

State-based Exchanges (SBE)

January 2013 (*Updated*)

The Affordable Care Act (ACA) establishes a health insurance exchange in every state. Exchanges are new competitive marketplaces offering an array of comprehensive health insurance plans for eligible small businesses and individuals, some of whom may qualify for federal tax credits to help cover the cost of coverage. Each exchange will be operated either by the state as a State-based Exchange (SBE), or by the federal government as a Federally facilitated Exchange (FFE). States also have the option to engage in a partnership with the FFE, resulting in a Partnership Exchange. The U.S. Department of Health and Human Services (HHS) — the federal agency charged with overseeing state development of exchanges as well as with administering the Federally facilitated Exchange — has issued guidelines that define the standards and options for states establishing a State-based Exchange.

While there are a number of functions and standards that are *required* for a state to obtain HHS approval of its exchange, there are many areas in which a state has significant flexibility to customize its exchange to best meet the needs of its residents. This guide outlines these decision points and is intended to aid state consumer advocates, policymakers and other stakeholders involved in State-based Exchange implementation. It encompasses the following areas in which states have various levels of flexibility:

- Exchange establishment
- Consumer assistance
- Plan management
- Eligibility and enrollment
- Small Business Health Options Program (SHOP)
- Essential Health Benefits (EHB)
- Basic Health Program (BHP)
- Risk adjustment and reinsurance

States interested in operating a State-based Exchange (SBE) must submit an Exchange Blueprint¹ to HHS for approval. The Blueprint outlines the required elements for which a state must demonstrate established policies and operational readiness. States seeking to launch an exchange in 2014 were required to submit their Blueprint by December 14, 2012; however, states that declined to operate an SBE in 2014 may apply to do so for a subsequent year. Several states have already received conditional approval of their exchange proposals² and are finalizing many of the policy decisions as part of their ongoing implementation activities. Such information may provide useful examples to other states as they consider how to design and structure their SBE and how to address the many decision points outlined in this guide.

¹ [Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges](#).

² See [Status of State Health Insurance Exchange Implementation](#) (Center on Budget and Policy Priorities)

How to Use This Guide

This guide summarizes the areas in which federal guidelines specifically defer to states for a final policy decision or offer states flexibility to enhance or tailor a particular State-based Exchange element. The guide, which will be updated periodically to reflect additional federal guidelines and requirements, is intended as a tool for stakeholders to identify policy recommendations regarding each of these areas. State decision points arise from rules (either proposed, interim final, or final) as well as guidance and other sub-regulatory notices issued by the federal government (see below). Where possible, questions listed in this guide include citations to the corresponding regulation or subregulatory guidance.

Relevant Federal Rules and Subregulatory Guidance

Health Insurance Exchanges

- [Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges](#)
- [45 CFR Parts 155, 156, and 157: Establishment of Exchanges and Qualified Health Plans: Exchange Standards for Employers](#) (Final and Interim Final rule)
- [45 CFR Parts 153, 155, 156, 157 and 158: HHS Notice of Benefit and Payment Parameters for 2014](#) (proposed rule)
- [Frequently Asked Questions on Exchanges, Market Reforms and Medicaid](#) (December 10, 2012)
- [Actuarial Value Calculator with Continuance Tables and Actuarial Value Calculator Methodology](#)

Essential Health Benefits and Private Market Reform

- [Essential Health Benefits Bulletin \(December 2011\)](#)
- [FAQ on Essential Health Benefits Bulletin](#) (December 2011)
- [Additional Information on Proposed State EHB Benchmark Plans](#)
- [45 CFR Parts 147, 155, and 156: Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation](#) (proposed rule)
- [45 CFR Parts 144, 147, 150, 154 and 156: Health Insurance Market Rules; Rate Review](#) (proposed rule)

Risk Adjustment and Reinsurance

- [Bulletin on the Risk Adjustment Program: Proposed Operations by the Department of Health and Human Services](#)
- [Bulletin on the Transitional Reinsurance Program: Proposed Payment Operations by the Department of Health and Human Services](#)
- [45 CFR Part 153: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment](#) (final rule)
- [45 CFR Parts 153, 155, 156, 157 and 158: HHS Notice of Benefit and Payment Parameters for 2014](#) (proposed rule)

Exchange Establishment

States interested in developing and operating a State-based Exchange (SBE) must commit to establishing both an individual market exchange and a SHOP exchange, and undergo a readiness review in advance of the start of the initial open enrollment period (which would start on October 1, 2013 for exchanges launching in 2014). Each state has the power to determine what kind of exchange it will operate as well as how it is structured, governed, and financed. States have flexibility in the following features of exchange design:

Exchange Structure

1. **Exchange model:** which exchange model will the state select? (45 CFR § 155.100)
 - a. State-based Exchange;
 - b. Partnership Exchange (partnering role in a Federally facilitated Exchange);³ or
 - c. neither (i.e. Federally facilitated Exchange).⁴
2. **Administration:** where will the state house the exchange? (§ 155.100)
 - a. new or existing government agency;
 - b. quasi-governmental agency (with an independent governing board); or
 - c. non-profit organization (with an independent governing board).
3. **Effective date:** in what year will the state launch its exchange? (§ 155.106)
 - a. 2014; or
 - b. after 2014 (i.e. 2015, 2016, or a subsequent year)
4. **Authority to Establish the Exchange:** by what means will the state authorize establishment of the State-based Exchange (SBE)?
 - a. legislation;
 - b. executive order; or
 - c. other.
5. **Regional exchange:** will the state partner with one or more other states to form a multi-state regional exchange? (§ 155.140)

Analysis

For additional analysis on exchange establishment legislation, please see: [State Health Insurance Exchange Laws: The First Generation](#) and [State Action to Establish Health Insurance Exchanges](#) (The Commonwealth Fund, July 2012)

³ See [State Partnership Exchange [LINK TO PARTNERSHIP GUIDE]] and [Guidance on the State Partnership Exchange](#).

⁴ See [General Guidance on Federally-facilitated Exchanges](#).

6. **Subsidiary exchanges:** will the state establish multiple exchanges in the state (if so, must be non-overlapping, cover the entire state in combination, and be at least as large as a geographic rating area)? (§ 155.140)

Governance

1. **Governing model:** how will the state arrange governance of the individual and the SHOP exchange? (§ 155.110)
 - a. single entity governing both programs; or
 - b. separate governing entities for individual exchange and SHOP exchange.

2. **Governing board size and appointment:** how many members (voting and non-voting) will there be on the governing board — if one is established — and how will members be nominated/selected?

3. **Governing board membership criteria:** what criteria, in addition to the minimum federal standards in the final rule, will the state use to define membership to the governing board? (§ 155.110)
 - a. prohibit any individuals with conflict of interest (e.g. insurers, brokers, providers, vendors);
 - b. limit the number of individuals with conflict of interest;
 - c. require a certain ratio or minimum number of representatives of consumer interest;
 - d. require a certain number of individuals with expertise; and/or
 - e. other.

4. **Governing board expertise areas:** what areas will the state define as requisite areas of expertise for board members in addition to those required in the final rules, listed below? (§ 155.110)
 - a. health benefits administration;
 - b. health care finance;
 - c. health plan purchasing;
 - d. health care delivery system administration;
 - e. public health; and
 - f. health policy issues related to the small group and individual markets and the uninsured.

5. **Governing principles:** what principles and standards will the state exchange develop in these areas, as required by the final rule? (§ 155.110)
 - a. ethics;
 - b. conflict of interest;

Analysis
For additional analysis on exchange governance, please see: Governing Issues for Health Insurance Exchanges (National Academy of Social Insurance, January 2011)

Analysis
For additional analysis on principles in exchange establishment, please see: Building a Consumer-Oriented Health Insurance Exchange: Key Issues (National Academy for State Health Policy, March 2012)

- c. accountability;
 - d. transparency; and
 - e. disclosure of financial interest.
6. **Governing board subcommittees**: what governing board subcommittees, if any, will the state exchange establish?
 7. **Governing board operations**: what policies will the state exchange establish for the following areas:
 - a. criteria for board officers, including chairperson;
 - b. initial and ongoing term limits of board members; and
 - c. quorum size.
 8. **Governing board authority**: what are the specific authority, functions, and responsibilities of the governing board?
 9. **Stakeholder consultation**: what process will be used to consult stakeholders and how frequently? (§ 155.130)
 10. **Advisory boards**: what formal advisory boards, if any, will the state establish to advise in exchange implementation and operations (including, but not limited to, the following)?
 - a. plan management;
 - b. consumer assistance;
 - c. eligibility and enrollment;
 - d. SHOP;
 - e. operations;
 - f. stakeholder-based (i.e. consumers, insurers, brokers, providers, etc); and/or
 - g. other.
 11. **Advisory board structures**: how will the state structure the advisory board, including the following areas:
 - a. role(s) of advisory board(s);
 - b. membership; and
 - c. duration (temporary or permanent).

Exchange Operations

1. **Rulemaking authority**: what authority will the state grant the exchange in terms of rulemaking?

2. **Administrative procedure authority**: what authority (or exemptions from state administrative procedure laws) will the state grant to the state exchange for the following administrative functions:
 - a. contracting and procurement;
 - b. human resources; and
 - c. other.

3. **Contracting functions**: with which eligible entities and for what functions, if any, will the state seek to contract? (§ 155.110)
 - a. Medicaid agency;
 - b. Department of Insurance;
 - c. other state agencies;
 - d. local counties or city governments; and/or
 - e. private vendors.

Financing

1. **Financing model**: what financing model(s) will the exchange use? (§ 155.160)
 - a. user fees/assessment on premium revenue of QHP issuers;
 - b. assessment on premium revenue of all individual market and small group issuers licensed in the state;
 - c. assessment on premium revenue of all issuers licensed in the state;
 - d. user fees on QHP consumers;
 - e. redirect a portion of revenue from existing state insurer tax(es);
 - f. redirect appropriated funds for expiring state health care program(s) or high risk pool;
 - g. website advertising sales;
 - h. general fund revenues; and/or
 - i. other.

2. **Financing notice to issuers**: how and when will the exchange notify issuers of any assessment (if one is used)? (§ 155.160)

3. **Financing and exchange markets**: how will the state apply any assessments to the individual exchange and SHOP exchange issuers?
 - a. uniform assessment on all issuers; or
 - b. different assessments on issuers in individual market and SHOP.

4. **Waste, fraud, and abuse monitoring**: how will the state exchange monitor for waste, fraud, and abuse?

Additional Resources

[Health Insurance Exchanges Under the Patient Protection and Affordable Care Act \(ACA\)](#)

(Congressional Research Service, January 2013)

[Exchange Implementation Workplan](#) (State Health Reform Assistance Network, September 2012)

[Establishing Health Insurance Exchanges: Three States' Progress](#) (Commonwealth Fund, July 2012)

[State Milestones for ACA Implementation](#) and [Overview of Final Exchange Regulations](#) (State Health Reform Assistance Network, April 2012)

[State Progress Toward Health Reform Implementation: Slower Moving States Have Much to Gain](#) (Urban Institute, January 2012)

[Sustaining Support For Exchange Directors: Models, Options, and Lessons](#) (National Academy for State Health Policy, January 2012)

[Options for Governance and Oversight](#) (Families USA, April 2011)

[Health Insurance Exchange Basics](#) (National Academy for State Health Policy, February 2011)

[Designing an Exchange: A Toolkit for State Policymakers](#) (National Academy of Social Insurance, January 2011)

Consumer Assistance

Exchanges must provide a number of resources to assist consumers in evaluating and obtaining coverage, including outreach and education, a website, a call center, a premium calculator and direct assistance in the form of Navigators, In-person Assisters, and Certified Application Counselors. Additionally, exchanges have the option to incorporate a role for insurance agents and brokers, who function in the current commercial marketplace. While there are certain standards for performance, training, availability, accessibility, and privacy, states have flexibility in developing specific aspects of consumer assistance to best support consumers interested in obtaining coverage. States can design the following aspects of an exchange's consumer assistance strategies:

Outreach and Education

1. **Outreach and education plan:** what are the state's plans for outreach, education, and marketing plans to inform consumers about options for coverage and insurance affordability programs?
2. **State-specific branding:** what branding will the state develop for outreach, education, online, and consumer assistance aspects of the exchange, including, but not limited to, the following?
 - a. exchange name;
 - b. logo; and
 - c. URL/web address;

Consumer Assistance Tools

1. **Call center design:** how will the state design its call center (including, but not limited to, the following elements)? (45 CFR § 155.205)
 - d. staffing and structure;
 - e. training and scope of responsibility;
 - f. policies and procedures; and
 - g. technology and equipment.
2. **Online Web Portal:** how will the state structure the online webportal used by consumers to apply for and select QHP coverage?
3. **Plan selection tools:** what tools will the state provide consumers to help evaluate health plan options? (§ 155.205)

Analysis

For additional analysis on plan selection tools, see: [Choice Architecture Design Decisions that Affect Consumers' Health Plan Choices](#) (Consumers Union, July 2012)

Navigator Grant Program

Exchanges are required to operate a navigator grant program that provides funding to entities or individuals to assist consumers in applying for and obtaining coverage through the exchange. Each exchange must fund at least two grantees, at least one of which must be a community and consumer-focused non-profit organization. The exchange must design a training program that covers certain minimum core competencies. Additionally, navigator programs must comply with exchange privacy and security standards and be accessible to persons with disabilities and those with limited English proficiency. States can further define the navigator grant program in the following areas:

1. **Navigator eligibility criteria:** what eligibility criteria – in addition to the minimum standards in the final rule – will the state adopt for navigators? (§ 155.210)
2. **Navigator entities:** which entities will be permitted to serve as navigators? (§ 155.210)
 - a. individuals;
 - b. organizations;
 - c. public entities;
 - d. other.
 - e.
3. **Navigator selection:** how will the exchange select navigators, including, but not limited to, the following considerations?
 - a. number and amount of grant awards;
 - b. priority areas and/or target populations (individuals and/or small employers); and
 - c. application process and selection criteria.
4. **Navigator certification:** will the state create and apply a certification or licensing process for navigators? (§ 155.210)
5. **Navigator training content:** what will be included in the requisite training program for navigators? (§ 155.210)
6. **Navigator training availability:** what parts of the training program, if any, will the exchange make available to entities that wish to receive training but are not funded as Navigators? (§ 155.210)
7. **Oversight of navigator training and certification:** which entity will oversee training and certification (if any) of navigators? (§ 155.210)
 - a. exchange;
 - b. Department of Insurance; and/or

Analysis

For additional analysis on structuring outreach and consumer assistance see: [Key Issues to Consider for Outreach and Enrollment Efforts under Health Reform](#) (Kaiser Family Foundation, February 2012)

Analysis

For additional analysis on developing a Navigator program, see: [Building on a Solid Foundation: Leveraging Current Programs and Infrastructure in Navigator Program Development](#) (State Health Reform Assistance Network, August 2012)

c. other.

8. **Navigator scope of work:** what specific functions and services will navigators provide to consumers in the individual exchange and the SHOP? (§ 155.210)

9. **Conflict of interest standards:** what conflict of interest standards will the state develop and apply to navigators? (§ 155.210)

10. **Navigator performance monitoring:** how will the exchange oversee and monitor the performance of navigators? (§ 155.210)

Analysis
For additional analysis on navigator and assister scope of work, see: Help Wanted: Preparing Navigators and Other Assisters to Meet New Consumer Needs (Families USA, December 2012)

11. **Navigator payment:** how will the exchange structure payments to navigator grantees (e.g. fixed grant amount, performance-based grant, hybrid of both payment structures, etc.)? (§ 155.210)

12. **Financing of navigator grant program:** how will the state fund the grant awards to navigators (federal exchange establishment grant funds are limited to the design and management of the navigator grant program; they cannot be used for actual awards to navigator entities)? (§ 155.210)

13. **Display of navigator information:** how will the state display information to consumers regarding the availability of navigators?

Analysis
For additional analysis on structuring outreach and consumer assistance see: Key Issues to Consider for Outreach and Enrollment Efforts under Health Reform (Kaiser Family Foundation, February 2012)

14. **Other application assistance:** what other entities, if any, will be permitted to provide application assistance to consumers?

In-person Assister Program

HHS encourages states to develop an In-person Assister (IPA) program, separate and distinct from the Navigator Grant Program, to expand capacity for consumer assistance. In-person Assisters will perform activities to educate the public about coverage options and assist consumers in applying for and enrolling in exchange coverage. States are permitted to seek exchange establishment grant funding to support the IPA program, and has flexibility in the following design and operational areas:

1. **In-person Assister eligibility criteria:** what eligibility will the state adopt for in-person application assisters?

2. **In-person Assister entities**: which entities will be permitted to serve as in-person application assisters?
 - a. individuals;
 - b. organizations;
 - c. public entities; and/or
 - d. other.

3. **In-person Assister selection**: how will the state select in-person application assisters, including, but not limited to, the following considerations?
 - a. number of and amount awards;
 - b. priority areas and/or target populations (individuals and/or small employers); and
 - c. application process and selection criteria.

4. **In-person Assister certification**: will the state create and apply a certification or licensing process for in-person application assisters?

5. **In-person Assister training**: what will be included in the requisite training program for in-person application assisters?

6. **Oversight of In-person Assister training and certification**: which entity will oversee training and certification (if any) of in-person application assisters?
 - a. exchange;
 - b. Department of Insurance; and/or
 - c. other.

7. **In-person Assister scope of work**: what specific functions and services will in-person application assisters provide to consumers in the individual exchange and the SHOP?

8. **In-person conflict of interest standards**: what conflict of interest standards will the state develop and apply to in-person application assisters?

9. **In-person Assister monitoring**: how will the state oversee and monitor the performance of in-person application assisters?

10. **In-person Assister payment**: how will the state structure payments to in-person application assisters (e.g. fixed grant amount, performance-based grant, a hybrid of both payment structures, etc.)?

11. **Display of In-person Assister information**: how will the state display information to consumers regarding the availability of in-person application assisters?

Analysis
<p>For additional analysis on assisters, see: Filling in Gaps in Consumer Assistance: How Exchanges can use Assisters (Families USA, November 2012).</p>

12. **Coordination with Navigator Program:** how will the state coordinate the In-person Assister Program with the Navigator program to avoid duplication and ensure maximum service to the community?
13. **Other application assistance:** what other entities, if any, will be permitted to provide application assistance to consumers?

Agents and Brokers

States have the option to permit agents and brokers to work with their exchanges and to define what role they will play in the individual-market exchange and the SHOP. If a state allows brokers to assist individuals in enrolling in QHPs, certain procedures and standards will apply, including the requirement for brokers to register with the exchange, receive training on QHP options and insurance affordability programs, and comply with certain privacy and conflict of interest standards. When considering a role for brokers in an exchange, states have a number of options, including:

1. **Role of brokers:** which of the following roles will the state permit brokers to play in assisting consumers that seek coverage through the exchange? (§ 155.220)
 - a. assist individuals in selecting and enrolling into a QHP;
 - b. assist individuals in applying for advance premium tax credits (APTC) and cost sharing reductions (CSRs);
 - c. assist employers in applying to and selecting plan(s) in the SHOP; and/or
 - d. no role.
2. **Web-based brokers:** will the state permit web-based brokers to play a role in offering exchange plans, and what additional requirements, if any, will be set? (§155.220)
3. **Oversight of broker registration:** which entity will oversee broker registration?
 - a. exchange;
 - b. Department of Insurance; or
 - c. other.
4. **Broker training:** what will be the training program for brokers assisting individuals in addition to the minimum standards in the final rule? (§ 155.220)
5. **Broker assistance to individuals that do not enroll in QHPs:** what requirements or standards will apply to brokers that assist individuals who may be or are found to be eligible for Medicaid, CHIP or Basic Health (if applicable) or those who will not enroll in any coverage and/or may seek assistance obtaining an exemption from the individual responsibility requirement?

Analysis

For additional analysis on agent and broker issues, see: [Recommended Consumer Protections for Web-based Agents and Brokers Offering Exchange Coverage](#) (Consumers Union, September 2012)

6. **Administering broker payments**: what entity will pay broker commissions?
 - a. QHP issuers;
 - b. exchange;
 - c. both entities (may vary between Individual Market Exchange and the SHOP); or
 - d. other.

7. **Broker enrollment responsibilities**: what standards will the state apply for brokers assisting consumers in the exchange ?
 - a. brokers must display and facilitate enrollment into all QHPs available in the exchange regardless of appointments in the market outside the exchange
 - b. brokers may restrict the display of and limit enrollment into only those QHPs offered by issuers with which the broker has appointments; or
 - c. other.

8. **Broker compensation level**: how will the state set the level of broker compensation?
 - a. fees must mirror what issuers pay brokers for enrollment into similar plans offered in the market outside the exchange;
 - b. fees must meet certain standards or fall within specified ranges established by the exchange;
 - c. fees will be set based on a fee schedule established by the exchange;
 - d. fees are set by the issuers and/or issuer-broker negotiations subject to exchange requirements;
 - e. no exchange policy or oversight of broker fees; and/or
 - f. other.

9. **Monitoring and enforcement of broker activity**: how will the state monitor broker performance and compliance with federal and state standards for working with the exchange?

10. **Presentation of broker information**: will the exchange list registered brokers on the exchange website, and if so, in what manner? (§ 155.220)

Additional Resources

[Top Ten Best Practices for State Reform Websites](#) (State Health Reform Assistance Network, November 2012)

[Recommended Consumer Protections for Web-Based Agents and Brokers Offering Exchange Coverage](#) (Consumers Union, September 2012)

[Making Health Insurance Choices Understandable for Consumers](#) (Consumers Union, February 2011)

[Navigators: Guiding People Through the Exchange](#) (Community Catalyst, June 2011)

Plan Management

The Affordable Care Act and the final rule on exchanges include significant details about the federal standards a plan must meet in order to be certified as a QHP and offered in an exchange. These include providing coverage that meets certain actuarial values, covering the Essential Health Benefits, and adhering to requirements on premium rating standards, transparency, accreditations, premium rating areas and geographic service areas, among others. However, much is left to the state to determine the specific standards and process for QHP certification and monitoring, including:

QHP Certification

1. **Oversight of QHP certification**: which entity will have primary responsibility for functions associated with the certification and monitoring of QHPs?

(45 CFR § 155.1000)

- a. exchange;
- b. Department of Insurance; and/or
- c. other.

2. **Selecting plans in the best interest of consumers**: how will the state determine that a plan is “in the best interest of consumers?” (§ 155.1000)

3. **QHP certification standards in subsidiary exchanges**: if a state establishes multiple subsidiary exchanges in the state, how will it apply QHP certification standards? (§ 155.1000)

- a. apply uniform standards and/or process in all subsidiary exchanges; or
- b. establish different standards and/or processes in each subsidiary exchange.

4. **QHP certification process**: what process will the state use to select QHPs to be offered in the exchange? (§ 155.1010)

- a. certification of all plans that meet minimum QHP standards set forth by HHS;
- b. certification of all plans that meet federal QHP standards and additional standards set by state;
- c. selective contracting with several plans that meet QHP standards;
- d. competitive procurement for plans that meet QHP standards, selected based on price, quality, and other factors;
- e. require some or all insurers licensed in the state to offer QHPs in the individual and SHOP exchange markets;
- f. require that all individual and small group market plans be QHPs sold only through the exchange; or
- g. other.

Analysis

For additional analysis on Plan Management considerations, please see: [Plan Management: Issues for State, Partnership, and Federally Facilitated Health Insurance Exchanges](#) (Georgetown University Health Policy Institute, May 2012)

Analysis

For additional analysis on QHP certification options for states, please see: [Active Purchasing for Health Insurance Exchanges](#) (Georgetown University Health Policy Institute, June 2011)

5. **QHP certification criteria**: what QHP certification criteria, if any, will the state develop in addition to minimum standards set in the final rule? (§ 155.1010)

6. **QHP certification timeline**: what timeline will the state use for certification of QHPs? (§ 155.1010)

7. **QHP certification compliance monitoring**: how will the state monitor QHPs for ongoing compliance with certification criteria? (§ 155.1010)

8. **QHP certification criteria for individual market and SHOP Exchanges**: how will the QHP certification criteria and process be applied to the individual and SHOP exchanges? (§ 155.1010)

- apply uniform criteria and process for the individual and SHOP exchanges; or
- establish different criteria and/or processes for the individual and SHOP exchanges.

9. **QHP issuer participation in exchange markets**: what participation requirements, if any, will the state apply to issuers seeking QHP certification?

- require QHP issuers to offer plans in both the individual market exchange and SHOP; or
- permit QHP issuers to offer in one or both markets.
- other.

10. **Geographic rating areas**: what standards will the state establish regarding geographic rating areas for plans sold in the individual and small group markets, including QHPs? (§ 147.102)

- one rating area for the state;
- multiple rating areas (up to seven) based on federal standards for geographic divisions; or
- an alternate standard approved by HHS.

11. **Geographic service areas**: what standards will the state establish regarding geographic service areas for plans sold in the individual and small group markets, including QHPs?

- QHP issuers must offer QHPs throughout a state;
- QHPs must be available throughout each geographic rating area where the issuer offers a QHP;
- each issuer must offer a QHP in each geographic rating area where it offers a product outside the exchange;
- QHP issuers may determine their own service areas; or
- other

12. **Merging individual and small-group markets**: will the state merge the individual and small-group markets into a combined risk pool?? (§ 155.705)

Analysis

For additional analysis on effective QHP certification standards, please see: [Consumer-Friendly Standards for Qualified Health Plans in Exchanges: Examples from the States](#) (Families USA, January 2013)

13. **Mitigating adverse selection between the exchange and outside markets:** what strategies, if any, will the state use to mitigate adverse selection between the exchange and the markets outside the exchange? (§ 155.1010)
- apply exchange QHP standards to all individual and small group market plans sold outside the exchange;
 - allow the sale of certain plans (such as catastrophic or other high deductible plans) only in the exchange;
 - require insurers in the individual and small group market inside and outside the exchange to sell plans at all coverage levels (Bronze, Silver, Gold etc.);
 - require QHP issuers to sell all of their exchange plans in the markets outside the exchange;
 - require all individual and small group issuers to participate in the exchange;
 - require that all individual and/or small group plans only be sold through the exchange;
 - establish policies that minimize or eliminate any incentive for brokers to steer individuals into or away from the exchange; and/or
 - other.

Analysis

For additional analysis on how states can mitigate adverse selection for the exchange, please see: [States Should Structure Insurance Exchanges to Minimize Adverse Selection](#) (Center on Budget and Policy Priorities, August 2010)

14. **Mitigating adverse selection among plans within the exchange:** what additional strategies, if any, will the state use to mitigate adverse selection among QHPs sold in the exchange?

Analysis

For additional analysis on how states can mitigate adverse selection between exchange QHPs, please see: [States Should Take Additional Steps to Limit Adverse Selection Among Health Plans in an Exchange](#) (Center on Budget and Policy Priorities, June 2011)

- limit or prohibit insurer flexibility on benefits and cost-sharing;
- require issuers to offer QHPs in all four precious metal levels within the exchange;
- conduct strict monitoring of issuer plan design, marketing, and other potentially discriminatory practices beyond minimum federal standards; and/or
- other.

15. **Streamlining QHP Design Options and Offerings:** what level of standardization, if any, will the state require of issuers to streamline QHP offerings in the exchange?

- require all QHPs to meet a standardized plan design for each metal level;
- require QHP issuers to offer at least one standardized plan design for each metal level, and a limited number of non-standardized plan offerings;
- require QHP issuers to offer at least one standardized plan design at certain metal levels (e.g. gold and silver, just silver etc) and a limited number of other plans at

Analysis

For additional analysis on optimizing QHP options, please see: [The Evidence Is Clear: Too Many Health Insurance Choices Can Impair, Not Help, Consumer Decision Making](#) (Consumer's Union, October 2012)

- any metal level;
- d. require QHP issuers to offer up to a limited number of plans at each metal level
- e. require no limitations on QHP design and offerings; and/or
- f. other

QHP Issuer Oversight and Monitoring

16. **QHP rate review:** with what process and timeline will the state conduct the review of QHP rates? (§ 155.1020)
17. **QHP transparency:** how will the state monitor and enforce transparency requirements for QHPs? (§ 155.1040)
18. **QHP marketing and benefit design review:** how will the state monitor and enforce requirements that QHPs not use marketing or benefit design strategies that discourage enrollment by individuals with significant health needs? (§ 156.225)
19. **QHP issuer accreditation:** what accreditation entity(ies) and with what timeline will the state set for QHP issuers to become accredited? (§ 155.1045)
20. **Network adequacy standards:** what standards and process will the state apply to ensure QHP network adequacy? (§ 155.1050, § 156.230)
21. **Essential Community Providers:** what standards and process will the state apply for ensuring that Essential Community Providers are sufficiently included in every QHP? (§ 156.235)
22. **QHP service areas:** what process will the state use for setting or evaluating QHP service areas? (§ 155.1055)
23. **QHP recertification:** what process, timeline and frequency will the state use to recertify QHPs? (§ 155.1075)
24. **QHP decertification:** what process will the state use to decertify QHPs that are no longer in compliance with certification criteria? (§ 155.1080)
25. **Appeals of QHP decertification:** what process will the state use for QHP issuer appeals of decertification? (§ 155.1080)

Additional Resources

[Health Insurance Market Reforms: Rate Review](#) (Kaiser Family Foundation, December 2012)

[The Evidence is Clear: Too Many Choices Can Impair, Not Help, Consumer Decision Making](#) (Consumers Union, November 2012)

[Actuarial Value Under the Affordable Care Act: Plan Valuation with the Consumer in Mind](#) (Consumers Union, June 2012)

[Creating A Usable Measure Of Actuarial Value](#) (Consumers Union, January 2012)

[Mitigating Risk in a State Health Insurance Exchange](#) (Blue Cross and Blue Shield Foundation of Massachusetts, December 2011)

[Medicaid Managed Care: How States' Experience Can Inform Exchange Qualified Health Plan Standards](#) (Center for Health Care Strategies, November 2011)

[Selecting Plans to Participate in an Exchange](#) (Families USA, February 2011)

Eligibility and Enrollment

To obtain coverage through an exchange, individuals must apply and be determined eligible. Exchanges must provide an eligibility and enrollment process that is seamless and features a “no-wrong door” approach, which ensures that all individuals are screened for eligibility for all insurance affordability programs including Medicaid, the Children’s Health Insurance Program (CHIP) and advance premium tax credits (APTC) and cost sharing reductions (CSR). Individuals who are not seeking financial assistance must still apply to enroll in a QHP and show that they reside in the state, are not incarcerated and are US citizens or lawfully present immigrants. While there are extensive federal guidelines governing the eligibility determination process, application form, notice requirements, and collection of premiums, HHS has provided states with a number of options in their structure and design, including:

Eligibility Determination and Enrollment Process

1. **Options for conducting eligibility determinations:** which entity(ies) will conduct eligibility determinations for exchange QHPs/subsidies and MAGI-based Medicaid/CHIP?⁵ (45 CFR § 155.302)
 - a. exchange determines eligibility for QHPs/APTC/CSR as well as MAGI-based Medicaid/CHIP;
 - b. exchange contracts with a state agency to determine eligibility for all insurance affordability programs;
 - c. exchange determines eligibility for QHP/APTC/CSR; state agency(ies) determines eligibility for Medicaid/CHIP; or
 - d. exchange uses the HHS Federally-managed service to determine eligibility for APTC/CSR; state agency(ies) determines eligibility for Medicaid/CHIP.
2. **Federal eligibility services:** if using the federally-managed service to determine eligibility for APTC/cost-sharing reductions, which entity will verify eligibility, provide notices and carry out other activities related to the eligibility determination? (§ 155.302)
 - a. exchange; or
 - b. HHS.
3. **Eligibility and enrollment IT Systems:** how will the state structure its IT systems for eligibility and enrollment?
 - a. upgrade the existing Medicaid or integrated eligibility and enrollment IT infrastructure to allow for exchange eligibility determinations;

Analysis

For additional analysis on state options in structuring eligibility and enrollment, please see: [Federal Requirements and State Flexibilities for Verifying Eligibility Criteria](#) (State Health Reform Assistance Network, May 2012)

⁵ See Appendix for breakdown of state options in structuring eligibility and enrollment for insurance affordability programs.

- b. develop or purchase a new separate IT system for exchange eligibility determinations that integrates with existing Medicaid or integrated eligibility and enrollment IT infrastructure;
 - c. develop or purchase a new IT system to perform eligibility determinations for both Medicaid and other public assistance and the exchange; or
 - d. other.
4. **Contracting services**: whether and to what extent will the state contract with outside vendors to perform eligibility determination functions for the exchange, subject to federal requirements? (§ 155.302)
 5. **Attestation as verification**: for which eligibility factors, if any, will the state accept attestation as verification, subject to federal requirements?
 6. **Data sources for verification of eligibility factors**: which data sources (including the federal data hub), will the state use to verify eligibility factors? (§ 155.315)
 7. **Modification of eligibility verification**: what modifications, if any, will the state apply to the eligibility verification process (must show that modification would reduce administrative costs and burdens on individuals)? (§ 155.315)
 8. **“Reasonable compatibility” standard**: how will the state implement “reasonable compatibility” and resolve inconsistencies when the attestation and verified information differ in a way that could affect eligibility for insurance affordability programs?
 9. **Threshold for report of changes in information**: will the exchange apply a threshold for reporting changes? (§ 155.330)
 10. **Report of changes in information**: will the exchange make “additional efforts to identify and act on changes” that may affect eligibility for QHPs or insurance affordability programs (must meet same standards as for modification of verification methods)? (§ 155.330)

Analysis
<p>For additional analysis on “reasonable compatibility standards in eligibility and enrollment, please see: “Reasonable Flexibility: Exploring Models to Help States Resolve Inconsistencies in Income for Medicaid, CHIP and Tax Credit Eligibility” (National Academy for State Health Policy Webinar, July 2012)</p>

Application Forms

1. **Application forms**: which standardized application forms will the state adopt? (§ 155.405 and 435.907)
 - a. single streamlined application form developed by HHS; and/or
 - b. state-developed alternative form (subject to HHS standards and approval).

2. **State-developed alternative application form:** if the state uses alternative application form(s), for what purposes will they be used? (§ 155.405)
 - a. for eligibility determination for exchange QHPs/APTC and MAGI Medicaid/CHIP;
 - b. for eligibility determination for exchange QHPs/APTC, MAGI Medicaid/CHIP and non-MAGI Medicaid; and/or
 - c. for eligibility determination for exchange QHPs/APTC, MAGI Medicaid/CHIP, non-MAGI Medicaid and other public benefit programs (e.g. TANF, SNAP etc.).

3. **Non web-based applications:** how will the exchange handle non-web based applications submitted via other means including but not limited to, the ones below? (§ 155.405)
 - a. mail (*required*);
 - b. telephone (*required*);
 - c. in-person (*required*);
 - d. mobile device/smart phone applications; and/or
 - e. other.

Notices

1. **Notice information:** what will the state include in notices that are required to be sent to applicants and enrollees? (§ 155.230)

2. **Notification format:** how will the state send notices to intended recipients? (§ 155.230)
 - a. electronic;
 - b. written; and/or
 - c. other.

Appeals Process

1. **Exchange appeals process:** how will the state structure its process for handling applicant appeals of exchange eligibility determinations? (§ 155.505)

Premium Payment

1. **Premium payment from qualified individuals:** how will the exchange structure the collection of premium payments from qualified individuals (note: individuals must be permitted to have the option to pay premiums directly to QHP issuers)? (§ 155.240)
 - a. only QHP issuers will bill and collect premiums;
 - b. only the exchange will bill and collect premiums on

Analysis

For additional analysis on state considerations on appeals, please see: [Optimizing Consumer Protections in State Health Insurance Exchanges](#) (The Community Services Society of New York, October 2012)

Analysis

For additional analysis on state options for premium collection, please see: [Premium Collection in State Based Exchanges](#) ((State Health Reform Assistance Network, January 2013)

- behalf of QHP issuers;
 - c. enrollees will have the option to receive bills from and make payments directly to QHP issuers or the exchange;
 - d. exchange will bill and collect first premium (to complete enrollment); QHP issuers will bill and collect all subsequent premiums; or
 - e. other.
2. **Premium payment process for qualified individuals:** if a state permits premium payment from enrollees through the exchange, what process(es) will be used? (§ 155.240)
- a. wire or electronic transfer (automated or per transaction);
 - b. mail (check, money order, or credit card);
 - c. in person (check, money order, credit card, or cash);
 - d. telephone (credit card); and/or
 - e. other.
3. **Payment from tribal nationals for qualified individuals:** will the state permit tribal nations to make aggregated premium payments on behalf of a group of tribal members (with accompanying terms and conditions)? (§ 155.240)
4. **Grace period for qualified individuals:** what grace period for non-payment of premiums will the state apply for enrollees who do not receive a subsidy? (§ 155.430)

Additional Resources

[State Experiences with Express Lane Eligibility: Policy Considerations and Possibilities for the Future](#) (National Academy for State Health Policy, December 2012)

[Eligibility and Enrollment Systems: An Advocate's IT Toolkit](#) (Georgetown Center for Children and Families, November 2012)

[Potential Roles for Safety Net Providers in Supporting Continuity Across Medicaid and Health Insurance Exchanges](#) (National Academy for State Health Policy, September 2012)

[Coordinating Human Services Programs with Health Reform Implementation](#) (Center on Budget and Policy Priorities, June 2012)

[Federal Requirements and State Flexibilities for Verifying Eligibility Criteria](#) (State Health Reform Assistance Network, May 2012)

[SHAP Enrollment and Eligibility Activities: Implications for Process and System Modernization under National Health Reform](#) (State Health Access Data Assistance Center, May 2012)

[The Paradigm Shift: Electronic Eligibility Verification for Health Insurance Exchanges](#) (Health Management Systems, May 2012)

[The Ideal Application Process for Health Coverage](#) (Enroll America, February 2012)

[Building a Relationship between Medicaid, the Exchange and the Individual Insurance Market](#) (National Academy of Social Insurance, January 2012)

Small Business Health Options Program (SHOP)

Each exchange must establish a Small Business Health Options Program (SHOP) to provide coverage options for qualified small employers with at least one employee (i.e. a group of 2 or more). The SHOP must allow employers to apply for coverage on an ongoing basis throughout the year and utilize uniform forms for employer application and employee enrollment. The SHOP must also provide a premium calculator displaying the cost of various coverage options and provide a mechanism for collecting aggregated premium payment from employers. However, a number of SHOP design elements are delegated to the state regarding employer eligibility, application and enrolment, employer plan selection and other details. Specifically, these include:

1. **Small employer size:** what will the state select as the maximum number of employees a small employer may have to be eligible for the SHOP exchange prior to 2016 (after which it must be 100)? (45 CFR § 155.20)
 - a. 50; or
 - b. 100.
2. **Large group market:** will the state expand SHOP eligibility to permit large employers to purchase coverage in the exchange in 2017 or later? (§ 155.705)
3. **Employee choice options:** what option(s) will a state make available to employers in terms of offering choice of plans for employees? (§ 155.705)
 - a. employers selects one plan tier (e.g. bronze, silver, gold, or platinum) from which employees can select a plan (*required*);
 - b. employer selects just one plan for all employees;
 - c. employer selects multiple plans within or across plan tiers from which employees can select a plan;
 - d. employer selects one issuer and makes all plans from that issuer available to employees; and/or
 - e. employer makes all plans in the SHOP exchange available to employees.
4. **Employer Contribution:** how will the state structure options for employer contributions to employee premiums, subject to nondiscrimination requirements?
 - a. allow employers to designate a benchmark reference plan under which the contribution will be based on a percentage of the age-adjusted rate;
 - b. allow employers to set the contribution as a percentage of a composite rate (if employer selects just one QHP);
 - c. allow employers to set the contribution as a defined fixed amount per employee;
 - d. allow employers to designate a fixed amount for the *employee* contribution and cover the balance of the premium costs; and/or
 - e. other.

Analysis

For additional analysis on employee choice architecture, see [Design Considerations in Structuring Employee Choice for SHOP Exchange](#) (State Health Reform Assistance Network, December 2012)

Analysis

For additional analysis on state options in structuring the SHOP Exchange, please see: [SHOPping Around - Setting up State Health Care Exchanges for Small Businesses: A Roadmap](#) (Center for American Progress and the Small Business Majority, July 2011)

5. **Merging markets**: will the exchange merge the individual and SHOP markets into a combined risk pool or maintain separate pools? (§ 155.705)
6. **Minimum participation**: what, if any, minimum participation rate will the SHOP require of Qualified Employers and how will it be calculated? (§ 155.705)
7. **SHOP QHP rate changes**: with what frequency will the SHOP permit issuers to change rates? (§ 155.705)
 - a. monthly;
 - b. quarterly; or
 - c. annually.
8. **Premium calculator**: how will the state design the premium calculator for Qualified Employers and Qualified Employees? (§ 155.705)
9. **Enrollment timeline**: what timeline and process will the SHOP set for Qualified Employers to apply, make plan selections, and enroll in SHOP QHPs? (§ 155.720)
10. **Grace period**: what grace period for non-payment of premiums will the state apply for Qualified Employers and Qualified Employees? (§ 155.720)
11. **Reconciliation of enrollment information**: how frequently will the exchange reconcile enrollment and employer information with issuers (HHS rules require no less than monthly)? (§ 155.720)
12. **Annual employer election period**: for what period of time and at what point will the exchange provide qualified employers the opportunity to select plan options for the subsequent plan year (must be for at least 30 days, commencing no later than 30 days in advance of the end of the current plan year)? (§ 155.725)
13. **SHOP application forms**: which application form will the exchange use for employers and employees? (§ 155.730)
 - a. model single employer application and model single employee application forms provided by HHS; or
 - b. state-developed alternative forms (subject to HHS standards and approval).
14. **SHOP employer and employee eligibility appeals process**: how will the state structure its process for handling employer and employee appeals of SHOP eligibility determinations? (§ 155.740)

Additional Resources

[Making California's new healthcare exchange work for small businesses](#), Small Business Majority (February 2012)

[Employers And The Exchanges Under The Small Business Health Options Program: Examining The Potential And The Pitfalls](#) (Timothy S. Jost, Health Affairs, February 2012)

[How will the Affordable Care Act affect small businesses and their employees?](#) (Kaiser Family Foundation, January 2012)

[Small-Employer \("SHOP"\) Exchange Issues](#) (Institute for Health Policy Solutions, May 2011)

[Building Successful SHOP Exchanges: Lessons from the California Experience](#) (Pacific Business Group on Health, 2011)

Essential Health Benefits

The Affordable Care Act requires that all plans sold in a state's individual and small group markets (including all QHPs sold through an exchange) cover the Essential Health Benefits (EHB). The EHB include the following ten broad benefit categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care.

Analysis

For additional information on state considerations on the Essential Health Benefits designation, please see: [Essential Health Benefits: Building a Better Benchmark](#) (Center on Budget and Policy Priorities, April 2012)

Although the Secretary was required by the ACA to establish a uniform EHB standard to apply to all states, HHS has partially delegated this responsibility to the states. Under this approach, states were required to select an EHB base-benchmark plan from among 10 possible reference plans and submit their selection to HHS by October 2012, with an opportunity to amend or update their selection by December 26, 2012. States that failed to make an affirmative selection will have a default plan designated as the EHB. The EHB benchmark provides detail on the specific services and any benefit limits that will be covered under each of the ten categories listed above. States are responsible for funding the cost of any state mandated benefits if such benefits are not included in the selected EHB benchmark plan.

The EHB benchmark applies not only to exchange QHPs but to all individual and small group plans sold in the state. States have the following considerations regarding EHB:

1. **EHB base-benchmark selection:** which of the following permitted options is the state selection for its EHB base-benchmark? (45 CFR § 156.100)
 - a. the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;⁶
 - b. any of the largest three state employee health benefit plans by enrollment;
 - c. any of the largest three national FEHBP plan options by enrollment; or
 - d. the largest insured commercial non-Medicaid Health Maintenance Organization (HMO) operating in the State; or
 - e. none (the state's benchmark defaulted to the largest plan by enrollment in the largest small group product in the state).

⁶ See [Essential Health Benefits: List of the Largest Three Small Group Products by State](#)

2. **Supplementing the EHB benchmark for missing benefits**: if a required benefit category was missing from the chosen base-benchmark plan, from which other benchmark plan(s) and by what process did the state supplement the missing benefit category or categories (a state may select a small group plan as its benchmark and then allow HHS to supplement any missing benefit categories)? (§ 156.110)
3. **Defining the habilitative services benefit category**: if the EHB base-benchmark plan does not include coverage for habilitative services, how will the state define this benefit category? (§ 156.110 and § 156.115)
 - a. specify the habilitative services plans must cover;
 - b. allow issuers to cover habilitative services at parity with rehabilitative services; or
 - c. allow each issuer to decide which habilitative services their plans will cover
4. **Issuer benefit substitution**: what standards or limitations, if any, will the state adopt regarding issuer substitution of benefits/benefit design flexibility within each EHB category? (§ 156.115)
 - a. prohibit substitution of benefits;
 - b. set guidelines for or limitations on the types of benefits and/or the extent to which benefits may be substituted within a category;
 - c. specify certain, limited benefit substitutions that issuers could choose to make; or
 - d. place no guidelines or limitations on issuer substitution of benefits within a category.

Additional Resources

[Digging in to Benchmark Plan Details](#) (National Academy of State Health Policy, updated January 2013)

[Essential Health Benefits. States will determine the minimum set of benefits to be included in individual and small group insurance plans. What lies ahead?](#) (Health affairs, April 2012)

[State Benefit Mandates and National Health Reform](#) (National Institute for Health Care Reform, February 2012)

[Drug Coverage in Essential Health Benefits Benchmark Plans: Formulary Analysis](#) (Avalere Health, January 2012)

Basic Health Plan

The Affordable Care Act offers states the opportunity to establish a program for individuals with incomes between 133 percent and 200 percent of the Federal Poverty Level (FPL). The Basic Health Plan can allow a state to tailor and align coverage and networks for people who may cycle between Medicaid and exchange coverage and to make coverage more affordable for this group by lowering premiums and cost-sharing relative to coverage that would be otherwise offered through the exchange. Under Basic Health, states would receive 95 percent of the amount of premium tax credits and cost-sharing reductions that would have otherwise gone to provide coverage to enrollees in Basic Health. Establishing a Basic Health Plan will affect a state's exchange design, including the size of the risk pool that will remain within the exchange and any coordination of coverage options. While a more detailed breakdown of Basic Health Plan options awaits the release of federal rules and future guidance, at this time, states have the following considerations that may affect their exchange planning:

1. **Basic Health Program option**: will the state create a Basic Health Program?
 - a. yes; or
 - b. no.

2. **Basic Health Program eligibility and Medicaid**: how will the state define eligibility for adults with incomes above 133 percent of the FPL (if they are currently eligible for Medicaid)?
 - a. maintain Medicaid eligibility; or
 - b. transfer eligibility to Basic Health Program.

3. **Administration**: which entity will oversee the Basic Health Program?
 - a. Exchange;
 - b. Medicaid agency;
 - c. Department of Insurance; or
 - d. other.

Analysis

For additional analysis on the Basic Health Program and its impact on state health reform implementation, please see [State Considerations on Adopting Health Reform's "Basic Health" Option](#) (Center on Budget and Policy Priorities, March 2012)

Additional Resources

[The Role of the Basic Health Program in the Continuum: Opportunities, Risks, and Considerations for States](#) (Kaiser Family Foundation, March 2012)

[Basic Health Plan: Is it an option for your State?](#) (Manatt Health Solutions, September 2011)

[Using the Basic Health Program to make Coverage More Affordable to Low-Income Households: A Promise Approach for Many States](#) (Urban Institute, September 2011)

Risk Adjustment and Reinsurance

The Affordable Care Act establishes several mechanisms to limit the risk of adverse selection and encourage insurers to compete based on price and quality, rather than on their ability to encourage enrollment by healthier-than-average individuals and discourage enrollment by those in poorer health. These risk mitigation strategies — risk adjustment, reinsurance and risk corridors — will play a critical role in stabilizing the individual and small group markets when the market reforms take effect in 2014 and ensuring the long-term viability of the exchanges. States are given options for two of these strategies: risk adjustment and reinsurance.

Risk Adjustment

1. **Administration:** if state establishes its own exchange, which entity will administer risk adjustment (HHS will operate risk adjustment in states without a state exchange)? 45 CFR (§ 153.310)
 - a. federal government; or
 - b. state.
2. **Management:** if administering risk adjustment, which entity will the state designate to manage the program? (§ 153.310)
 - a. Department of Insurance;
 - b. exchange;
 - c. other.
3. **Financing:** if administering the risk adjustment program, how will the state finance its operations? (§ 153.310)
 - a. fee on all issuers subject to risk adjustment;
 - b. fee on QHP issuers; or
 - c. other.
4. **Methodology:** if administering the risk adjustment program, which methodology will the state use? (§ 153.320 and § 153.230)
 - a. federal risk adjustment methodology developed by HHS; or
 - b. state-modified federal methodology or other state-developed methodology (subject to federal approval).
5. **Data collection:** if using a state-administered risk adjustment program, what data will states request of plans? (§ 153.340)
 - a. default federal distributed approach (where insurers do not submit claims and encounter data); or
 - b. centralized approach (where the state risk adjustment program would collect insurers' claims and encounter data).

Analysis

For additional analysis on risk adjustment design and its impact on states, please see [Ensuring Effective Risk Adjustment](#) (Center on Budget and Policy Priorities, May 2011) and [Allowing Insurers to Withhold Data on Enrollees' Health Status Could Undermine Key Part of Health Reform](#) (Center on Budget and Policy Priorities, December 2011)

6. **Data validation:** if using a state-administered risk adjustment program, what audit procedures will the state establish to ensure risk adjustment data is valid and accurate? (§ 153.100)
 - a. federal validation audit procedures; or
 - b. state procedures

Reinsurance

1. **Administration:** which entity will administer reinsurance in the state? (§ 153.210)
 - a. federal government; or
 - b. state.
2. **Management:** if administering reinsurance, which entity will the state use to manage the program? (§ 153.200)
 - a. non-profit established by state; or
 - b. non-profit with which the state contracts.
3. **Supplemental program:** if administering reinsurance, will the state establish a supplemental reinsurance program with additional contributions and payments to complement the federal program? (§§ 153.100 and 153.110)
 - a. add-on fee for all entities required to make reinsurance contributions;
 - b. fee on all individual market issuers;
 - c. fee on all issuers in individual and small group markets; and/or
 - d. other.
4. **Collection of additional contributions:** if establishing a supplemental program, what contribution methodology will it use to finance additional payments and administrative costs? (§ 153.220)
 - a. federal methodology; or
 - b. state methodology.
5. **Additional payment methodology:** if establishing a supplemental program, what methodology will the state use? (§ 153.230)
 - a. federal formula; or
 - b. state formula (change to attachment point, reinsurance cap and/or coinsurance).

Additional Resources

[Analysis of HHS Final Rules On Reinsurance, Risk Corridors And Risk Adjustment](#) (Wakely Consulting Group, April 2012)

[Risk Adjustment and Reinsurance: A Work Plan for State Officials](#) (State Health Reform Assistance Network, December 2011)

Appendix. Options for Managing Eligibility Determinations of Insurance Affordability Programs⁷

State-based Exchange

Option	Medicaid/CHIP Initial Assessment⁸	Medicaid/CHIP Eligibility Determination⁹	QHP/APTC/CSR Eligibility Determination
SBE determines eligibility for all insurance affordability programs	N/A	SBE & Medicaid Agency	SBE
SBE contracts with state Medicaid agency to determine eligibility for all insurance affordability programs	N/A	Medicaid Agency	Medicaid Agency
SBE determines eligibility for QHP and tax credits and screens for Medicaid/CHIP eligibility, Medicaid agency retains control of Medicaid and CHIP final determinations	SBE	Medicaid Agency	SBE
SBE uses HHS Federally-managed service for QHP and tax credit eligibility and screens for Medicaid/CHIP eligibility, Medicaid agency retains control of Medicaid and CHIP final determinations	HHS	Medicaid Agency	HHS

Abbreviations

APTC	Advance Premium Tax Credits
CHIP	Children’s Health Insurance Program
CSR	Cost-Sharing Reductions
FFE	Federally facilitated Exchange
HHS	U.S. Department of Health and Human Services
QHP	Qualified Health Plan
SBE	State-based Exchange

⁷ Insurance Affordability Programs is defined as Medicaid, CHIP, Exchange QHPs, APTC/CSR, and the Basic Health Program (if applicable). If the Basic Health Program is adopted by the state, eligibility for that program may be integrated with the eligibility and enrollment process for either Medicaid/CHIP or the Exchange, if separate.

⁸ In states in which Medicaid and Exchange eligibility is under separate oversight, the Exchange (SBE or FFE) must conduct an initial Medicaid/CHIP assessment and refer applications to the Medicaid/CHIP entity to make the official eligibility determination and enrollment.

⁹ Medicaid and CHIP determinations may be overseen by the same agency or separate agencies depending on whether or not the states operates CHIP under a separate agency that independently makes CHIP determinations. For the purposes of this chart, it is assumed that eligibility is performed by the same agency (“Medicaid Agency”).