

PRIMER:

LEGISLATIVE WORK GROUP

This document provides the Legislative Work Group of the Advisory Task Force with an overview of some activities for the New Mexico Health Insurance Exchange, as well as questions for which the Advisory Task Force requests guidance. Work Group members should develop and record recommendations, and submit them to the Advisory Task Force and to the New Mexico Human Services Department.

*New Mexico
Health
Insurance
Exchange
Advisory
Task Force*



Exchange Functions

Section 1311(d)(4) specifies the following core functions that an exchange must provide:

- Certification, recertification and decertification of plans
- Setup and operation of a toll-free hotline
- Establishment and maintenance of a website providing information on plans to current and prospective enrollees
- Assignment of a price and quality rating for listed plans
- Presentation of plan benefit options in a standardized format
- Information on Medicaid and CHIP eligibility and facilitation of eligibility determination for individuals in these programs
- An electronic calculator to determine the actual cost of coverage, including eligibility for premium tax credits and cost sharing reductions
- Certification of individuals exempt from the individual responsibility requirement
- Information to the Treasury Department and employers about certain individuals identified in Section 1311 (d)(4)(I)
- Establishment of a Navigator program that provides grants to entities and/or individuals assisting consumers as described in Section 1311(i)
- Enrollee satisfaction survey results under Section 1311(c)(4)
- Provision for open enrollment periods under Section 1311(c)(6)
- Consultation with stakeholders, including tribes, under Section 1311(d)(6)
- Publication of data on the exchange's administrative costs under Section 1311(d)(7)

Exchange Overview

The Patient Protection and Affordable Care Act (PPACA), in Section 1311, includes two basic federal requirements for exchanges. These requirements include: 1) the minimum functions exchanges must undertake; and 2) oversight responsibilities the exchanges must implement in certifying and monitoring the performance of Qualified Health Plans ("plans"), as defined in Section 1301.

States must determine how policies and processes will be coordinated among the exchange, state insurance regulatory entities, state health subsidy programs such as Medicaid and CHIP, and health and human services programs. States must consider issues such as streamlining eligibility and enrollment, consumer assistance programs, and technical processes.

Plan Certification

Insurers must agree to charge the same premium rate for plans on the exchange whether they are offered only on the exchange or are also offered directly from the issuer through an agent. Plans offered on the exchange must comply with state and federal regulations. The rule largely leaves it up to the states to determine the requirements (whether flexible or stringent) for carriers being able to participate in the exchange.

Metal Tiers

There are four distinct tiers, "metal tiers", at which plans may offer coverage: bronze, silver, gold, and platinum. Each tier corresponds to an actuarial value (AV). The AV measures the percentage of health care costs the health plan will cover. For example, in a gold plan, the consumer is expected to pay 20%

of medical costs, while the plan will cover the remaining 80%. Pursuant to Section 1301 part c, issuers agree to offer at least one qualified health plan in the silver level and at least one plan in the gold level.

<u>Metal Tier</u>	<u>Actuarial Value (AV)</u>
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

Eligibility

The final rule outlines standards and processes for exchanges to consider whether consumers are eligible for all available programs using a single, streamlined application, meaning that consumers do not have to guess what programs for which they are eligible. Consumers must be able to easily notify the exchange of any changes that might affect their eligibility, such as marriage, divorce, or a job change. In addition, a state-based exchange may determine eligibility for advance payments of the premium tax credit and cost-sharing reductions.

Oversight Responsibilities

Section 1311(c) requires U.S. Department of Health and Human Services (HHS) to develop regulatory standards in five areas that insurers must meet to be certified as qualified health plans by an exchange:

- Marketing
- Network adequacy
- Accreditation for performance measures
- Quality improvement and reporting
- Uniform enrollment procedures

Additional areas where exchanges must ensure plan compliance with regulatory standards established by HHS include:

- Information on the availability of in-network and out-of-network providers as identified in Section 1311(c)(1)(B) and (C), including provider directories and availability of essential community providers
- Review and posting of past premium increases and plan justifications for current premium increases under Section 1311(e)(2)
- Public disclosure of plan data identified in Section 1311(e)(3)(A), including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by the Secretary
- Timely information about cost sharing, including an Internet website and other means, for items and services from specified providers as described in Section 1311(e)(3)(C)
- Information for participants in group health plans as described in Section 1311(e)(3)(D)
- Information on plan quality improvement activities as specified in Section 1311(g)

Financial Sustainability/Operating Costs

PPACA's language regarding financial sustainability is broad: "charge assessments or user fees to participating health insurance issuers, or otherwise generate funding, to support operations." Existing exchanges fund operational costs in a variety of ways. Massachusetts insurers, for example, pay the Massachusetts exchange, the "Connector," an assessment of about 4%, which funds a budget of more than \$40 million a year to pay for staff, consultants, and IT. New York's HealthPass, a private, non-state-established exchange, derives revenue from a 2% to 4% assessment on insurers. Utah's exchange is financed by assessing a fee to employers of \$6 per employee per month. Connecticut's Health Connections also funds its administrative infrastructure through employer dues. While PPACA allows taxes and fees to be assessed against insurers in the individual exchange, it prohibits a state from levying taxes and fees against consumers in the individual exchange. PPACA neither contemplates nor prohibits fees to be assessed against individuals, employers, or insurers in the Small Business Health Options Program (SHOP).

Whether in the individual or small business exchange, and regardless of upon whom the tax or fee is assessed, all charges add to the cost of insurance premiums. States have options other than assessments. HHS, in a notice of proposed rulemaking issued in July 2011, has effectively given states *carte blanche* with respect to exchange financing:

States may use broad-based funding (which may include general state revenues, provider taxes, or other funding that spreads costs beyond imposing assessments or user fees on participating issuers), as long as the use of such funding does not violate other state or federal laws.

Possible options for financing the ongoing costs of the exchange include, but are not limited to:

- Transaction fees on plans sold in the exchange
- Advertising on the exchange Web site
- Assessments on carriers participating in the exchange
- Assessments on all carriers in the market, regardless of participation in the exchange
- Replacing or repurposing existing revenue streams, such as using funds from the high risk pool
- Broad-based assessments on the health care market, such as providers, hospitals, health systems, pharmacies, etc.
- A combination approach

Additional Resources:

[Patient Protection and Affordable Care Act of 2010](#), P.L. 111–148, Section 1311

HealthCare.gov

[Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers](#), 45 CFR Parts 155, 156, & 157, Federal Register, Vol. 77 No. 59 (Mar 27, 2012)

Questions

- A. Certification/decertification and other carrier participation requirements
 - 1. Should carriers be required to participate in both the individual and small group markets?
 - 2. Should carriers participating in the exchange be required to offer plans at more than the two levels of coverage required by federal law (i.e., Silver and Gold)?
 - 3. Should health plans inside the exchange be subject to enhanced regulation on rate review or reporting requirements?
 - 4. What criteria, such as relative quality and price of benefits, should be used to rate plans available through the exchange?
 - 5. Does a qualified health plan need to be available to everyone statewide, or can it be offered to only those in one region of the state?

- B. Where should regulatory oversight responsibility be housed?

- C. Financial Sustainability/Operating Costs
 - 1. Should exchange-related assessments be imposed ? If so, against whom (consumers, insurance carriers, providers, employers, hospitals, etc.)?
 - 2. What other ways could be used to fund operating costs?

Please track additional questions that may emerge as part of this process. Work Group Leader will summarize the recommendations from this group. Please submit any questions or written recommendations to the Work Group Leader.