PRIMER:

EXCHANGE MARKET REGULATION

This document provides the Market Regulation Work Group of the Advisory Task Force with an overview of the statutory and regulatory guidance on exchange market regulation, as well as the critical questions the Task Force is asked to answer. Work Group members should develop and record recommendations, and submit them to the Advisory Task Force and to the New Mexico Human Services Department.

HUMAN SERVICES DEPARTMENT

New Mexico Health Insurance Exchange Advisory Task Force

Background Information

The Patient Protection and Affordable Care Act (PPACA) includes two basic federal requirements for exchanges, found in Section 1311. These requirements include: 1) the minimum functions exchanges must undertake directly or, in some cases, by contract; and 2) oversight responsibilities the exchanges must exercise in certifying and monitoring the performance of Qualified Health Plans (hereafter referred to as "plans" or "QHP"s), as defined in Section 1301.

Exchange Functions

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

- Certification, recertification and decertification of plans
- 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
- Certification of individuals exempt from the individual responsibility requirement

Additional exchange functions include:

- Enrollee satisfaction survey results under Section 1311(c)(4)
- Provision for open enrollment periods under Section 1311(c)(6)
- Publication of data on the exchange's administrative costs under Section 1311(d)(7)

Oversight Responsibilities for Certification of Plans

Section 1311(c) requires U.S. Department of Health and Human Services (HHS) to develop regulatory standards in five areas that insurers must meet in order 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)

Marketing

Issuers must not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs. In addition, they must comply with any applicable state laws and regulations regarding marketing by health insurance issuers.

Network Adequacy

Health plans will often contract a network of providers from which consumers may choose to receive their medical care. HHS stated in the final rule on March 27, 2012 that plans must include essential community providers and "maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay." New Mexico currently requires a certain number of primary care providers within 30, 45, and 60 miles of an enrollee depending on whether the enrollee lives in urban, rural, or frontier areas. It also has standards relating to wait time in setting appointments for routine care and urgent care.[1]

Other Participation Requirements

Insurers agree to charge the same premium rate for each of their qualified plans regardless of whether they are offered through the exchange or directly from the issuer through an agent. However, they may vary premiums depending on geography. Health insurers offering plans on the exchange agree to offer a child-only plan at the same level of coverage as any QHP. Plans offered in the exchange must also comply with state insurance laws and federal requirements in the Public Health Service Act.

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.

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

[1] "A Profile of Medicaid Managed Care Programs in 2010: Findings from a 50 State Survey." Kaiser Commission on Medicaid and the Uninsured. September 2011.

Additional Resources*:*

Patient Protection and Affordable Care Act of 2010, P.L. 111–148, Section 1311

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)

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Questions

A. Certification/decertification and other carrier participation requirements
    1. What should the requirements be for a carrier to operate on an exchange?
        a) Should carriers be required to participate in both the individual and small group markets?
        b) 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)?
        c) Should carriers be required to offer more than one plan at any one metal level?
    2. What criteria should be used for certifying plans on the exchange, other than Essential Health Benefits?
        a) Should health plans inside the exchange be subject to enhanced regulation on rate review or reporting requirements?
    3. Should carriers be given a limited timeframe in which to decide if they will participate in the exchange?
    4. What criteria, such as relative quality and price of benefits, should be used to rate plans available through the exchange?

B. Other
    1. How should provider network adequacy be determined?
    2. How large or small of a geographic region should a health plan be required to be made available? (i.e., 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?)
    3. What should the standard format for presenting coverage options to consumers look like?

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