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Federally Facilitated Exchanges Are Almost Ready

RESOURCE LINK

Letter to Issuers on Federally-facilitated and State Partnership Exchanges

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On March 1, 2013, the Center for Consumer Information and Insurance Oversight ("CCIIO") and the Centers for Medicare & Medicaid Services ("CMS") released lengthy and detailed draft guidance[1] regarding the federally facilitated exchanges ("FFEs") that will operate in the 26 states[2] that have chosen not to establish their own exchange or partner with CMS. Although the guidance was issued in draft form, CCIIO and CMS allowed only two weeks for the public to submit comments and, as described below, CMS intends to start accepting issuer applications to the FFEs on April 1, 2013. As such, it seems unlikely that the guidance will be materially revised.

In addition, the application form and instructions are available online for issuers that have notified CMS of their intention to submit and obtain a CMS Health Insurance Oversight System ("HIOS")[3] plan ID. The form is lengthy and requires the submission of extensive and detailed data. Therefore, it is important to start the process as early as possible to ensure that all information and data are loaded in a timely manner.

The guidance sets forth the anticipated time frames for the various activities that an issuer will be required to perform in order to obtain certification as a qualified health plan ("QHP"). The tight timeline is as follows (all dates are in 2013):

Now:	Issuers should have obtained (or be in the process of obtaining) plan IDs from HIOS
April 1–30	Issuers submit QHP applications in HIOS
May–June 16	CMS reviews the applications
June 17	CMS releases the results

[1] *See* "Letter to Issuers on Federally-facilitated and State Partnership Exchanges," *available* at http://cciio.cms.gov/resources/files/issuer-letter-3-1-2013.pdf.

[2] These states include Alabama, Arizona, Arkansas, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Missouri, Montana, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin, and Wyoming.

[3] HIOS is the tool required by CMS to be used for the submission of application materials from the plan to CMS.

June 17–21	Issuers revise the QHP applications based on identified deficiencies and resubmit to HIOS
July 31	CMS receives final state evaluation findings and recommendations
August	CMS reviews state evaluation findings and recommendations
August 22–26	Issuers review data during the plan preview period and submit data corrections
September 4	CMS notifies all issuers of QHP certification decisions for the FFEs
September 5–9	Issuers sign an agreement with the exchange

With respect to network adequacy, CMS indicates that it will accept a state's determination of network adequacy if CMS has determined that the state has "sufficient network adequacy reviews." CMS will make this determination based on whether the state has the authority and means to assess adequacy, and whether the state uses standards at least as stringent as those set forth in 45 C.F.R § 156.230(a) relating to Medicare Advantage products. CMS also will accept the findings of accrediting organizations approved by the U.S. Department of Health and Human Services regarding network adequacy; for 2014, the only approved accrediting organizations are the National Committee for Quality Assurance and URAC. The guidance also provides detailed requirements regarding the inclusion of essential community providers, which are providers that serve predominantly low income, medically underserved individuals, including federally qualified health centers. The Patient Protection and Affordable Care Act ("PPACA") requires that QHPs include a sufficient number and geographic distribution of these providers in order to be certified; the guidance provides a link to a non-exhaustive list of the providers and detailed information regarding how to determine if the QHP has enough of them.

With respect to benefit design, CMS intends to review products to ensure compliance with the minimum essential benefits but also will conduct non-discrimination reviews to determine whether a product design might discourage consumers with greater health care needs from purchasing the product. In addition, CMS intends to review an issuer's products for "meaningful differences" and will limit the number of QHP products that a single issuer can offer on the exchange to those with meaningful differences.

The guidance also describes the minimum requirements for a compliance plan and requires that the plan be submitted with the application. CMS has indicated that it intends to conduct limited market conduct reviews or audits regarding an issuer's exchange requirements and potentially other regulatory requirements as well, in addition to market conduct reviews performed by the state regulators.

Moreover, the guidance addresses rate reviews and indicates that CMS will not duplicate state rate reviews for those states that, as the agency has determined, have an effective rate review process but will conduct "outlier reviews" of plan rates that seem to be out of line with others for similar products.

Finally, the guidance indicates that the states will remain responsible for enforcing the market reform provisions of PPACA, which include provisions such as the medical loss ratio requirements to spend a required percentage of the premium on health care costs, the exclusion of annual limits, the coverage of preventive services without cost sharing, and the coverage of young adults. However, the guidance notes that CCIIO will step in and enforce these provisions if a state does not.

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For more information about this issue of *IMPLEMENTING HEALTH AND INSURANCE REFORM*, or for assistance with preparing an application to an exchange, please contact the author below or the member of the firm who normally handles your legal matters.

Linda V. Tiano
Member of the Firm
Epstein Becker Green
Washington, DC
(202) 861-1812
LTiano@ebglaw.com

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Lisa C. Blackburn
Business Development Manager
National Health Care and Life Sciences Practice
Epstein Becker & Green, P.C.
1227 25th St., NW, Suite 700
Washington, D.C. 20037
phone 202/861-1887 – fax 202/296-2882
lblackburn@ebglaw.com

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