certification deadline to allow issuers to file with their respective State DOIs and seek any additional necessary approvals.

HHS intends to release the QHP Issuer Application in early 2013 through an electronic plan management system. HHS will also make the application available to the general public. The application will outline the data and other documents that we believe are necessary to illustrate compliance with QHP certification standards. In 2012, HHS will release for public comment a model application that includes relevant issuer, rate, and benefit data standards to help issuers prepare for the submission process. HHS also intends to release a rate and benefit data submission module shortly after the release of the QHP Issuer Application and will begin a plan-level review in early spring 2013. We anticipate that FFEs will complete agreements with issuers of certified QHPs in late summer 2013, as described in the next section. Open enrollment for the 2014 coverage year will begin on October 1, 2013.

As indicated in the final rule on Reinsurance, Risk Corridors, and Risk Adjustment,[4] HHS will release both a draft and final notice of benefit and payment parameters with additional detail on key parameters for finalizing issuers' data submissions, including user fee, risk adjustment, risk corridor, and reinsurance methodologies.

Other Plan Management Functions

An FFE will also perform activities in addition to QHP certification, including QHP issuer account management, QHP oversight, and recertification. HHS plans to provide technical assistance and support to issuers on an ongoing basis following QHP certification through designated account managers. The Account Manager will serve as the issuer's point of contact, coordinate technical assistance and communication across business areas, and assist issuers in navigating FFE and State requirements. HHS expects States (even those not participating in the plan management Partnership model) to play a primary role in areas of traditional State responsibility, with an FFE assuming a primary role in oversight in areas that fall outside the scope of States' regulatory authority; are Exchange-specific; or where Federal funds are involved. An FFE will coordinate its oversight and management activities with State regulators to streamline processes and reduce duplication of effort to the extent possible. In addition to ensuring ongoing compliance with QHP certification requirements, an FFE will also recertify QHPs periodically in future years. Other plan management functions that an FFE will perform include:

- Reconsiderations of FFE certification decisions: Each FFE will provide a process for issuers to request reconsiderations of QHP certification decisions.

- QHP agreements: HHS will enter into agreements with QHP issuers to memorialize certification and procedural requirements. This process will take place after the end of the QHP certification process.

- Plan data display on the FFE Web site: Each FFE will allow issuers to view and validate plan data before public display on the FFE Web site.

- Recertification and the annual process for plan review: An FFE will establish a process for recertification. At a minimum, each FFE will annually ensure compliance with issuer licensure, solvency, accreditation data, review network adequacy and plan-level rate and benefit data, and consider changes to service areas and changes in ownership, mergers, or acquisitions.

- Decertification: Each FFE will establish a process for decertification of QHPs that fall out of compliance with QHP certification standards.

[4] Published at 77 Fed. Reg. 17220 (March 23, 2012).

- User fees: HHS will support the ongoing operations of FFEs by developing and implementing a system to calculate and collect user fees from participating issuers. HHS will include detailed information about FFE user fees in the draft notice of payment and benefit parameters that we plan to release this fall.

Accreditation and Quality Reporting

The Affordable Care Act includes several provisions to improve the quality of care delivered by QHPs and increase the availability of quality data that can inform plan selection. Specifically, the Affordable Care Act requires QHP issuers to implement quality improvement strategies, enhance patient safety through certain contracting requirements, and publicly report quality data. In addition, the Affordable Care Act directs the Secretary to develop and administer a rating system and an enrollee satisfaction survey system, the results of which will be available to consumers. HHS intends to issue future rulemaking on quality reporting and disclosure requirements.

QHP issuers participating in an FFE will be required to be accredited by an accrediting entity and comply with quality reporting requirements that HHS will specify in future rulemaking. HHS intends to propose a phased approach to accreditation and quality data reporting and display in an FFE to accommodate new QHP issuers and Medicaid plans without Exchange or accreditation experience.

HHS also intends to propose a phased process for recognizing accrediting entities. In phase one, the entities that HHS believes will be equipped to provide the statutorily required accreditation review by 2013 certification – the National Committee for Quality Assurance (NCQA) and URAC – would be recognized as accrediting entities on an interim basis subject to conditions. In phase two, we would adopt an application and review process for the recognition of additional accrediting entities.

We intend to propose that an FFE will accept existing health plan accreditation from NCQA and URAC on issuers' commercial or Medicaid lines of business in the same state in which the issuer is seeking to offer Exchange coverage until the fourth year of certification (for example, 2016 certification for the 2017 coverage year). HHS intends to propose that QHP issuers without this existing accreditation must schedule this accreditation in their first year of certification and be accredited on QHP policies and procedures by the second year of certification. By the fourth year of certification, all QHP issuers must be accredited on the QHP product type having fulfilled the requirements to submit performance data to the accrediting entity.

Similarly, HHS intends to propose a phased approach to new quality reporting and display requirements for all Exchanges and expects that State-based Exchanges may adopt a similar approach prior to final regulatory standards. For example, HHS intends to propose that reporting requirements related to all QHP issuers will start in 2016. HHS intends to support the calculation of the QHP-specific quality rating for all QHP issuers in all Exchanges. The QHP-specific

quality rating would be available for display in 2016 open enrollment for the 2017 coverage year. In the interim, an FFE will display existing Consumer Assessments of Healthcare Providers and Systems (CAHPS) results from accredited commercial and/or Medicaid product lines when these existing CAHPS data are available for the same QHP product types and adult/child populations (for example, HMO Adult CAHPS results for HMO QHPs, Child CAHPS results for child-only QHPs). FFEs will not display other data drawn from the accreditation data, such as clinical measures results.

HHS intends to engage in rulemaking for quality reporting and disclosure requirements for all Exchanges. HHS also intends to solicit stakeholder input on the most effective ways to align the quality reporting and display requirements for QHPs in 2016 and beyond with related quality measurement initiatives across HHS (for example, the National Quality Strategy, section 2717 of the Affordable Care Act, and quality reporting requirements under Medicare and Medicaid).

Eligibility for Insurance Affordability Programs and Enrollment in the Individual Market

Each FFE will determine individuals' eligibility for enrollment in a QHP and for APTC and CSR; assess or determine eligibility for Medicaid and the Children's Health Insurance Program (CHIP); and assist eligible individuals in comparing, selecting, and enrolling in a QHP. The Exchange final rule and the Medicaid and CHIP final rule[5] lay out a streamlined process for determining eligibility for enrollment in a QHP through the Exchange, APTC, CSR, Medicaid, and CHIP. Achieving this vision requires a high level of coordination across programs in information technology, program management, and business operations. In the FFE context, HHS is developing a dynamic Web-based system to support eligibility determinations for all insurance affordability programs, and an eligibility workforce to handle exceptions and manual processing of applications. We will continue to work with States to ensure coordination with State eligibility processes.

Determining Eligibility

Together, the creation of Exchanges, along with insurance reforms, APTC, CSR, and the changes to Medicaid eligibility established in the Affordable Care Act, will expand access to health benefits to millions of consumers. To offer a seamless consumer experience, each FFE must allow consumers to receive eligibility determinations for multiple programs using a single, streamlined application, regardless of where consumers submit their applications. HHS is creating a model electronic application for potential use by all States, including States where an FFE operates. In addition to the Web- and paper-based eligibility applications, HHS will create model notices consistent with those established in the Exchange and Medicaid final rules. The application and notices will be written in plain language and will be tested to ensure that consumers understand the content and requirements. FFEs will also provide information to

[5] Published at 77 Fed. Reg. 17144 (Mar. 23, 2012).

consumers in a manner that is accessible to people with disabilities and those with limited English proficiency.

A well-coordinated eligibility process is essential to the consumer experience and we believe that it can be accomplished through the eligibility determination process outlined below. Consistent with 45 CFR 155.302, there will be two approaches for determining applicants' eligibility for Medicaid and CHIP based on MAGI for applications submitted to an FFE:

(1) The FFE will determine Medicaid and CHIP eligibility based on MAGI and electronically transmit the determination and all information for any eligible applicants to the State Medicaid and CHIP agency. The Medicaid and CHIP agency will accept the FFE's determination and provide for enrollment in Medicaid or CHIP coverage.

(2) The FFE will conduct assessments of Medicaid and CHIP eligibility based on MAGI as part of the determination of eligibility for APTC and CSR. The FFE will electronically transmit all information for any potentially eligible applicants to the State Medicaid and CHIP agency, which will make final determinations and notify the Exchange if the State Medicaid or CHIP agency finds that the applicant is ineligible.

Under either option, an FFE will assess or determine Medicaid and CHIP eligibility based on the State's applicable Medicaid and CHIP MAGI-based income standards, citizenship and immigration status, other eligibility requirements, and standard verification rules and procedures consistent with 42 CFR parts 435 and 457. HHS will release more detailed information about the eligibility determination process in future guidance.[6]

Key Areas of Engagement: Information Technology

In the following areas, coordination across an FFE, Medicaid, and CHIP is particularly important. HHS is working with State Medicaid and CHIP agencies in these and other areas to reduce administrative burden and further streamline the process for consumers.

- Verification of an existing eligibility determination for Medicaid or CHIP: In order to determine eligibility for APTC and CSR, and to ensure that an FFE is able to direct individuals to the appropriate program, each FFE will connect with the State Medicaid and CHIP agencies to verify whether an individual has already been determined eligible for Medicaid or CHIP.

- Verification of income: Each FFE will use data from certain State-based data sources used by State Medicaid and CHIP agencies to support assessments or determinations of eligibility for

[6] As specified in the Medicaid and CHIP final rules, State Medicaid and CHIP agencies will accept applications and make Medicaid and CHIP eligibility determinations. The FFE will also make Medicaid and CHIP eligibility assessments and/or determinations for individuals who apply directly to the FFE. Within this context, the Federal government will not charge States for eligibility assessments or determinations for Medicaid and CHIP based on applications submitted to the FFE.

Medicaid and CHIP and to support eligibility determinations for APTC and CSR. These data sources include the State Wage Information Collection Agency (SWICA) and the State unemployment benefits agency.

- Electronic transmission and receipt of application information for eligible/potentially eligible individuals: An FFE will electronically transmit application data and other information for individuals determined eligible or assessed as potentially eligible for Medicaid or CHIP to the State Medicaid and CHIP agencies in a timely and secure manner. All FFEs will also receive application data and other information electronically from the State Medicaid and CHIP agency for applicants screened as potentially eligible for enrollment in a QHP, APTC, or CSR.

Key Areas of Engagement: Business Processes and Customer Services

- Identifying eligibility model and rules for Medicaid and CHIP: Each FFE and the respective State Medicaid and CHIP agencies will work together to identify roles and responsibilities related to Medicaid and CHIP eligibility determinations. Whether the FFE is determining eligibility or conducting an assessment of eligibility for Medicaid and CHIP, the FFE will obtain relevant information from the State, such as regarding the State's applicable MAGI-based income standards for Medicaid and CHIP.

- Customer service to support eligibility and enrollment: All FFEs will have a call center for individuals. The FFE, the State Medicaid and CHIP agencies, and other entities providing customer service in a State, including the Department of Insurance, will coordinate closely to share information, create protocols to help consumers resolve issues, and ensure smooth handoffs among entities.

- Outreach and education: The FFE's outreach and education efforts will be most effective when coordinated closely with the relevant State agencies and stakeholders. This coordination could include ensuring that messaging is synchronized to the greatest extent possible.

- Notices: There are a number of potential interactions between the consumers, FFEs, and State Medicaid and CHIP agencies. To ensure that consumers receive clear, accurate, and actionable information about their eligibility for enrollment in a QHP and for insurance affordability programs, an FFE and the State Medicaid and CHIP agencies will work closely to ensure that notices to applicants clearly describe next steps and customer service contact information. We intend to provide further detail on notices.

- Program planning and management: Some families will have members with coverage in Medicaid or CHIP and FFEs; in addition, individuals may transition between programs as circumstances change. To offer the best possible support for these individuals and families,

an FFE and the State Medicaid and CHIP agencies will work together to identify and resolve issues that cross programs.

- Appeals: We are evaluating how the Exchange appeals process will coordinate with State Medicaid and CHIP agencies, and we intend to provide further guidance and proposed rulemaking on this topic in the future.

Process for Engagement

HHS and State Medicaid and CHIP agencies will develop project plans and formal and informal processes to support eligibility determinations, inform the development of and updates to standard operating procedures and enrollment processes, to create a positive and seamless consumer experience. Both the Exchange and the Medicaid and CHIP eligibility rules outline mutual responsibilities and call for a memorandum of understanding to specifically identify roles, responsibilities, and timelines. Data sharing agreements and standards for information exchanges will be particularly critical. Further guidance and toolsets will be forthcoming to delineate tasks, schedules, and specifications for development and testing of FFE and Medicaid and CHIP interactions. HHS plans to support the coordination effort with a cross-functional team covering eligibility operations; data sharing from the business, technology, and legal perspectives; and customer service, outreach, and education. HHS will continue to reach out to States to begin these discussions, and encourages State Medicaid and CHIP agencies to initiate dialogue.

Consumer Support, Outreach, and Education

HHS will conduct an outreach and education campaign to raise awareness of and promote enrollment in QHPs and insurance affordability programs through an FFE. As described earlier in this document, we encourage States to consider a State Partnership in consumer assistance. States already have relationships with local community and business organizations that will be critical for effective outreach and assistance to consumers. FFEs will assist consumers in receiving eligibility determinations for all insurance eligibility programs, comparing and selecting QHPs, and enrolling in a QHP. FFEs will offer a Web site, toll-free hotline, and other in-person assistance, which will also be accessible to persons with disabilities and those with limited English proficiency. FFEs will establish Navigator programs by awarding grants to eligible entities that can assist consumers in understanding insurance affordability programs, comparing and selecting QHPs, and interacting with QHP issuers, State agencies, and the FFE. Navigators will also conduct public education and outreach about Exchanges and provide referrals to other resources, as appropriate. It is HHS' intent to award Navigator grants prior to 2014,[7] with the goal of establishing a fully operational Navigator program in every FFE by October 1, 2013, so that all entities and individuals serving as Navigators are fully trained, certified, and ready to serve consumers, including those with disabilities and limited English

[7] This and some other activities are subject to the availability of Federal funds.

proficiency. In addition to the Navigator program, HHS envisions that consumers will be able to receive in-person assistance from a variety of other consumer resources, including agents and brokers.

HHS expects that licensed agents and brokers will continue to assist consumers in accessing health insurance, and will work with agents and brokers to promote enrollment through the Exchange. To the extent permitted by a State, an FFE will permit agents and brokers to enroll individuals in a QHP "through an Exchange" if the agent or broker ensures that an individual completes the eligibility verification and enrollment application using the Exchange Internet site or the agent or broker's site that meets certain conditions; the Exchange transmits the enrollment information to the QHP issuer; and the agent or broker meets other applicable requirements (an agreement, training, and registration). HHS will provide licensed agents and brokers with a portal to the FFE Web site if applicable standards are met.[8] The portal will allow agents and brokers to help individuals apply for eligibility for enrollment in a QHP and for insurance affordability programs, and if applicable, select and enroll in a QHP through an FFE. To the extent permitted by a State, HHS intends to work with Web-based brokers that meet all applicable requirements to help consumers select health plans online. Additionally, consistent with the Exchange final rule, HHS intends to use an application programming interface (API) to allow individuals to enroll in QHPs through an FFE with the assistance of Web brokers.

Other FFE functions related to Eligibility for Insurance Affordability Programs and Enrollment in the Individual Market

- Management of QHP eligibility and enrollment data: Each FFE will transmit eligibility and enrollment data to QHP issuers promptly, securely, and without undue delay, and will require issuers to acknowledge receipt of such information. Each FFE will reconcile eligibility and enrollment data. In addition, each FFE will need detailed, up-to-date information on premium payments and coverage effective dates from QHP issuers to administer APTC and CSR.

- Establishment and maintenance of the Internet Web site: HHS will establish and maintain an FFE Internet Web site. The Web site will provide a calculator that facilitates the comparison of out of pocket costs for available QHPs after the application of any APTC and CSR.

Federally Facilitated-SHOP

FF-SHOPs will provide small employers with new ways to offer employee health coverage, better information about coverage options, and easier benefit administration. In addition, small employers who participate in a SHOP may qualify for the small business health insurance premium tax credit of up to 50 percent of the employer contribution.

[8] *See* 77 Fed. Reg. at 18449 (to be codified at 45 C.F.R. §155.220).

The Affordable Care Act defines the small group market as employers with 1-100 employees, but permits States to establish an upper limit of 50 employees in 2014 and 2015. For purposes of FF-SHOP eligibility, HHS will adopt State definitions of the small group market in 2014 and 2015. HHS will count full-time equivalent employees to determine employer size consistent with the definitions in the Public Health Service Act as required by the law.

FF-SHOPs will provide a number of tools and resources to assist employers, employees, and agents and brokers in evaluating coverage options available through the FF-SHOP and selecting a health plan. For example, the FF-SHOP Web site will allow employers to model various choice scenarios (such as by changing the employer contribution percentage) before making a final selection. The FF-SHOP will also support employers and small group issuers by collecting a single, aggregated payment from each employer and distributing that payment to QHP issuers based on participating employees' plan selections. Other functions that an FF-SHOP will offer include:

- Health plan data collection: An FF-SHOP will accept changes in rates quarterly, with new rates applying for an entire coverage year beginning at the time of initial plan issuance or annual renewal.

- Multi-State employers: Multi-State employers participating in the FF-SHOP will offer coverage to all eligible employees either through the FF-SHOP serving the employer's primary place of business or through the State-based or FF-SHOP serving each employee's primary worksite.

- Administrative support: An FF-SHOP will provide for premium aggregation and other office functions, such as employer billing, receipt of payments, disbursements to plans, and payment reconciliation.

- Consumer services: FF-SHOPs will provide consumer support, including informational resources and application support through an Internet Web site, call center, and outreach and education.

- Role of agents and brokers: HHS anticipates that agents, brokers, and other producers will be a primary channel small businesses use to access coverage through an FF-SHOP. In addition to providing assistance with enrollment activities, HHS anticipates that agents and brokers will continue to be a primary point of contact for a variety of administrative, billings, and claims-related issues, and will work with FF-SHOPs to assist their clients in resolving these issues.

HHS will release future guidance on a number of topics related to the development and operation of FF-SHOPs, including policy issues related to States' small group markets, employer contribution models, and specific operational decisions, such as payment grace periods and maximum allowable new hire waiting periods.

IV. Stakeholder Input

HHS will work closely with local stakeholders to implement each FFE, including in States where a Partnership is operating. HHS is committed to creating a transparent process for FFE development in each State, and will seek input from stakeholders and provide technical assistance to those stakeholders working with an FFE. We anticipate that HHS will continue to engage with the stakeholder community through forums and workshops to implementation and operational issues and outreach and enrollment strategies. HHS will convene implementation sessions and other venues for discussion and input on FFE operations. HHS is also exploring with the National Association of Insurance Commissioners (NAIC) whether an advisory board can or should be created in States where such boards do not already exist. We welcome input on opportunities for HHS to work with local stakeholders including consumers, plans, providers and employers, to develop a successful Exchange in every State.

HHS also anticipates stakeholder consultation focused on FF-SHOPs. HHS recognizes that the successful operation of an FF-SHOP will benefit from the wealth of experience in State agencies. HHS intends to work with States to engage stakeholders and gather input, and believes that drawing on State expertise, discussing issues of joint interest, and exploring actions to facilitate the development of employee choice models of small group insurance will benefit the employer and employee experience in FF-SHOPs.

HHS recognizes the potential that FFEs will have to improve access to health coverage for American Indians and Alaska Natives in States that do not establish State-based Exchanges. Accordingly, we intend to consult with Tribes both in the development of FFEs and on an ongoing basis, consistent with the Presidential memorandum of November 5, 2009 and HHS' tribal consultation policy. The Affordable Care Act and the Exchange final rule include a number of provisions that uniquely affect American Indians and Alaska Natives, including but not limited to special enrollment periods and cost-sharing reductions for eligible individuals or individuals who obtain covered services from an Indian Health Provider. In addition, the Exchange final rule states that section 206 of the Indian Health Care Improvement Act, related to payment of Indian health providers by third party payers, will apply to QHPs participating in an Exchange. HHS intends to consult with Tribes to implement FFE policies that impact American Indians and Alaska Natives, and will release more specific information about this consultation and policies unique to these populations in the near future.

Educating Exchange stakeholders about FFE policy and providing technical assistance to States, issuers, consumer advocates, and the general public will be a key goal of HHS' outreach effort. Stakeholder input will both inform the implementation of policies articulated in this guidance, and future decision-making. The perspectives and feedback of local stakeholders will be particularly critical as each FFE begins to review and certify QHPs, offer plan selections to potential enrollees, conduct eligibility determinations, and enroll individuals into coverage.

Finally, we note that additional information on the operation of Exchanges in the U.S. Territories will be included in a future guidance.[9]

V. Comments

We are open to comments on this outline for State Partnerships and FFEs. Please send comments on this guidance to FFEcomments@cms.hhs.gov by June 18, 2012. Comments will be most helpful if commenters organize them by the subsections of this document (for example, "Plan Management" or "FF-SHOP").

[9] The term "State" means the 50 States and the District of Columbia. Therefore, there will be no federally-facilitated Exchange in a territory that does not choose to establish a State-based Exchange.