COMMUNITY CATALYST

Assessing Consumer Protections in the July 2011 HHS Exchange Regulations

The U.S. Department of Health and Human Services (HHS) released the first round of Exchange regulations on many aspects of the health insurance Exchanges on July 11, 2011. Based on Community Catalyst's work to help develop state Exchanges around the country, this document highlights 10 important priorities for consumers and outlines key areas that require stronger protections or clarification in the federal regulations. State consumer advocates can use this guide to review the regulations and understand what is at stake for consumers moving forward.

1. Ensure Good Governance and Prevent Conflicts of Interest

The ACA gives states enormous flexibility in how they structure and govern Exchanges. The regulations:

- Support transparent decision-making by requiring Exchange boards to convene regular, public board meetings that must be announced in advance. Additionally, Exchanges must develop ethics principles, conflict of interest standards, and require Board members to disclose financial conflicts of interest. [§155.110(c)(2), §155.110(d)(1), §155.110(d)(2)]
- Minimize some potential conflicts of interest on Exchange boards by preventing a **majority** of conflicted individuals from serving on these boards. However, conflict of interest is not clearly defined and the regulation applies only to insurers and brokers. [§155.110(c)(3)]
- Require a majority of board members to have relevant experience in health benefits and health policy. [§155.110(c)(4)]
- Require Exchanges to regularly consult with stakeholders, including advocates, educated health care consumers, insurers and brokers. [§155.130]

The regulations could better protect consumers by:

- Prohibiting anyone who works for, consults with, represents, is a member of an association of, or is on the board of an insurer, insurance broker, or health care provider from serving on a board of an Exchange.
- Requiring a certain number of consumers on Exchange boards, to ensure that the needs of people enrolling in Exchange plans are taken into account.
- Requiring Exchanges to have a Consumer Advisory Committee — comprised of consumer advocates and non-profit organizations with relevant knowledge and expertise — to inform the board.

2. Navigators

Navigators should be trusted community organizations who can best help consumers select an affordable, quality health plan. The regulations:

- Stipulate that Exchanges must choose two types of Navigators from eight types of entities. HHS is seeking comments on more stringent requirements that would require at least one of the Navigators to be a community or consumer-oriented nonprofit organization. [Overview, p. 46]
- Allow each state to determine the licensing and certification standards for Navigators. [§155.210(b)(1)(iii)]
- Require Navigators to be experts in "eligibility, enrollment, and program specifications" of the Exchanges and educate the public about the Exchanges. [§155.210(d)(1)] HHS wants comments on potential standards, or requirements for grant awards, for Navigators. [Overview, p. 47]
- Prohibit Navigators from having conflicts of interest, but specifics are not described. HHS is seeking comments to clarify this issue. [§155.210(b)(1)(iv) and Overview p. 46]
- Prohibits Navigators from receiving compensation from insurers selling Qualified Health Plans (QHPs). However, Navigators may receive compensation for enrolling people in plans outside Exchanges. [§155.210(c)(2) and Overview, p. 47]
- Codify the linguistic and cultural competency requirements for Navigators, but do not provide specifications. [§155.210(d)(5)] HHS is seeking comments on this issue and on increasing access to information for individuals with limited English proficiency and people with disabilities. [Overview pp. 48, 51]

The regulations could better protect consumers by:

- Prohibiting states from requiring Navigators to be licensed as brokers.
- Requiring states to designate at least one community-based organization as a Navigator.
- Requiring Navigators to demonstrate competency in the Exchange, Medicaid and other public programs and the private insurance market in the state.
- Outlining strict conflict-of-interest standards for Navigators, including anyone receiving financial compensation from insurers for enrolling people in certain health plans in or outside of the Exchange.
- Clarifying the linguistic and cultural competency requirements for Navigators.

3. Enrollment and Eligibility

It is critical to minimize barriers to enrollment in Exchange and public insurance plans. The regulations:

- Require Exchanges to provide consumer assistance, as well as outreach and education. The regulations encourage Exchanges to operate call centers outside of normal business hours. [§155.205(d), §155.205(e), §155.210(d), Overview, p. 39]
- Require Exchanges to regularly consult with stakeholders, including advocates of hard-to-reach populations. [§155.130]

The regulations could better protect consumers by:

- Requiring states to provide multi-lingual and culturally competent consumer enrollment assistance through: in-person support, staffed telephone hotlines, and contracts with community groups to increase enrollment.

- Requiring states to take all necessary steps to minimize wrongful denials of eligibility for public plans and subsidized Exchange plans. The appeals process for eligibility determinations will be covered in future regulations. [Overview p. 38]

4. A Seamless Interface between Medicaid and Exchanges

Exchanges and Medicaid programs need to develop systems that make it easy for people to keep their coverage when they move between Exchange plans and Medicaid. The regulations:

- Do not provide specifics on how Medicaid programs and the Exchange should work together. Much of that detail will be provided in a regulation later this year.
- Require Qualified Health Plans (QHPs) to have provider networks with a sufficient number of essential community providers that serve predominantly low-income, medically underserved individuals. [§156.235 and Overview pp. 126-128]
- Codify ACA requirements for Exchanges to develop a single streamlined application for enrollment in QHPs, premium and cost-sharing tax credits, Medicaid, CHIP and Basic Health Plans. [§155.405]

The regulations could better protect consumers by:

- Clarifying what constitutes a "sufficient" number of essential community providers in a manner that is broad enough to ensure adequate access to care while still allowing Exchanges to engage in selective contracting to promote high-quality, cost-effective care. HHS wants comments on this issue. [Overview, p.128]
- Requiring states to eliminate burdensome processes such as fingerprinting for CHIP, Medicaid, and Exchange-based health plans to reduce barriers to enrollment.

5. Qualified Health Plans (QHPs)

The ACA requires Exchanges to certify QHPs that meet the health care needs of consumers. The regulations:

- Provide Exchanges with considerable discretion to certify, re-certify and de-certify QHPs. The recertification process may be less intensive than initial certification. [§155.1075]
- While Exchanges must monitor QHPs for "ongoing" compliance with certification requirements, they are given latitude to decide if insurers must "demonstrate compliance" or if they will be allowed to "agree to comply" with requirements. [§155.1010(d) and Overview p. 98, 102]
- Clarify that multi-state plans are exempt from the QHP certification process. It is not clear how Exchanges can ensure that multi-state plans are high-quality and affordable. [§155.1010(b)]

The regulations could better protect consumers by:

- Defining the Essential Health Benefits (EHBs) that must be offered by all QHPs. HHS may issue regulations on EHBs this fall.
- Providing clearer guidelines about the process and criteria by which Exchanges must certify, re-certify and de-certify QHPs.
- Clarifying the strategies the federal Office of Personnel Management will use to ensure that multi-state plans provide affordable, quality plans to consumers.

- Creating and enforcing an HHS-based consumer complaint process and penalty system for Exchanges that fail to comply with these regulations.

6. Active Purchasing

The term "active purchasing" includes many tools that Exchanges can use to increase quality and decrease the cost of plans. These strategies include selective contracting, rate negotiation, and piloting new reimbursement strategies. The regulations:

- Describe several types of active purchasing strategies that Exchanges can use including, but not limited to: competitive bidding, selective contracting, negotiating rates, and establishing selection criteria. [Overview pp. 99-100]
- Do not require Exchanges to conduct the above activities and clarify that Exchanges may accept "any qualified plan." [Overview pp. 99-100]
- Empower Exchanges to develop criteria for health plans beyond the minimum required by the ACA. [Overview p. 99]

7. Rate Review

Consumers in Exchange plans must be protected from escalating premiums through the rate review process. The regulations:

- Require insurers selling QHPs in an Exchange to post justifications for rate increases on their websites. [§156.210(c)]
- Encourage Exchanges to leverage existing state rate review whenever possible by collaborating closely with state insurance regulators.
- HHS is seeking comments on the ACA's requirement that Exchanges consider rate increases in determining whether to make a plan available. [Overview pp. 103-104]

The regulations could better protect consumers by:

- Requiring the rate review processes to be transparent by having a public comment period and a consumer advisory committee in the rate review process, and publicly publishing results of all rate review determinations.
- Providing further guidance on how insurance regulators and Exchanges should interact, including how the Exchange may disapprove health plans because of rate increases.

8. Preventing Adverse Selection

Minimizing adverse selection helps to maintain affordable health care plans for consumers. HHS has issued draft regulations on risk adjustment and reinsurance for the Exchanges, but these rules will not fully mitigate the effects of adverse selection. Most of the rulemaking that would decrease the chance of adverse selection must happen at the state level, and is not in the purview of the federal government. Therefore, federal regulations will only have limited effects on adverse selection. Advocates should focus on educating state-level decision makers on ways to prevent adverse selection in the Exchange. The regulations:

- Codify the ACA requirement that insurers charge the same premium rate inside and outside of the Exchange. [§156.255(b) and Overview p. 134]
- Indicate that Exchanges can be financed by assessing fees on insurers in the Exchange. The regulations do not require Exchanges to assess the same fees on plans outside the Exchanges to reduce the chance of adverse selection; states have jurisdiction over fees assessed on plans outside the Exchange. [§156.50 and Overview p.117]

9. Establish Clear Timelines and Benchmarks for State Exchanges

States must operationalize their Exchanges by January 1, 2014. States must demonstrate, by January 1, 2013, that Exchanges are on track to be operational within the following year. These regulations lay out additional milestones that Exchanges are expected to meet:

- By January 1, 2013, Exchanges must receive written approval (or conditional approval) from HHS to offer QHPs on January 1, 2014. [§155.105(a)]
- Open enrollment periods must begin on October 1, 2013 and Exchanges must be able to support enrollment by this date. [§155.410((b), Overview p. 21]
- Exchanges must certify QHPs prior to the open enrollment periods. [§155.1010(c)]
- By December 22, 2013, Exchanges must ensure a coverage date of January 1, 2014. [§155.410(c)(1)]
- While the regulations did not set a specific date, HHS is seeking comments on the date by which Navigator programs should be operational. HHS is proposing "no later than the first day of the initial open enrollment period."[Overview pp. 48-49]
- In addition, the regulations describe the process HHS will use to determine if a state is prepared to operate an Exchange. HHS will require Exchanges to submit a formal readiness plan and complete the HHS readiness assessment. The assessment process for receiving approval (or conditional approval) has not been established. HHS is considering a 90-day review period and is seeking comments on the review process and timeline. [§155.105(b),§155.105(c) and Overview p. 23]
- Once an Exchange is approved, it must receive written approval from HHS before making any significant changes. HHS is considering using the Medicaid/CHIP State Plan Amendment process and seeks comments on this approach. [§155.105(e), Overview p. 23]

10. Federal Exchange

States that do not show adequate progress in developing state-based Exchanges by January 2013 will have their Exchange administered by the federal government. To date, HHS has provided few details about the federal Exchange. The regulations:

- Codify the ACA requirement that states without approval (or conditional approval) will participate in the federal Exchange. The federal Exchange may be run by HHS or through a non-profit. [§155.105(f)]
- Are not explicit about how the federal Exchange will operate, except to note that the federal Exchange will perform the same general functions as state Exchanges. [§155.105(f)]
- Clarify that states that have not created Exchanges by January 1, 2013 will be allowed to do so at a later date. They will be required to get approval, or conditional approval, from HHS 12 months prior to the effective date of coverage. [§155.106(a)]
- Any Exchange that plans to cease operations must notify HHS at least 12 months prior to closure and must develop a transition plan with HHS. [§155.106(b), §155.106(b)]

The regulations could better protect consumers by:

- Further explaining the process by which HHS will determine if states will participate in the federal Exchange.
- Detailing how the federal Exchange will operate with state programs, including Medicaid.