State Decisions: Federally Facilitated Marketplace (FFM) States

Data coordination
Will state confirm insurer licensure, solvency, and good standing?
In order to certify a plan as a QHP, an FFE must verify that it is offered by a QHP issuer that is licensed, solvent, and in good standing with the state. This could be done in several ways: • The state could verify licensure, solvency, and good standing for the FFE. • The FFE could accept documentation or attestations from the company. • The FFE could require the submission of financial reports to verify solvency. States may want to consider to what extent they wish to participate in this process. Some considerations may include: • Administrative burden on the Department of Insurance. • Administrative burden on the carrier • Potential for miscommunication or fraud • Potential for federal government to perform its own solvency review for QHP certification purposes
Will state confirm producer licensure and appointment?
HHS has signaled that, to the extent permitted by a state, an FFE will permit agents and brokers to enroll individuals in a QHP through an Exchange using a portal to the FFE website, if the agent has registered with the FFE, signed an agreement to abide by privacy and security requirements, and completed training in the range of QHP options and in other insurance affordability programs. It is unclear what other requirements might be placed upon producers as part of this agreement or what penalties HHS would be able to impose for violations of the agreement. It is likely, however, that HHS would want to verify the licensure and appointment status of agents before authorizing them to make enrollments "through the Exchange." States may want to consider: • Whether and how they will provide verification of licensure and appointment to the FFE • The content of FFE producer training programs and the extent to which the state wishes to assist in the development of those programs • Potential conflicts between standards contained in the FFE producer agreement and state requirements • Administrative burdens on the Department of Insurance, producers, and carriers • Whether to allow continuing education credit for FFE training
Rates and forms
Will state inform FFE of state rate and form review outcomes?
While the FFE will be able to make QHP certification decisions based upon standards contained in the final Exchange rule and upon other standards developed by the FFE, all QHPs sold on the Exchange must also meet all requirements of state law and regulation that do not prevent the application of the federal law, including rate and form approval requirements. These requirements will apply to all plans in the state, whether sold through Exchanges or outside of them. In addition, the Exchange must receive and disclose justifications for all QHP premium increases. Initially, HHS has said that it will not place additional certification requirements on QHPs in an FFE, though it could still exclude plans sold by issuers that have a history of requesting premium increases that have been found unjustifiable in under the rate review process established by the ACA. In addition, it could also decline to recertify a QHP based upon premium increases. As part of its certification process, an FFE will likely want to certify that a potential QHP has met all requirements of state law and that its forms and rates have been approved by the state if that is required. States may want to consider:

- Whether and how to provide this verification.
- Administrative burdens on Departments of Insurance and on carriers
- Potential for additional federal reviews of QHP forms to assess compliance with state law.

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

Will state review forms for federal law requirements?

Many of the market reforms in the ACA will be primarily enforced through the form review process. These requirements will apply to all plans in the state, whether sold through Exchanges or outside of them. Under HIPAA, if states fail to enforce provisions of the law, HHS will step in and directly enforce them, as it has with external appeals requirements in some states. In addition, if states did not review policy forms for compliance with federal law requirements, an FFE would do so as part of the QHP certification process.

States may wish to consider:

- Entering into an enforcement arrangement with HHS to clarify the role of the state insurance department
- Potential for federal involvement in form review
- Administrative burden on Department of Insurance
- Administrative burden on carriers submitting forms for review to both states and HHS

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

Will state review plans for compliance with actuarial value requirements?

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

States may wish to consider:

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

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

Network adequacy

Will state provide information about network adequacy reviews to FFE?

An FFE must ensure that a QHP offers a sufficient choice of providers and provides information to enrollees and prospective enrollees on the availability of in- and out-of-network providers. The final Exchange rule gives Exchanges broad leeway to develop standards that suit individual state markets and does not set additional standards. Initial guidance on FFEs indicates that, in states "meeting federal standards" the FFE will verify the states review. In other states, the FFE will review network adequacy data submitted in the QHP Issuer Application. It is still unclear what will be required under these federal standards.

States may want to consider:

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

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

Will state review networks for presence of essential community providers?

The ACA and the final Exchange rule require QHPs to include essential community providers, who serve primarily low-income, medically underserved populations, in their networks. They are required to reimburse these providers at predominating rates, but no lower than Medicaid reimbursement rates. Verifying the presence of these providers in networks is a new element of the network adequacy review process that has not traditionally been performed by states.

States may want to consider:

- Whether to verify QHP compliance with this requirement during any network adequacy review, assuming that this is a part of the federal standards referenced in the previous section.
- The potential for federal involvement in network adequacy review if the state does not undertake it.
- Any additional administrative burden on the Department of Insurance and carriers (*Note: states engaging in network adequacy reviews may consider incorporating this data into that review*)

Marketing

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

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

States may wish to consider:

- Whether and how to share state marketing standards with the FFE.
- Potential for duplicative examinations if state does not coordinate with FFE.
- Impact of federal marketing examinations upon state oversight and upon QHP issuers, including impact of any monetary penalties levied by the FFE.

Comment [JS1]: I just added this to a different section…I didn't remove from the document.

Market reforms and Plan Management Activities

Will the state enter into a "Partner/Not a Partner" arrangement ?

HHS is allowing interested states to attest that they will perform all the plan management activities listed in Section 4.0 of the Blueprint in time for the 2013 QHP selection process. Interested states are required to submit a letter from its Governor or Insurance Commissioner attesting that the state will: (1) have the legal authority and operational capacity to conduct the plan management activities required to support certification of QHPs, as described in 45 CFR 155.1010(a); (2) collect and analyze information on plan rates, covered benefits, and cost-sharing requirements pursuant to 45 CFR 155.1020; (3) help ensure ongoing plan compliance and resolve consumer complaints described in 45 CFR 155.1010(a)(2); (4) provide issuer technical assistance as needed; (5) help manage decertification of issuers and associated appeals in compliance with 45 CFR 155.1080; and (6) participate in a one-day review of its operational plans and capacity to perform these functions.

Comment [JS2]: It is expected there will be an official term to identify these states.

States may wish to consider:

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

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

The ACA provides for open enrollment periods in Exchanges in order to help protect the market from adverse selection with the implementation of guaranteed issue, adjusted community rating, prohibition of preexisting condition exclusions, and other market reforms in 2014. HHS issued final regulations allowing for open enrollment periods in the outside market, so long as those open enrollment periods overlap with the Exchange open enrollment period.

States may wish to consider:

- Whether carriers may enroll individuals outside of an open enrollment period and what sorts of underwriting activities are permissible outside the enrollment periods, if any.

Ensuring the state has a process in place to effectively monitor insurer solvency during a condensed time period of high enrollment (new open enrollment period). Also consider whether the state has the tools it needs to allow a plan to stop enrolling in a guaranteed issue environment if solvency issues arise.

Essential Health Benefits

In final regulations issued in February 2013, HHS set forth the criteria for the selection of a state EHB benchmark plan. States may designate an essential health benefits benchmark plan selected from one of four options and supplemented to include benefits in each of ten statutorily prescribed categories. If a state does not designate a benchmark plan, HHS will use the largest plan by enrollment in the state's small group market. The state will be required to defray the cost of any state-mandated benefits not included in the benchmark plan for all individuals enrolling though the Exchange. The regulation includes a list of EHB benchmark plans for each state.

States may wish to consider:

- EHB packages must comply with nondiscrimination requirements.
- It is still unknown how the states will "pay" for the cost of mandated benefits not included in the EHB package these benefits.
- How best to balance cost and comprehensiveness of the benefit package to suit the needs of state residents.
- How to best minimize the chance that the state will have to pay for the cost of state mandates in coverage sold through the Exchange.
- The Administrative burden associated with determining whether a specific health plan's benefit package is "substantially equal" to the selected EHB benchmark; this is a separate issue as to whether a benefit substitution within a category is actuarially equivalent.
- Plans offered in the large group market cannot impose annual dollar limits on EHBs.
    - Will benefit substitutions, as described in the final EHB regulation, be used to substitute annual dollar limits in the large group market?

Will state restrict actuarially equivalent benefit substitutions?

Final HHS regulations on essential health benefits permit plans to make actuarially equivalent substitutions of benefits within benefit categories (except for prescription drugs). It also clarified that states retain the authority to restrict or prohibit these substitutions.

States may wish to consider:

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

Will state require meaningful difference between plans outside of Exchange?

HHS has indicated that it will review QHPs sold on an FFE by the same issuer for "meaningful difference" to ensure that a manageable number of distinct plan options are offered. While HHS has not yet provided detail as to what standards would be used to determine if differences are meaningful, states could extend this requirement to the individual and small group markets outside the Exchange if they wished.

States may wish to consider:

- The impact of meaningful difference requirements on consumer choice.
- The impact of meaningful difference requirements on consumer decision making.
- Administrative burden on the Department of Insurance of reviewing plans for meaningful difference.

Will state enact and enforce federal rating rules?

The ACA imposes new adjusted community rating requirements and a requirement that all of a carrier's enrollees in the individual market be considered part of a single risk pool and that all enrollees in the small group markets be considered to be part of a second single risk pool unless a state opts to merge the individual and small group markets, in which case all non-grandfathered plans' risk would be merged. If states do not enforce these requirements, HHS would step in to do so, reviewing rates and forms for evidence of compliance.

States may wish to consider:

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

Will state specify age bands?

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

States may wish to consider:

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

Will state specify geographic variation and rating areas?

Final HHS Market Regulations require that a state's rating areas must be based on one of the following geographic divisions: counties, three-digit zip codes, or MSAs and non-MSAs and will be presumed adequate if they meet either of the following conditions: (1) As of January 1, 2013, the state had established by law, rule, regulation, bulletin, or other executive action, uniform geographic rating areas for the entire state; or (2) After January 1, 2013, the state establishes by law, rule, regulation bulletin or other executive action for the entire state no more geographic rating areas than the

number of MSAs in the state plus one. Under these standards, geographic rating areas may be noncontiguous, but the area encompassed by the geographic rating area must be separate and distinct from areas encompassed by other geographic rating areas. States have the option to seek approval form HHS for a greater number of rating areas as long as the areas are based on counties, three-digit zip codes, or MSAs and non-MSAs. If a state does not establish rating areas or a state's rating areas are determined to be inadequate, the default will be one rating area for each MSA in the state and one rating area for all other non-MSA portions of the state, as defined by the Office of Management and Budget. Future HHS guidance will be issued that will establish a process and timeline for states to update their rating areas.

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States may wish to consider:

- Current requirements and practices in the state for variation of premiums based upon geography
- Impact on rating areas on premiums in the state
- Additional administrative burdens on Department of Insurance and carriers
- More detail is needed on the circumstances under which CMS would use the county, three digit zip code, or MSA options as the federal default.

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

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

States may wish to consider:

- How to determine whether two plans are "substantially the same"
- Additional administrative burden on the Department of Insurance (*Note: The SERFF system is being modified to provide functionality to assist in identifying product filings that will be sold both inside and outside the exchange*)

Will state license CO-OP plans?

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

States may wish to consider:

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

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

Multi-State Plans will be offered in the Exchanges in all 50 states, plus the District of Columbia and are deemed certified as QHPs by the ACA. The ACA requires that the Multi-State Plan issuers be licensed in every state in which they operate. The NPRM on the establishment of the Multi-State Plan program indicates that a MSP issuer must offer coverage in at least 31 states in its first year of participation; 36 states in its second year; 44 states in its third year; and all states in each subsequent year. It also indicates an issuer need not offer coverage in all service areas of a state if it submits a plan with its initial and renewal MSPP applications for expanding to the entire state. The NPRM requires MSPP issuers to offer a uniform benefits package within a state that is substantially equal to the EHB benchmark plan in a state or one of the OPM-selected EHB benchmark plans (the 3 largest FEHBP plans) supplemented by adding: any state mandated benefits enacted prior to 12-31-2011 that are included in the state EHB benchmark; pediatric dental and vision coverage from the FEDVIP; and habilitative services specified by each state or by OPM and any state mandated benefits. If a state requires mandated benefits beyond the EHB benchmark package to be sold to MSP enrollees, it must assume the cost of those additional benefits.

States may wish to consider:

- Whether to grant licenses to issuers that intend to offer policies that do not comply with state law and consider themselves to be operating outside of state enforcement authority.
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Reinsurance

How will the state handle complaints?

The handling of consumer complaints will likely depend on the level of coordination between the federal government states and exchanges. Exchanges, including FFEs, are statutorily required to have a call center available to consumers with questions related to applying for insurance affordability programs or commercial insurance through the exchange.

States may wish to consider:

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

Will state supplement HHS payment parameters ?

The transitional reinsurance program will operate from 2014-2016 and will provide a total of $20 billion in payments to nongrandfathered individual market plans paid for with assessments on all fully-insured and self-insured health insurance plans. In its draft Notice of Benefit and Payment Parameters, HHS proposes uniform reinsurance payment parameters for the reinsurance program. CMS proposes that a State may supplement the HHS reinsurance payment parameters, but must pay for those supplementary parameters with additional State reinsurance collections for State funds (instead of funds collected by HHS under the national contribution rate). HHS also proposes: a per capita rate under which contributions would be collected annually by HHS from al l applicable health insurers and group health plans; exclusion of certain types of plans from the reinsurance contribution requirement; and standards governing the calculation of contributions.

States may wish to consider:

- Impact of federal payment parameters on health insurance marketplace
- Temporary nature of the program
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Will state end its high risk pool?

Consumer Education and Outreach

Navigators and Application Counselors

When provisions of the ACA take effect in 2014, education and outreach to consumers will be important to ensure that individuals are aware of the requirement to obtain health insurance coverage and of other changes taking place in the marketplace. The law creates a new navigator program that uses grants awarded by Exchanges to fund individuals and organizations to provide information to consumers regarding coverage options and the availability of subsidies. In an FFE, HHS will be selecting and providing some oversight of navigators. Final HHS Exchange regulations require Navigators to meet any licensing, certification, and other standards established at the state level. Proposed HHS regulations also create application counselors to do the following: provide information about insurance affordability programs and coverage options; assist individuals and employees to apply for coverage in a QHP through the Exchange and for insurance affordability programs; and help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs. The NPRM requires applications counselors to be certified by the exchange. Training is a requirement for certification. There is no federal funding to support the work of application counselors.

States may wish to consider:

- The extent to which they would like to assist the FFE's outreach and education efforts
- The extent to which they may make recommendations and suggestions regarding Navigator selection
- Whether and how best to license, certify, and/or regulate navigators and any entities that engage in activities requiring licensure in the state
    - A state pursuing licensure or certification of Navigators will need to consider whether to require state specific training and the specifics of that requirement, i.e. subject areas, number of training hours required, whether passage of an examination is required, etc.
    - Whether to require that Navigators refer consumers to licensed agents when consumers want services only a licensed agent is authorized to provide.
    - The extent to which a state imposes conflict of interest provisions and safeguards to ensure navigators or application counselors working in medical facilities, like hospitals, are not steering consumers into health plans that benefit medical facilities or the providers working in them.
- The extent to which the conduct of navigators will be monitored and regulated if states establish no regulatory regime for navigators and the risks that such a vacuum poses to consumersThe extent to which a state wants to ensure consumers have resources available to find an agent that meets their needs; close in proximity, appointed with a company the consumer prefers or appointed with all carriers in the exchange, etc. Maybe this is search tool on the department's website.
- The extent to which they wish to make existing state stakeholder outreach groups available to the FFE for consultation
- Additional administrative burden on Department of Insurance and other state agencies

Comment [JDG3]: Sarah Lueck: This addition should not be added because it fails to recognize that the federal government will have standards and criteria for navigators to ensure that they provide accurate and helpful advice to consumers as they apply for eligibility determinations, select a plan, and complete enrollment—much like Medicare SHIPs successfully do today.

Will the state insurance department work with the Tribes or will HHS be the primary contact?

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

definition of Native American and verification of Native American Status.

States may wish to consider:

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

Future decisions

Will state transition to partnership or SBE?

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

States may wish to consider:

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

Will state seek a state innovation waiver?

The ACA permits states to apply for state innovation waivers that would allow states to implement alternative means towards achieving the same policy goals as the ACA, including waivers of the individual and employer mandates, health insurance exchanges, premium subsidies, and cost-sharing reductions. These waivers would go into effect in 2017, though legislation has been introduced and endorsed by the administration that would move the effective date of the state innovation waivers up to 2014.

States may wish to consider:

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

Medicaid

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

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

States may wish to consider whether:

- Federal Medicaid determinations could reduce workload on state Medicaid agency
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Will the state expand the Medicaid program, and how far?

The Supreme Court decision, which upheld the individual mandate, prohibited the federal government from

conditioning continued funding for the state's existing Medicaid program upon expansion of the program to 133% of the federal poverty level (FPL). States therefore have the option to expand or not expand their programs. It is still unclear whether a state will be permitted to expand their programs to a level below 133% of FPL. Many other questions regarding the expansion of Medicaid are also still unresolved.

States may wish to consider:

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