Potential Areas of Involvement for State Public Health Institutes/State and Local Health Departments in Establishment of Health Insurance Exchanges under the Affordable Care Act

Introduction

A key provision of health reform establishes state-level Health Insurance Exchanges to organize the health insurance marketplace for individuals and small businesses. This memo provides background on the roles and responsibilities of Exchanges, and sets out important implementation dates. It also describes potential opportunities for state and local health departments and other public health stakeholders to engage in the Exchange process.

Background: Health Insurance Exchanges under the Affordable Care Act

A major goal of the Affordable Care Act (ACA) is the establishment of efficient and competitive health insurance markets for individuals and for small businesses. To this end, ACA calls for states and territories to establish “Health Insurance Exchanges” through which individuals and small business can purchase qualified health plans.

By January 1, 2014, each state may establish two types of Exchanges: the “American Health Benefit Exchange,” which will let individuals purchase health insurance, and the Small Business Health Options Program, or “SHOP” Exchange, which will assist small businesses in enrolling their employees in qualified health plans in the small group market. States may choose to combine their Exchanges for individuals and for small businesses into a single Exchange, as long as there are adequate resources to meet the needs of both kinds of consumers. In addition, states can consider developing regional or multi-state Exchanges.

ACA provides tax credits to help low- and moderate-income individuals buy insurance coverage through an Exchange. Therefore, it is expected that Exchanges will be the primary vehicle through which health insurance is expanded to low- and moderate-income people who are currently uninsured and not included in the Medicaid expansion population.

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1 Small businesses are defined as those with 100 or fewer employees, though for plan years beginning before January 1, 2016, states may choose to limit Exchange access to businesses with 50 or fewer employees.
2 According to the most recent estimates from the Congressional Budget Office, starting in 2016, between 20 million and 23 million people will become covered through new Exchanges. Another 16 to 17 million will newly enroll in Medicaid or CHIP. Congressional Budget Office, “Updated April 2012
The law mandates that every Exchange provide information to consumers to compare available plan options based on price, benefits, services and quality. In addition, the Exchange must help individuals identify any other health coverage for which they are eligible, including Medicaid and CHIP, and facilitate enrollment in these programs where appropriate. Exchanges are required to maintain both toll-free hotlines and websites to make information available in a clear, accessible format.

Exchanges will offer a choice of “qualified health plans” (QHPs) that vary in coverage levels, but meet certain standards in categories of care and limits on patient cost-sharing. To qualify for participation in the Exchanges, all QHPs must cover a set of “essential health benefits” in ten categories outlined in the Affordable Care Act. The categories are 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; and pediatric services including oral and vision care. Department of Health and Human Services, “Essential Health Benefits: HHS Informational Bulletin” (Updated Feb. 24, 2012) (available at http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html).

For states that are unable or unwilling to establish Exchanges, ACA directs the Secretary of Health and Human Services to establish and operate an Exchange in that state. All of the provisions above will apply to these “Federally-facilitated exchanges” (FFEs). State governments may choose to partner with the Federal government by performing plan management functions, consumer assistance functions, or both; the Federal government will still be responsible for some centralized functions, such as operating a website and consumer hotline.

Where there is no State participation, the Federal government will conduct all functions of the Exchange. Public health stakeholders in states that are not developing their own Exchanges should still consider

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3 The categories are 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; and pediatric services including oral and vision care. Department of Health and Human Services, “Essential Health Benefits: HHS Informational Bulletin” (Updated Feb. 24, 2012) (available at http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html).


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engaging in the issues discussed in this memo as the federal government works to establish Exchanges in such states.

**Timeline of Major Steps in the Establishment of Exchanges**

*Note – all projected dates are subject to change*

**July 27, 2010:** HHS issued a Request for Comments on the Planning and Establishment of State-Level Exchanges.  

**November 18, 2010:** HHS issued an Initial Guidance to States on Exchanges.  

**March 12, 2012:** HHS issued a final rule regarding State Exchanges, with detailed information on state requirements, enrollment, eligibility, and insurance subsidies.  

**January 1, 2013:** ACA requires the HHS Secretary to assess state Exchange planning efforts and to make a determination as to whether each state will have an Exchange operational by **January 1, 2014**. If the Secretary determines that a state will not have an Exchange operational by 2014 or that a state has not taken the actions necessary to adopt federal standards for Exchanges, the Secretary will establish and operate an Exchange within that state, potentially with State collaboration.  

**January 1, 2014:** States that elect to establish an Exchange must adopt and have in effect: (i) all federal standards and criteria for the establishment and operation of Exchanges; and (ii) a state law or regulation that the HHS Secretary determines adequately implements Exchange standards within the state.  

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6 Department of Health and Human Services, “Initial Guidance to States on Exchanges” (available at www.healthcare.gov/center/regulations/guidance_to_states_on_exchanges.html).

Considerations for Public Health Departments and Partners

There are a number of ways in which state and local public health departments, public health institutes, and community-based organizations may consider engaging with the Exchange development process in their states, regardless of whether the Exchanges are run at the State or Federal level.

- **Determine the Status of the State Exchange Process.** In September of 2010, HHS awarded grants to 48 states and DC to begin planning the development of Exchanges. However, since that time, not all states have decided to establish their own Exchanges. The Kaiser Family Foundation has developed a database that tracks the status of Exchange development within each state; another website supported by the National Academy for State Health Policy and the Robert Wood Johnson Foundation provides a forum for state-specific exchange of information. As of March 2012, 13 states and DC had established Exchanges; three states had plans to establish Exchanges; twenty states were studying their options; twelve had seen no significant activity; and two had explicitly decided not to create Exchanges. Health departments and other interested parties should consult this and other resources to determine whether their state is developing an Exchange and, if yes, which agency or other entity will be administering it.

As discussed above, in states that are unable or unwilling to establish an Exchange, the federal government will be creating and running Exchanges, with the potential for some State involvement. Tracking these developments and decisions within each state will be key to understanding how the uninsured will access coverage and how public health departments can be involved. However, all of the issues below will be important regardless of whether the State or Federal government is running a given Exchange.

- **Governing Board and/or Advisory Group Membership.** Exchanges will be governed by a board, and many states are also establishing advisory groups to the Exchange. Public health departments and others may consider recommending to state legislatures and others with influence over the design of Exchanges that the governing board or advisory group include one or more members with public health expertise. This will help decision-makers remain cognizant of public health and community-level health concerns throughout the entire process, both

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during Exchange establishment and once Exchanges are operational. State and local groups interested in the public health implications of the Exchange could also set up a communication network to share information learned during these meetings, as appropriate.

- **Other Stakeholder Consultations.** The Affordable Care Act requires Exchanges to consult with stakeholders “relevant to carrying out” their required activities, including consumers enrolled in qualified health plans, people with experience with qualified health plan enrollment, representatives of small businesses and the self-employed, state Medicaid offices, and advocates for enrolling hard-to-reach populations. State and local health departments and related organizations may ask that state and local public health groups be formally included in their respective states’ consultation processes.

- **Outreach and Enrollment.** As discussed above, the Exchanges are expected to be the primary mechanism for expanding coverage to low- and moderate-income uninsured people. All individuals and families with income between 133% and 400% of the poverty level will be eligible for premium tax credits if they enroll in plans through the Exchange. Public health departments and organizations may be valuable sources of information and expertise on how to best reach this population.

  A specific avenue for engagement is the “Navigator” grant program. Exchanges are required to offer grants to entities to act as Navigators, providing public education about qualified health plans in the Exchange, distributing information about enrollment and tax credits, facilitating enrollment, and providing culturally and linguistically appropriate information. Entities eligible for Navigator grants may be private or public entities. In the March 2012 final rule, HHS stated that at least one Navigator grantee in each state must be a “[c]ommunity and consumer-focused nonprofit group.” Public health departments and their partners should determine if a public health-focused organization would be an appropriate applicant for this slot.

- **Interface with Medicaid and Basic Health Programs.** Starting in 2014, eligibility for the Medicaid program will be expanded to all individuals below 133% of the Federal Poverty Level, regardless of family or disability status.11 In most states, this will represent a significant expansion of the program, most notably to childless adults. Exchanges will be required to provide information appropriate to all individuals seeking insurance coverage, including information about eligibility and enrollment in Medicaid or CHIP. Under the March 2012 final rule, Exchanges may conduct eligibility assessments for Medicaid and CHIP, or they may make an initial assessment and then transition the full assessment to the state Medicaid agency. Public health organizations with experience serving

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11 A standard 5% deduction applies, so the effective income limit will be 138% of poverty or about $30,000 for a family of four.

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uninsured populations may seek ways to collaborate with Exchanges to best reach the Medicaid expansion population with culturally and linguistically appropriate information and enrollment assistance.

States have the option under ACA to establish “basic health programs” for low-income residents with income between 133% and 200% of the Federal Poverty Level. Basic health programs must provide at least the essential health benefits and must include substantial cost-sharing restrictions. Individuals eligible for these standard health plans must not be otherwise eligible for Medicaid, Medicare, or for minimum essential coverage or employer-sponsored coverage.

Public health organizations may want to engage with Exchanges and state Medicaid programs about how best to address enrollees whose income levels fluctuate and impact their eligibility for Medicaid, the basic health program (if applicable in that state) and Exchange subsidies. Advocacy efforts may be needed to ensure that prevention-related benefits offered to Medicaid enrollees – as well as other benefits - are consistent with those offered in the Exchange. Ensuring consistency in the benefits offered across programs would provide a steady level of health care service even when individuals inevitably switch between health insurance programs.

- **Essential Benefits Package.** In December 2011, HHS issued a bulletin outlining the approach the department plans to take regarding the essential benefits package that all qualified health plans in Exchanges must offer. Under this planned approach, states will select as a benchmark one of the following: one of the three largest small group plans in the state by enrollment; one of the three largest state employee health plans by enrollment; one of the three largest federal employee health plan options by enrollment; or the largest HMO plan offered in the state’s commercial market by enrollment. The selected plan will be considered “typical employer coverage” for purposes of the Exchange in that state, and plans offered through the Exchanges must reflect the same scope of services.

As discussed above, plans in Exchanges must offer ten categories of services. If the selected benchmark plan fails to cover all ten categories, the state can look at other plans, such as federal employee health plans, to decide what coverage to require in the missing categories.

Public health departments and organizations familiar with the preventive and other health needs of underserved populations in the state may want to make recommendations regarding the selection of benchmark plan and how states choose to cover benefits in any categories not covered by that plan.

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13 See supra note [3].
• **Essential Community Providers.** To qualify for Exchanges, health plans must include within their networks certain “essential community providers” (ECPs) that serve predominantly low-income, medically-underserved individuals. The March 2012 final rule states that plans in Exchanges must contract with “a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP’s service area, in accordance with the Exchange’s network adequacy standards.”

While this rule gives states a certain amount of flexibility, the preamble offers examples of how states may choose to further expand access to ECPs. First, while the state is required to deem certain statutory categories of providers to be ECPs, they may also use the ACA definition – “providers that serve predominantly low-income, medically underserved individuals” – to identify a broader set of entities. Second, the preamble notes that states may offer health plans incentives to contract with essential community providers beyond the federal minimum standard.

Effective implementation of the essential community provider requirement is extremely important in ensuring that underserved populations are able to access the benefits in the essential health benefit package. Safety-net providers – such as community health centers, family planning clinics, STD clinics, school-based health centers, public hospitals and public health departments – often represent the primary or sole source of care for many medically-underserved populations.

Given the flexibility that states have with regard to essential community providers under the final rule, public health entities may wish to closely monitor how their states implement HHS regulations on ECPs. Activities could include an assessment of the role and capacity of particular safety-net providers within the state to support an argument for broad inclusion of ECPs in qualified health plan networks. In addition, it may be helpful to assess the capacity of such providers to participate in insurance networks, including their ability to do third-party billing, and promote efforts to improve this capacity if necessary. Interested parties may wish to encourage states to broaden the definition of essential community provider, and to create incentives for plans in Exchanges to contract with higher levels of such providers than the federal minimum standard requires.

• **Linkages to Broader Public Health Programs.** Public health departments and organizations may consider ways in which their Exchanges could also link people to state and local public health information, whether through the Exchange hotline or website, or through Navigators. For example, based on information that individuals provide to determine eligibility for Medicaid or for Exchange premium tax credits, they could also be offered the option of learning more about

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14 Department of Health and Human Services, “Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers,” *supra* note [8].

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applicable public health programs for which they or their families might be eligible. Exchanges could also offer information about public health education opportunities, healthy food availability, or community-based health programs funded through the Community Transformation Grant program. Similar efforts could be made to link small businesses with public health information for their employees. Public health departments and organizations could work with Exchanges to determine how to make such information available in a way that offers easy access without overwhelming consumers.

- **Public Health Surveillance and Monitoring.** Exchanges, and the qualified plans that they include, will be required to report a wide range of health quality information. Public health departments and other organizations may wish to consider how this information will be used to improve the quality of health services within the state. The data may be valuable not only for plan-specific improvements, but also for assessing overall health trends in the state.

Such surveillance and analysis may be particularly useful in the area of health and healthcare disparities. The Affordable Care Act requires that all government health programs collect information on race, ethnicity, sex, primary language, and disability status. The HHS Secretary may also require data collection beyond these five categories.

Information from Exchanges and qualified health plans, stratified by these and other categories, could be excellent sources of data for public health analyses of disparities in health and health status. As HHS guidance on data collection is developed, public health departments and organizations may wish to initiate conversations with Exchanges regarding the use of this data for public health analyses.

**Conclusion**

It is increasingly apparent, given the flexibility that HHS is granting to states, that many important decisions about health insurance Exchanges will happen at the state level. Even in states that have decided not to create Exchanges for now, federal or hybrid federal-state Exchange establishment will involve state-level factors. For implementation to be carried out in a way that addresses public health priorities and needs, public health institutes, state and local health departments, and their partners should actively engage throughout the process.