DEPARTMENT OF HEALTH & HUMAN SERVICES

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Subject: Guidance on the State Partnership Exchange

I. Purpose

Through a hybrid model called a State Partnership Exchange, States may assume primary responsibility for many of the functions of the Federally-facilitated Exchange permanently or as they work towards running a State-based Exchange. For example, states may carry out many plan management functions through what is referred to throughout this guidance as a State Plan Management Partnership Exchange. In addition, states can choose to assume responsibility for in-person consumer assistance and outreach, through what is referred to throughout this guidance as a State Consumer Partnership Exchange. States also have the option to assume responsibility for a combination of these main Exchange activities.

With a State Partnership Exchange, states can continue to serve as the primary points of contact for issuers and consumers, and will work with HHS to establish an Exchange that best meets the needs of state residents. This guidance provides a framework and basic roadmap for states considering a State Partnership Exchange. This guidance also describes how the Department of Health and Human Services (HHS) will work with states independent of State Partnership Exchange.

Contents

Working with States to Implement Exchanges ... 3
I. State Partnership Exchange Overview ... 3
II. State Plan Management Partnership Exchange ... 4
Overview of the State Plan Management Partnership Exchange ... 4
Plan Management Function: QHP Certification Process ... 6
Plan Management Function: Issuer Account Management ... 7
Plan Management Function: Issuer Oversight ... 8
Plan Management Function: Quality ... 8
Issuer and Plan Data Collection ... 9
Recommended State Plan Management Exchange Timeline ... 10
III. State Consumer Partnership Exchange ... 12
Navigators ... 12
In-Person Assistance Programs ... 13
Interaction with Agents and Brokers ... 14
Interaction with Consumer Assistance Programs (CAPs) ... 15
Timing of Consumer Assistance ... 15
Consumer Partnership: Outreach and Education ... 15
Outreach and Education ... 15
Branding ... 16
Timing and Deliverables ... 16
Minimum Standards for State Activities and Deliverables for a State Consumer Partnership Exchange. ... 17
The Outreach and Education Plan should include a plan for developing: ... 17
IV. HHS Role in a State Partnership Exchange ... 17
Initial Approval of a State Partnership Exchange ... 18
Federal Support of a State Partnership Exchange ... 18
Transition from a State Partnership Exchange to an State-based Exchange in Future Years ... 18
Conclusion ... 19

Working with States to Implement Exchanges

The Affordable Care Act directs HHS to establish a Federally-facilitated Exchange (FFE) in any state that does not elect to establish a State-based Exchange and in any state where the Secretary determines (by January 1, 2013) that there will not be an operational State-based Exchange by January 1, 2014. HHS continues to work with states establishing State-based Exchanges. For other states, HHS will structure the FFE so that state knowledge and expertise can be integrated into the FFE to the greatest extent possible. This guidance outlines the various options that states have to provide input and guidance, and take ownership over significant components of the operation of an FFE, primarily through a State Partnership Exchange. The State Partnership Exchange options provide states with a high level of participation in plan management and consumer assistance/outreach either on a permanent basis or as a stepping stone to a State-based Exchange in the future. For states with neither a State-based nor State Partnership Exchange, we describe how HHS can integrate traditional state regulatory functions and activities into FFE operations.

I. State Partnership Exchange Overview

On May 16, 2012, HHS released General Guidance on the FFE[1] that provided basic information regarding State Partnership Exchanges. A State Partnership Exchange enables a state to be actively involved in Exchange operations, continue to play a primary role in interacting with issuers and consumers in the state, and make recommendations as to how local market factors should inform the implementation of Exchange standards. The overall goal of a State Partnership Exchange is to enable the Exchange to benefit from efficiencies when states have existing regulatory authority and capability, and to provide a framework for tailoring aspects of the FFE to state markets and residents while maintaining a positive and seamless experience for consumers. The State Partnership Exchange can also serve as a path for states toward future implementation of a State-based Exchange.

A State Partnership Exchange enables states to assume primary responsibility for carrying out certain activities related to plan management, consumer assistance and outreach, or both. We welcome states' ideas on how best to make this hybrid model work. In areas where the law prohibits HHS from completely delegating responsibility to a state, HHS will work with states to agree upon processes that maximize the probability that HHS will accept state recommendations without the need for duplicative reviews from HHS. This guidance provides states and other stakeholders with details regarding the State Partnership Exchange option for the 2014 benefit year. HHS intends to provide further details throughout Exchange establishment and may refine the policies included here in future years of operation.

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[1] http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf

II. State Plan Management Partnership Exchange

HHS recognizes that State Departments of Insurance (DOIs) have a longstanding regulatory role with the health insurance issuers that will participate in the FFE. HHS believes that preserving the DOI’s traditional roles and responsibilities in the insurance market generally by having a state role in the operation of the Exchange is important to ensure market parity inside and outside the Exchange, and to guard against adverse risk selection within the Exchange.

In addition, HHS recognizes that even where a state with an FFE does not participate in a State Partnership Exchange, states will continue to perform regulatory activities such as reviews of health plan rates, benefits, and provider networks with respect to all plans offered in the state, both inside and outside the Exchange. Therefore, even where a State Partnership Exchange is not operating, HHS will work with states to integrate state reviews into the FFE’s process for certifying QHPs.

Overview of the State Plan Management Partnership Exchange
In a State Plan Management Partnership Exchange, the scope of state responsibilities includes: recommending plans for QHP certification, recertification and decertification; QHP issuer account management; and day-to-day administration and oversight of QHP issuers. States in a State Partnership Exchange will carry out similar plan management activities for stand-alone dental plans certified by the Exchange.

The chart below summarizes the functions, activities, and responsibilities that a state and HHS will perform for a State Plan Management Partnership Exchange in 2013 and 2014. State Partnership Exchange recommendations and activities must be consistent with applicable law (statutes and regulations), FFE guidance and timelines, standard operating procedures (SOPs), and policies.

Chart 1: State and HHS Activities under a State Plan Management Partnership Exchange (2013-2014)

State Activities	HHS Activities
QHP Certification Process	
• Issue QHP application • Collect issuer and plan data to support QHP certification and Exchange operations[2] • Submit rate review determinations to HIOS[3] • Verify issuer compliance with actuarial value (AV) and cost-sharing reduction plan variation standards in support of the QHP certification process[4] • Submit recommendations to HHS regarding QHP certification and recertification (including for stand-alone dental plans and CO-OPs) • Transmit timely and standardized issuer and plan data to HHS to populate the Exchange website and to support ongoing Exchange operations in an HHS-approved system (i.e., SERFF, HIOS)	• Develop data standards in conjunction with states for QHP data collection and ongoing data reporting • Receive, approve (as appropriate), implement and oversee a state's certification and recertification recommendations
QHP Issuer Account Management	
Day-to-day issuer account management activities specifically related to plan management, including: • Serve as point of contact for issuer questions and issues related to QHP certification and other QHP responsibilities • Manage communications with QHP issuers and the FFE related to Exchange issues and monitoring • Resolve, track, and coordinate consumer complaints as necessary with HHS	• Coordinate responses to issuer questions and issues related to other FFE functions, including eligibility, enrollment and financial management received by the state • Provide technical assistance to issuers as needed related to Exchange operational requirements that are not traditional state functions • Ensure receipt of updated issuer information • Respond to consumer complaints received via the federal customer service channels for the State Partnership Exchange or refer to the state entity, as appropriate, for tracking and resolution of complaints
QHP Issuer Oversight and Monitoring	
• Ensure continued compliance with QHP certification standards • Take compliance actions under state law against QHP issuers due to violation of state insurance laws and regulations, and inform HHS accordingly for Exchange records and Exchange action as well, if	• Oversee QHP issuers related to Exchange operations outside of the scope of traditional state insurance oversight and QHP certification, including compliance with: • Enrollment transaction requirements, enrollment reconciliation

[2] The state will be allowed to utilize the HHS Health Insurance Oversight System (HIOS) for issuer and plan data collection or another system approved by HHS in connection with participation in a State Partnership Exchange.

[3] HIOS refers to the HHS Health Insurance Oversight System. SERFF refers to NAIC's System for Electronic Rate and Form Filing.

[4] The state will have access to the actuarial value (AV) calculator and will be responsible for verifying issuers' compliance with AV standards, including applicable cost-sharing reduction plan variations. Rules concerning issuer compliance with AV standards are proposed at 77 FR 70643.

appropriate • Recommend Exchange compliance actions for QHPs to HHS and coordinate state law enforcement with Exchange enforcement where appropriate • Coordinate with HHS on Exchange operational oversight, i.e. compliance with Exchange standards	• Eligibility and enrollment standards for eligibility determinations made by the Exchange (see 45 CFR 155.302 for options provided to an Exchange with respect to eligibility determinations) • Financial management operations as applicable • Other operational requirements related to the FFE website, call center, customer service, etc. • Coordinate with the state on oversight findings • Receive and review state enforcement recommendations in connection with Exchange operations, make Exchange enforcement decisions, and take enforcement actions, as appropriate
Quality	
• Coordinate with HHS on data collection requirements related to quality, such as accreditation, including those that will be specified in future rulemaking • Conduct other quality or performance monitoring, at the discretion of the state, under state law or to inform QHP certification recommendations • Provide a web link to additional quality data that will display on the Exchange Internet website that connects to the state DOI or other state agency websites [*optional*]	• Develop quality rating, quality improvement strategy, enrollee satisfaction survey, phase two process for recognizing accrediting entities and other data standards for quality data collection and ongoing data reporting

Plan Management Function: QHP Certification Process

With a State Plan Management Partnership Exchange, states will have flexibility in how they carry out their role in QHP certification while applying the QHP certification standards in a manner consistent with FFE policies. A state could perform an alternate review if it meets or exceeds the FFE standards in connection with how QHP certification standards are applied; such flexibility is intended to address insurance market conditions unique to the state. Commenters to the General Guidance on the FFE suggested that some standardization should exist across states served by FFEs, while encouraging some ability for states to tailor interpretation and application of FFE standards to state-specific markets. To assist states in developing processes and procedures for the state role in QHP certification, HHS is publishing its planned approach to QHP certification reviews.

Appendix A describes how HHS will evaluate potential QHPs against all QHP certification standards in the FFE. HHS believes that articulating a reasonable interpretation for each standard will improve the state-federal relationship, streamline HHS' process for reviewing state work, and offer issuers additional consistency in complying with state and federal standards.

HHS will work closely with states operating a State Plan Management Partnership Exchange to negotiate a state-specific MOU based on the state's approved Blueprint for a State Partnership Exchange. In addition to describing how HHS and the state will work together to implement plan management functions, the MOU will include some description of how the state will review QHPs for certification.

While the law does not allow HHS to completely delegate QHP certification to states with an FFE, HHS will work with states to agree upon processes that maximize the probability that HHS will accept state recommendations without the need for duplicative reviews from HHS. Specifically, HHS will accept or respond to state QHP recommendations within 14 business days of receipt, on the condition that the state has followed processes previously outlined in the Blueprint application and MOU agreement. HHS does not intend to re-review QHP data or otherwise duplicate work performed by the state. HHS will notify the state in writing of any concerns that preclude HHS approval of its recommendations; the state will have nine business days following this notification to respond to HHS' concerns and request reconsideration of HHS' decisions. HHS will notify the state of its final decision and basis for the decisions within five business days of receipt of the state's response.

The final rule[5] outlining standards for the Consumer Operated and Oriented Plan Program (CO-OP) states that CO-OP QHPs that meet the program standards, Exchange-specific standards, and federal standards may be deemed as QHPs by HHS or an entity designated by HHS. In a State Plan Management Partnership Exchange, the participating state's responsibilities will include providing recommendations to HHS to assist in the determination of whether or not the CO-OP meets the requirements for a QHP, with the final determination to deem the CO-OP left to HHS.

Plan Management Function: Issuer Account Management

States in a State Plan Management Partnership Exchange will coordinate with HHS with regard to issuer account management and ongoing monitoring of QHP issuers. To facilitate this relationship, HHS anticipates that QHP issuers operating in a State Partnership Exchange will have a designated Federal Account Manager, who will serve as a point of contact between the QHP issuer and HHS for questions and issues related to federal activities, such as administration of advance payments of the premium tax credit. The Federal Account Manager will assist QHP issuers by providing policy clarifications and other assistance with the program on an as-needed basis.

We expect that states will develop their own mechanisms to support and monitor QHP issuers on an ongoing basis in order to have a primary role in overseeing QHP issuers on day-to-day matters. Specific roles and responsibilities for the states and for the Federal Account Manager in

[5] http://www.gpo.gov/fdsys/pkg/FR-2011-12-13/pdf/2011-31864.pdf

this area will be outlined in guidance and procedures to be developed by HHS with input from states participating in a State Partnership Exchange.

Plan Management Function: Issuer Oversight

States that participate in a State Plan Management Partnership Exchange will assume the first line of responsibility with respect to QHP issuer oversight. Consistent with the state's regulatory authority and state law, HHS expects that the state will have primary responsibility for investigating QHP performance. This will include responsibilities such as managing certain types of consumer complaints about issuers, examining potential QHP issuer non-compliance with applicable laws, and ensuring ongoing compliance with the QHP agreement and certification standards.

Specifically, the state will work with HHS and existing consumer assistance programs to ensure the resolution of consumer complaints in the State Partnership Exchange. We expect that the state will continue to oversee the successful resolution of complaints received through channels that exist today, prior to the existence of the Exchange and outside of the Exchange, such as issuer customer service channels or other existing state-based resources.

States will maintain their responsibility for enforcing state law, including those relevant to QHP certification and decertification. The state will also be responsible for developing and implementing a process to make recommendations to HHS for decertification (based on violations of federal law or regulations, or other reasons). HHS will monitor and address matters that directly relate to other areas of FFE or federal operations, including instances in which federal funds such as cost-sharing reductions, advance payments of the premium tax credit, and risk corridor payments, may be directly implicated.

Plan Management Function: Quality

States that participate in a State Plan Management Partnership Exchange will coordinate with HHS on quality reporting and display requirements. As indicated in the General Guidance on the FFE, HHS intends to propose in future rulemaking that quality reporting requirements related to all QHP issuers (other than accreditation reporting) become a condition of QHP certification beginning in 2016 based on the 2015 coverage year; such regulatory proposals would be part of the implementation of Affordable Care Act sections 1311(c)(1)(E), 1311(c)(3), 1311(c)(4), 1311(g), and 1311(h). States may collect additional quality data (and collect data prior to 2016) directly from issuers or third party entities (such as accrediting entities) for use in applying the consumer interest standard of QHP certification under 45 CFR 155.1000, making QHP certification determinations, conducting QHP performance monitoring, and providing consumer education and outreach.

States will apply accreditation requirements proposed in 45 CFR 155.1045 as part of recommending QHP certification when a state participates in a State Plan Management Partnership Exchange. This role will also include requiring issuers with existing accreditation to

authorize the release of data from the accrediting entity to the Exchange as part of the application for QHP certification. Under the current regulatory proposal,[6] each FFE will collect accreditation information from all health plans and issuers seeking QHP certification. An FFE Internet website will display accreditation status for QHP issuers based on QHP issuers' existing commercial, Medicaid or Exchange accreditation from recognized accrediting entities.

Until QHP-specific quality ratings are available, each FFE Internet website will display Consumer Assessment of Healthcare Providers and Systems (CAHPS) data results from accredited commercial product lines when these existing CAHPS data are available for the same QHP product types and adult/child populations.[7] If applicable CAHPS commercial data are not available, the FFE Internet website will display CAHPS data available from accredited Medicaid product line results if these data are available for the same QHP product types and adult/child populations. Each FFE will collect these data from the recognized accrediting entity and display them for the applicable QHP issuers. States participating in a State Partnership Exchange will collect and transmit to HHS this accreditation-related data on QHP issuers and ensure that QHP issuers understand that the Exchange Internet website will display data from existing accreditation, if applicable, as part of the QHP certification process developed by the state for the State Partnership Exchange.

Issuer and Plan Data Collection

One key to operating a successful State Plan Management Partnership Exchange is the collection of data from issuers (either as part of the QHP certification process or during management of QHP issuers) and the transfer of that information to HHS for use in overall Exchange administration. Issuer and plan-level data are integral to many portions of Exchange operations.

Issuer-level information will include administrative data, including high-level identifying information and contacts. This information will be used to identify issuers in the plan management system and by other FFE business areas as they develop points of contact with the issuers and facilitate operational activities. Issuer-level information also includes information related to issuer compliance with QHP certification standards.

Plan-level data will include information on rates and benefits. Such information is key for Exchange and HHS functions in the administration of advance payments of cost-sharing reductions and advance payments of the premium tax credit.[8] The collection of rate and benefit

[6] The CMS Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation; Proposed Rule, CMS-9980-P, was proposed at 77 FR 70643 (Nov. 26, 2012); includes a proposal concerning the accreditation timeline for QHPs seeking certification by all FFEs, including State Partnership Exchanges.

[7] HHS intends to propose rules for QHP quality rating subject to section 1311(c)(3); our intent is that such ratings will be available for display beginning in the 2016 open enrollment period for the 2017 coverage year.

[8] Rules concerning the administration of cost-sharing reductions are proposed at 77 FR 73117 and advanced payments of the premium tax credit at 77 FR 70643.

data will also be used for oversight and transparency purposes, as well as monitoring market trends.

Due to the integral role that plan management data plays in overall FFE operations, states participating in a State Partnership Exchange will use a data collection tool that aligns with the overall FFE infrastructure. Therefore, states that choose a State Plan Management Partnership Exchange will have the option to use the Health Insurance Oversight System (HIOS) or an HHS-approved State system for data collection. HHS is aware that some states are hoping to leverage their existing data collection systems to support a State Plan Management Partnership Exchange, and HHS encourages states to begin discussions with CCIIO staff to explore how they can use existing resources to facilitate this.

In this spirit, HHS is working with the National Association of Insurance Commissioners (NAIC) to enable states to use the System for Electronic Rate and Form Filing (SERFF) as part of the QHP submission and certification process in a State Plan Management Partnership Exchange. HHS and the NAIC are developing QHP submission interfaces to ensure that SERFF collects the full list of data elements necessary for QHP certification, and to enable seamless data transmissions between SERFF and HHS.

States participating in a State Plan Management Partnership Exchange will complete their part of the QHP certification process and remit the specified plan data and recommendations via SERFF or HIOS to HHS by July 31, 2013. Issuers will verify the accuracy of the data that has been submitted to HHS in a number of ways, including the upload and verification of plan data on the FFE Internet website, verification of premiums quoted by the premium calculator, and issuer system trainings.

Recommended State Plan Management Exchange Timeline

The chart below serves as a guideline for states participating in a State Partnership Exchange to implement all necessary plan management activities before open enrollment begins.

	State Activities Connected to Participation in State Plan Management Exchange
Through Feb. 2013	• Participate in design reviews under section 1311(a) cooperative agreements, if applicable.[9] Such reviews may include amendments to existing cooperative agreement terms or state applications for new cooperative agreements containing terms and activities the state performs in connection with the State Partnership Exchange.

[9] Grants Funding Opportunity Announcement released on June 29, 2012, page 57-60. http://www07.grants.gov/search/search.do;jsessionid=YvVZPtbTL5Hy4Tgw7g4MdBGQtHdhycbgLRHvKdNhlQ5zQ2gnMYxc!-1618278613?oppId=180734&mode=VIEW

Early 2013	• Begin to identify the entity performing plan management functions and governance structure.
	• Begin to submit evidence of legal authority to perform plan management functions.
	• Begin to:
	  o Develop procedures for day-to-day oversight and monitoring of QHPs.
	  o Develop plan for supporting QHP issuers and providing technical assistance.
	  o Develop approach for QHP issuer recertification, decertification, and appeal of decertification recommendations.

Feb. 15, 2013	• Last date to submit a declaration letter indicating that the state plans to pursue a State Partnership Exchange and the Blueprint Application. • Last date for a state to submit an initial application for a section 1311 cooperative agreement to establish a grant relationship with CMS that will allow the state to become an operational State Partnership Exchange for plan year 2014. A state can continue to seek additional funding through 2014 to continue building functions for a State Partnership Exchange, to create linkages to the FFE and to build State-based Exchange functions if the state intends to transition to a State-based Exchange in later years.
April 2013	• Suggested start to the QHP certification submission process.
May-June 2013	• Participate in consultations with HHS to ensure successful operation of the QHP certification process.
July 31, 2013	• Complete the QHP certification process and send final recommendations and QHP data to HHS.
August 2013	• Plan-preview period on FFE website to address any QHP issuer data errors.

Working with States Outside of a State Plan Management Partnership Exchange

HHS recognizes that determination of whether issuers and health plans meet QHP certification standards outlined in 45 CFR 156.200 involves activities that oftentimes are already or will be performed by state regulators under state law, including state laws that address 2014 market reforms. For example, we know that many states will conduct reviews for: coverage of essential health benefits (EHB), including formulary reviews for EHB purposes; compliance with actuarial value and market rating reforms; and rate increases, consistent with state authority and federal law.

Additionally, HHS recognizes that determination of whether plans meet several other QHP certification standards – including, for example, network adequacy – are closely related to market-wide standards, and may rely upon the same data and state authority, such as in the case of marketing standards. Therefore, HHS anticipates integrating state regulatory activities into its decision-making for QHP certification determinations in the FFE, provided that states make these determinations and provide information to HHS consistent with federal standards and FFE timelines. Unlike in states where there is a State Plan Management Partnership Exchange, in which the state will recommend QHP certification decisions to HHS, in this context, a state will evaluate whether a health plan or issuer meets particular certification standards as a part of its established state regulatory role.

HHS will consult with states to provide technical assistance and consultation on market-wide standards and other QHP certification standards, as needed. That consult will determine how HHS should prepare to conduct QHP certification for an FFE in the state in a manner that leverages the state's approach to reviewing health plans under state law and in connection with market reform standards. As with State Plan Management Partnership Exchange activities, state reviews that follow HHS' planned approach will be relied upon by HHS in making QHP certification decisions. HHS will be responsible for ensuring that QHPs meet all QHP certification standards that the state does not review. To the extent possible under applicable law, HHS will use the same process to review state recommendations and state findings, as described previously in this document in connection with State Partnership Exchanges. We note that states will not be asked to undertake reviews or analyses beyond those that would be conducted as a matter of state law.

HHS will also work with states to determine the format and delivery date for information and analyses that the states wish to share with HHS in this context.

III. State Consumer Partnership Exchange

A State Consumer Partnership Exchange draws on the state's knowledge and experience regarding the needs of consumers in the state to support a simplified, seamless consumer experience. In a State Consumer Partnership Exchange, a state is responsible for the day-to-day management of the Exchange Navigators and the development and management of a separate and distinct in-person assistance program, and can choose to be responsible for outreach and educational activities. HHS will operate the call center and website for the State Partnership Exchange, and be responsible for the funding and award of Navigator grants.

Navigators

Section 1311(i) of the Affordable Care Act directs that Navigators conduct public education to target Exchange-eligible populations, assist qualified consumers in a fair and impartial manner with the selection of QHPs and information on tax credits and cost-sharing reductions, and refer consumers to any consumer assistance or ombudsman programs that may exist in the state. Navigators must provide this information in a manner that is culturally and linguistically appropriate and accessible by persons with disabilities. Navigators will engage in locally-focused work. Navigator grantees could include individuals and organizations that often target their outreach to specific ethnic, geographic, or other communities.

States that choose to operate a State Consumer Partnership Exchange will conduct the day-to-day management of the Navigator program, including ongoing monitoring of Navigator activities and providing technical assistance to Navigators. Consistent with the Exchange final rule,[10] HHS

[10] Exchanges Final Rule: 45 CFR 155.210

will establish conflict of interest, cultural and linguistic competency, and training standards that will apply to Navigators in FFEs and State Consumer Partnership Exchanges. The state will ensure that Navigators are adhering to those FFE standards, as well as to the State Consumer Partnership Exchange's privacy and security standards developed by HHS in operation of the State Partnership Exchange.[11] HHS will develop and operate the Navigator training program, which will culminate in an assessment that all grantees are required to pass in order to operate as Navigators. The state will be able to develop additional training modules, if they choose to do so, that Navigators would take. HHS and the state will also work together on an ongoing basis to ensure that both parties remain appropriately informed about Navigators and the work they are performing. We anticipate that the state with a State Consumer Partnership Exchange will notify HHS of any concerns or problems about Navigators.

Additionally, states participating in the State Consumer Partnership Exchange can use section 1311(a) cooperative agreement funds to: (1) build the infrastructure necessary to manage the network of Navigators in their state and (2) if the state is transitioning to a State-based Exchange, build and test Navigator programs to be used by the State-based Exchange. However, monies authorized under section 1311(a) of the Affordable Care Act cannot be used to fund Navigator grants.

In a State Consumer Partnership Exchange, Navigators will be funded through federal grants. It is legally required that HHS retain ultimate authority over the Navigator grant process, including selecting Navigator grantees and awarding Navigator grants, and the approval of grantee activities and budgets.

In-Person Assistance Programs

HHS anticipates that not all communities or eligible individuals will have easy access to a Navigator. Some communities may not have entities that apply to be Navigators, while other entities intending to serve specific communities may not be selected to receive a Navigator grant. To help ensure that consumers who need in-person assistance have access to such assistance from a State Consumer Partnership Exchange, the participating states will build additional programs, distinct and apart from the Navigator program, that will be available to help consumers in those states. The same training standards and training program that apply to Navigators will also apply to in-person assistance programs. As with Navigator training, states with a State Consumer Partnership Exchange will be able to supplement the HHS-developed training with state-specific modules for their in-person assistance programs.

The state will be responsible for developing, implementing, and managing a program consistent with 45 CFR 155.205 (d) and (e); for the State Consumer Partnership Exchange, such programs

[11] Exchanges Final Rule: 45 CFR 155.210 and 155.260

should also be consistent with guidance in the General Guidance on the FFE released earlier this year. HHS anticipates that states with a State Consumer Partnership Exchange could provide this assistance with state employees as well as through contracts or grants, funded by federal 1311 grants, made under state law. This will allow states (as applicable) to adjust the number of personnel as necessary during the course of the year to respond to consumer demand (for example: providing additional resources during initial or annual enrollment periods).

In a State Consumer Partnership Exchange, states will have broad authority to develop in-person assistance programs subject to guidance provided by HHS. In-person assistance programs are distinct from the Navigator program, and the state must support them in a manner that ensures coordination with the Navigator program in order to avoid duplication of effort.

States operating a State Consumer Partnership Exchange can use section 1311 funds to set up and fund first year costs for in-person assistance programs and are permitted, but not required, to contract with state consumer assistance programs[12] – such as those established under section 2793 of the Public Health Service Act – to perform these services. We note that these programs may not replace Exchange Navigator grant programs. Establishment and operation of a Navigator grant program is a minimum Exchange function for all Exchanges, including all State-based and Federally-facilitated Exchanges. In-person assistance programs and personnel may supplement Navigator programs and serve different distinct consumer assistance requirements of Exchanges.[13]

Interaction with Agents and Brokers

All states, regardless of what type of Exchange is in operation, can determine whether to permit agents and brokers to enroll consumers in QHPs through the Exchange. In addition, all states will continue to set standards for the agent and broker industry and to play their traditional role in licensing and overseeing agents and brokers.

Agents and brokers in all FFE states, including in states where a State Consumer Partnership Exchange is operating, will use the FFE agent and broker web portal, which will allow agents and brokers to sign an agreement with the Exchange[14] and complete Exchange training and registration. Agents and brokers are also eligible to serve as Navigators for a State Partnership Exchange. However, agents and brokers who choose to work as Navigators cannot be compensated for enrolling individuals into either QHPs or other non-QHP health insurance or health plans, consistent with 45 CFR 155.210(d)(4). HHS plans to issue further guidance on the role of agents and brokers in the Exchange.

[12] Exchange establishment cooperative Agreement Funding FAQ released June 29, 2012: http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html

[13] Exchange final rule 155.205(d): http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

[14] Exchange final rule 155.220(d): http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

Interaction with Consumer Assistance Programs (CAPs)
Through grants from HHS, over the past two years, CAPs have assisted consumers with private health insurance issues. This assistance ranges from helping consumers find appropriate health insurance to helping them file appeals with their issuers. Just as consumers today need help and have questions about their health plans, consumers in QHPs and in other private health plans will continue to need assistance with post-enrollment issues such as claim denials, billing issues, and incorrect cost sharing. Navigators are statutorily required to refer consumers with these types of concerns to programs, such as CAPs, for additional assistance.

Timing of Consumer Assistance
Although open enrollment for Exchanges begins on October 1, 2013, Exchange-related in-person outreach and education will ideally begin prior to that. Having a baseline understanding of health insurance will help consumers make plan selections in an Exchange. Consumers will also benefit from a basic understanding of Exchanges, QHPs, and affordability provisions prior to open enrollment so they can make informed choices about their health insurance options.

In order to conduct necessary outreach activities and help improve the health insurance literacy of consumers, it is recommended that in-person activities in State Consumer Partnership Exchanges begin in the summer of 2013. Once open enrollment begins, in-person consumer assistance will become a combination of both public education and enrollment assistance.

Consumer Partnership: Outreach and Education
The State Consumer Partnership Exchange allows states the opportunity to conduct outreach and education. States may develop and execute, with HHS approval, activities to promote the FFE as well as brand and promote in-person assistance programs, including Navigators.

To the extent permissible under applicable law, HHS will share consumer research with states via the Collaborative Application Lifecycle Tool (CALT), including branding and message testing among various audiences. States are encouraged to use this research in their outreach and education efforts, to test their outreach and education materials, to develop branding and messaging, and to conduct further testing.

Outreach and Education
We strongly encourage states participating in a State Consumer Partnership Exchange to engage local stakeholders in the role of information intermediaries, including coordination with other health and human service programs within the state to extend and broaden outreach. This might include providing referral information on applicant or enrollee notices, emails, websites, and through call center assistance.

States are encouraged to develop their own outreach and education materials and activities but can use materials developed by HHS as well. Such materials could include information regarding

eligibility and enrollment options, program information, benefits, and services available through the Exchange and other insurance affordability programs available within the state. The materials should be culturally and linguistically appropriate based upon the state's expertise with such populations. This includes making materials accessible to persons with limited English proficiency and disabilities.

HHS will work closely with states participating in the State Consumer Partnership Exchange to provide updates on its outreach and education plans as they are developed, to avoid duplication of efforts for planning and outreach purposes within the state. States can increase the intensity of consumer outreach efforts at the local level, taking into consideration the best strategies to reach the public and encourage enrollment in the Exchange. As a state starts transition to a State-based Exchange and receives conditional approval of its Exchange Blueprint, it may expand its online consumer presence to include broader education information beyond what is on the FFE website.

Branding

States participating in a State Consumer Partnership Exchange are encouraged to brand consumer assistance programs, including CAPs and Navigators, within their state and use these programs as a primary outreach channel in motivating consumers to seek in-person assistance. States may promote and brand the Navigator and in-person assistance programs within their states through various mechanisms, including state-branded in-person assistance websites, earned and paid media, and outreach to eligible consumers.

States may also develop strategies to promote the FFE website. While the name of the FFE program and the FFE website (URL) will not change state to state because all the FFEs (and State Partnership Exchanges) will share administrative infrastructure, there will be opportunities to include state-specific icons (such as a flag or seal) on state-specific sections of the FFE website. Additionally, while states may not alter the search engine optimization (SEO) on the FFE website, they could provide tailored search capabilities on any branded in-person assistance websites.

Timing and Deliverables

The following provides guidance on deliverables and the timeline for states participating in a State Consumer Partnership Exchange.

Deliverable from State to HHS in connection with a State Consumer Partnership Exchange	**Timeline**
Outreach and Education Plan with high-level timeline of strategies and execution dates	March 29, 2013
Paid and Earned Media Plan	June 15, 2013

Minimum Standards for State Activities and Deliverables for a State Consumer Partnership Exchange.

The Outreach and Education Plan should include a plan for developing:

- Consumer-focused content that clearly explains all consumer eligibility and enrollment options, program information, benefits, and services available.
- Content written in plain language, free of jargon and using active task-based labels whenever possible.
- Culturally and linguistically appropriate outreach methods
    a. If paid media is utilized, an overview including timing and channels (for example, television, radio, print, out-of-home, and online)
    b. A clear call to action referencing the FFE website.
- Education about :
    a. Eligibility and enrollment
    b. Program information
    c. Benefits and services available through the Exchange and other insurance affordability options
- Outreach and education targeted to various stakeholders.
- Performance metrics for tracking results
- Content development plans should include consumer testing, including testing among persons with limited English proficiency and persons with disabilities, to make sure content and language resonate with target audiences and should identify the types of auxiliary aids and services available and any language assistance services.

IV. HHS Role in a State Partnership Exchange

HHS will carry out all minimum Exchange functions not performed by states in the State Partnership Exchange, such as enrollment, establishment and maintenance of the Exchange Internet website, and the call center. In addition, HHS remains responsible for overall operation of the State Partnership Exchange and, as described in this document, will review the activities of the state. In response to the State Partnership Exchange options proposed earlier this year in the General Guidance on the FFE, a number of stakeholders requested a State Partnership Exchange option for a state to carry out activities for eligibility determinations. The Exchange final rule[15] establishes additional flexibility for Exchanges and states that is independent from a State Partnership Exchange regarding eligibility determinations; State-based Exchanges are encouraged to review those options. We also note that states can elect to perform, or use federal

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[15] 45 CFR 155.302 of the Exchange final rule, available online at: http://www.gpo.gov/fdsys/pkg/FR-2012-03-27/pdf/2012-6125.pdf

government services for, the reinsurance program. The risk adjustment program will be operated by HHS for any state without an approved State-based Exchange (*see* 45 CFR 153.310(a)(2)).

The federal government will be responsible for conducting stakeholder as well as regular and meaningful Tribal consultations consistent with the HHS Tribal Consultation Policy, in states with a State Partnership Exchange. It is expected that states will participate in stakeholder and Tribal consultations, and engage in discussions with stakeholders and federally recognized tribes regarding State Partnership Exchange functions that pertain to their plan management and consumer assistance activities. After each Tribal consultation and on an ongoing basis, it is expected that states and HHS will discuss feedback provided during the consultation sessions and how to address the comments in the context of the applicable State Partnership Exchange.

Initial Approval of a State Partnership Exchange

To operate a State Partnership Exchange in 2014, a state must complete the relevant portions of the Exchange Blueprint[16] and be approved or conditionally approved by HHS for the functions and activities the state will perform. State Partnership Exchange approval standards mirror State-based Exchange approval standards for plan management and the relevant consumer activities, and include standards related to sharing data and coordinating processes between the state and the Exchange. States have until February 15, 2013 to submit a declaration and Blueprint Application for approval as a State Partnership Exchange for the 2014 coverage year.

Federal Support of a State Partnership Exchange

The June 29, 2012 Frequently Asked Questions described how a state may receive funding for its start-up year expenses for activities related to establishing a State Partnership Exchange, as well as costs associated with transition to and establishment of a State-based Exchange[17]. After section 1311 grant funds to states are no longer available, HHS anticipates continued funding, under a different funding vehicle, for state activities performed for a State Partnership Exchange on behalf of the FFE. Additionally, to the extent permissible under applicable law, HHS intends to make HHS-developed tools and other resources available to states participating in either a State Partnership Exchange or State-based Exchange.

Transition from a State Partnership Exchange to an State-based Exchange in Future Years

States that seek HHS approval to operate a State-based Exchange for coverage years beginning after January 1, 2014 (for example, January 1, 2015) should follow the same process and similar timeframes for states seeking to operate an Exchange beginning in January 1, 2014. For example, a state operating a State Partnership Exchange for plan year 2014 that intends to transition to a State-based Exchange for plan year 2015 will submit a Declaration Letter and a Blueprint Application to HHS by November 18, 2013.

[16] http://cciio.cms.gov/resources/files/hie-blueprint-11162012.pdf

[17] http://cciio.cms.gov/resources/factsheets/hie-est-grant-faq-06292012.html.

States are encouraged to notify HHS of their intent to transition between Exchange models as early as possible to ensure a seamless transition process, which will likely include developing appropriate transitional procedures and processes. When approved as a State-based Exchange, the state would assume the flexibility and responsibilities of that model under the Affordable Care Act and associated regulations.

Conclusion

A State Partnership Exchange provides opportunities for states to shape the implementation of Exchanges for their residents. Because the statute does not provide for divided authority or responsibility between states and the federal government, HHS developed the State Partnership Exchange options to maximize state participation and responsibility within this legal framework. In areas for which HHS cannot completely delegate responsibility to a state that participates in a State Partnership Exchange, HHS will work with states to agree upon processes that maximize the probability that HHS will accept state recommendations without the need for duplicative reviews from HHS.

We look forward to working with states and other stakeholders, including consumers, healthcare providers, issuers, tribes, and other groups to implement State Partnership Exchanges in a manner that achieves our shared goal of increasing access to affordable, high-quality coverage. We welcome public comment on the State Partnership Exchange described in this document.

Appendix A: HHS Approach for Certification of FFE QHPs for the 2014 Coverage Year

Note: with regard to market-wide reforms, HHS will defer to state approvals that are done consistently with federal regulations and guidance (in the table, such deferrals are summarized as "confirm"). Otherwise, HHS will perform the review for the FFE.

	Statutory/Regulatory Standard	HHS Approach for Certification of QHPs
Standards that Apply to All Non-grandfathered Individual and Small Group Plans		
EHB standards*	Issuer offers coverage that is substantially equal to the coverage offered by the benchmark plan (45 CFR 156.115).	• Confirm that issuer offers coverage that is substantially equal to benchmark plan**; • If the issuer is substituting benefits, confirm that the issuer has demonstrated actuarial equivalence of substituted benefits**; and • Collect issuer attestation of compliance with all EHB standards.
EHB Formulary review*	Plan covers at least the greater of: 1. One drug in every USP category and class; OR 2. The same number of drugs in each category and class as benchmark plan. (45 CFR 156.120)	• Confirm the number of drugs per category and class**; and • Collect issuer attestation of compliance with EHB formulary standards.
Prohibition on Discrimination	An issuer cannot discriminate based on an individual's age, expected length of life, present or predicted disability, degree of medical dependency, quality of life, or other health conditions (45 CFR 156.125).	• Confirm review for non-discrimination. If state has not reviewed, conduct outlier test to identify potentially discriminatory benefit designs**. • Collect issuer attestation of compliance with non-discrimination standards.
AV standards*	Offers plans at metal levels specified in statute (45 CFR 156.135).	Confirm that the AV for each QHP meets specified levels (or falls within allowable variation): • Bronze plan: 60% (58 to 62%) • Silver plan: 70% (68 to 72%) • Gold plan: 80% (78 to 82%) • Platinum plan: 90% (88 to 92%) Review for unique plan designs, if applicable.
Standards that Apply to QHPs Seeking Exchange Certification		
Licensure and solvency	Licensed by and in good standing with the state (45 CFR 156.200(b)(4)).	• Confirm that state has licensed the issuer and determined that the issuer is in good standing; or • Collect issuer attestation to meeting state licensure and solvency requirements.
Network adequacy	Network includes sufficient number and types of providers (including providers that treat substance abuse and mental health conditions) to ensure that all services are available without unreasonable delay (45 CFR 156.230). Note: also applies to stand-	Collect attestation that issuer meets standard **plus** one of the following: • If HHS determines that state has an effective network adequacy review***, HHS will confirm that the state has approved the issuer's network; • If HHS determines that a state does not have

	alone dental plans.	an effective network adequacy review, HHS will accept the issuer's attestation alone if the issuer is accredited for an existing line of business (commercial or Medicaid) by an HHS-recognized accrediting entity; or • If HHS determines that a state does not have an effective network adequacy review and the issuer is not accredited, HHS will collect an access plan for the QHP. HHS will also collect provider network data from a sampling of selected issuers following certification, and will also monitor accessibility complaints. Obtain link to issuer's provider directory for display on the Exchange website.
Inclusion of ECPs	Network includes sufficient number and geographic distribution of ECPs, where available, to ensure reasonable and timely access to a broad range of ECPs (45 CFR 156.235). Note: also applies to stand-alone dental plans.	Based on HHS-developed ECP list, verify one of the following: • Issuer achieves at least 20% ECP participation in network in the service area, agrees to offer contracts to at least one ECP of each type available by county, and agrees to offer contracts to all available Indian providers****; • Issuer achieves at least 10% ECP participation in network in the service area, and submits a satisfactory narrative justification as part of its Issuer Application; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its Issuer Application. Justifications submitted by issuers that fail to achieve either standard will undergo stricter review by CMS. The above standard is a transitional policy to accommodate first year timeframes.
	Issuer that provides a majority of covered services through employed physicians or a single contracted medical group complies with the alternate standard established by the Exchange (45 CFR 156.235(b)).	Verify one of the following: • Issuer has at least the same number of providers located in designated low-income areas[18] as the equivalent of at least 20% of available ECPs in the service area; • Issuer has at least the same number of providers located in designated low-income areas as the equivalent of at least 10% of available ECPs in the service area, and submits a satisfactory narrative justification

[18] HHS will consider a low-income area a Health Professional Shortage Area (HPSA) or a zip code in which at least 30 percent of the population have incomes below 200 percent of the federal poverty limit.

		as part of its Issuer Application; or • Issuer fails to achieve either standard but submits a satisfactory narrative justification as part of its Issuer Application. The above standard is a transitional policy to accommodate first year timeframes.
Marketing	Complies with state marketing laws and regulations (45 CFR 156.225(a)).	• Collect issuer attestation to meeting state marketing standards.
Accreditation*	Be accredited based on local performance by an accrediting entity recognized by HHS on the timeline established for an FFE (45 CFR 155.1045). Issuers must authorize the release of their accreditation survey data.	• Verify that issuer meets FFE accreditation timeline requirements. • Collect and verify information on issuers' existing accreditation (if applicable). • Verify that issuer has authorized release of accreditation data.
Service area	The service area of a QHP must be at minimum an entire county, or a group of counties, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, in the best interest of the qualified individuals and employers, and was established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations (45 CFR 155.1055).	Conduct automated check to identify partial-county requests. If a partial county request is identified, conduct case-by-case manual review of justification**.
Rate increases for QHPs	Exchange must review all rate increases and justifications, along with recommendations provided under Public Health Service Act section 2794(b) and rate increase trends inside and outside the Exchange, and take such information into consideration when making QHP certification determinations (45 CFR 155.1020(b)).	Confirm the results of Effective Rate Review programs.
Non-discrimination	Issuer does not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation (45 CFR 156.200(e)).	Collect issuer attestation to meeting regulatory standards.
Non-discrimination	QHP issuer does not employ benefit designs that will discourage the enrollment of individuals with significant health needs (45 CFR 156.225(b)).	• Conduct outlier analysis or other automated test to identify possible discriminatory benefits**. • Review benefit designs identified outliers and/or results of automated test.

		• Collect issuer attestation to meeting regulatory standards.
Plan Variations for Individuals Eligible for Cost-Sharing Reductions and for American Indian/Alaska Native Populations*	Issuer must offer three silver plan variations for each silver QHP, and one zero cost sharing plan variation and one limited cost sharing plan variation for each metal level QHP. Silver plan variations must have a reduced annual limitation on cost sharing, cost sharing requirements and AVs that meet the required levels within a de minimis range. Benefits, networks, non-EHB cost sharing, and premiums cannot change. All cost sharing must be eliminated for the zero cost sharing plan variation. Cost sharing for certain services must be eliminated for the limited cost sharing plan variation.	Conduct automated review via rate and benefit templates. Review AV for non-standard plan designs using approach described above.

*These standards are currently the subject of regulatory proposals and their inclusion here is subject to adoption of final rules that are consistent with the proposals.

**To the extent permissible under applicable law, HHS will make available an analytic tool, analytic parameters, or other resources (e.g., scenarios) to support states.

***HHS would determine whether a state has an effective network adequacy review based upon whether the state has statutory authority to review issuers' networks, and whether the authority allows the state to determine whether the issuer/health plan maintains a network sufficient in number and type of providers to ensure that all services will be accessible without unreasonable delay.

****Contracts offered must reflect the generally applicable payment rates of the issuer, and must account for the payments to FQHCs under 1902(bb), unless the FQHC and issuer mutually agree on other rates. Contracts offered to Indian providers are encouraged include the QHP Addendum for Indian providers.