Advisory

MINTZ LEVIN
Mintz Levin Cohn Ferris Glovsky and Popeo PC

Health Law | Employee Benefits

AUGUST 30, 2012

HHS Issues Updated Blueprint for Health Insurance Exchanges under the Affordable Care Act

BY GARY E. BACHER AND ALDEN J. BIANCHI

The Patient Protection and Affordable Care Act (the "Act") calls for the establishment by 2014 of "American Health Benefit Exchanges" (or, simply, "exchanges"), the principal purpose of which is to provide eligible individuals and small businesses with access to affordable health insurance under "Qualified Health Plans" ("QHPs"). Individuals will only be eligible to enroll in an exchange plan if they are not enrolled in Medicare, Medicaid, or other acceptable employer coverage as a full-time employee, and certain low-income individuals may qualify for a tax credit toward their premium costs and cost-sharing subsidies that will be available only through an exchange. Small businesses will be able to provide their employees with access to QHPs through one or more Small Business Health Options Program (SHOP) exchanges, which may be combined with, or operated independently from, other exchanges.

As envisioned by the Act, States may — but they are not required to — establish one or more "state-based exchanges." Where a state declines to do so, the Act directs the Department of Health and Human Services (HHS) to establish and operate a "federally-facilitated exchange." Alternatively, a state may elect to administer and operate certain exchange-related activities associated with plan management and/or consumer assistance under a "state partnership exchange." With respect to state partnership exchanges, however, HHS has observed that

> "HHS, as the party responsible for Exchange implementation, will provide as much flexibility as possible; however, HHS will need to ratify inherently governmental decisions made by the State Partner."

Under a March 27, 2012, final rule, HHS must either approve or conditionally approve state-based exchanges or state partnership exchanges no later than January 1, 2013, for operation in 2014. To receive approval, a state must complete and submit an "Exchange Blueprint" by November 16, 2012 that documents how its exchange meets or will meet all applicable legal and operational requirements for plan year 2014. A Blueprint is made up of two components: 1) a Declaration Letter from the State outlining the type of Exchange model the state chooses to pursue; and 2) an Exchange Application. As part of its Exchange Blueprint a State must also demonstrate operational readiness to execute Exchange activities. In any case, technical and financial assistance will continue to be available through 2014.

On August 14, 2012, HHS issued its final "Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges" (the "Blueprint"). The Blueprint explains and facilitates the application process. It also directs HHS to determine whether the State will operate reinsurance and/or risk adjustment programs or will use Federal government services for these activities.

The Blueprint describes the various options available to the states in the following chart:

State-Based Exchange	State Partnership Exchange	Federally-facilitated Exchange
State operates all exchange activities; however, the state may use Federal government services for the following activities: • Premium tax credit and cost-sharing reduction calculations • Exemptions • Risk adjustment program • Reinsurance program	State operates activities for: • Plan management • Consumer assistance • Both States may elect to perform or can use Federal Government services for the following activities: • Reinsurance program • Medicaid and CHIP eligibility: assessment or determination	HHS operates; however, state may elect to perform or can use Federal government services for the following activities: • Reinsurance program • Medicaid and CHIP eligibility: assessment or determination

The Blueprint also provides a checklist of the activities and characteristics of an exchange, including legal authority and governance; consumer and stakeholder engagement and support; eligibility and enrollment; plan management; risk adjustment and reinsurance; the SHOP exchange; organization and human resources; finance and accounting; technology; privacy and security; oversight, monitoring, and reporting; and contracting, outsourcing, and agreements. In an important clarification, the Blueprint focuses on the use of web-based brokers, although, in a nod to concerns raised by consumer groups, the Blueprint calls for their close oversight.

According to the Kaiser Family Foundation,[1] to date, only 15 states plus the District of Columbia have established state-based exchanges to work toward meeting ACA's requirements, and three states, Arkansas, Delaware, and Illinois, are planning to pursue a state-federal partnership exchange. Seven states have declared that they will not create a state-based exchange. These include Louisiana, New Hampshire, Texas, Florida, South Carolina, and Alaska. Another 16 states have not yet committed to a health insurance exchange strategy, but are continuing planning, and nine states have not shown significant exchange planning activity.

* * *

View Mintz Levin's Health Law attorneys.

Read and subscribe to *Health Law & Policy Matters* blog.

View Mintz Levin's Employee Benefits attorneys.

Read and subscribe to *Employment Matters* blog.

Endnotes

[1] http://www.kff.org/healthreform/upload/8213-2.pdf.

Follow Us 

2197-0812-NAT-HL-ELB