

SUBTITLE B—STATE EXCHANGES AND CONSUMER ASSISTANCE

State Exchanges and Marketing Requirements

Current Law

No specific provision exists in Federal law today regarding a health insurance exchange. At the state level, however, Massachusetts established a health insurance Connector, which is described below for illustrative purposes.

In 2006, in tandem with substantial private health insurance market reforms, Massachusetts created the Health Insurance Connector Authority, governed by a Board of Directors, to serve as an intermediary that assists individuals in acquiring health insurance. In this role, the Health Connector manages two programs. The first is Commonwealth Care, which offers a government-subsidized plan at three benefit levels from a handful of health insurers to individuals up to 300 percent of the Federal poverty level (FPL) who are not otherwise eligible for traditional Medicaid or other coverage (e.g., job-based coverage). The second is Commonwealth Choice, which offers an unsubsidized selection of four benefit tiers (gold, silver, bronze, and young adult) from six insurers to individuals and small groups.

Under state law, the Board of Directors, with its 11 board members, has numerous responsibilities, including the following: determining eligibility for and administering subsidies through the Commonwealth Care program, awarding a seal of approval to qualified health plans offered through the Connector's Commonwealth Choice program, developing regulations defining what constitutes "creditable coverage," constructing an affordability schedule to determine if residents have access to "affordable" coverage and may therefore be subject to tax penalties if they are uninsured, and developing a system for processing appeals related to eligibility decisions for the Commonwealth Care program and the individual mandate.

Chairman's Mark

Plan Participation. All private insurers in the individual and small group markets that operate nationally, regionally, statewide, or locally must be available in a newly established state exchanges, if the insurers are licensed by a state (that is, a state has determined that the plans meet all the market-reform requirements).

Establishment of State Exchanges. States would be required to establish an exchange for the individual market and a Small Business Health Options Program (SHOP) exchange for the small group market, with technical assistance from the Secretary, in 2010. This requirement may encompass a single exchange with separate resources for individual and small-group customers. The Secretary would be required to establish and maintain a database of plan offerings for use by state exchanges. The database would enable the review of state-specific information. The Secretary could contract out to a private entity for the operation of the plan database.

In 2010, 2011 and 2012, so-called "mini-medical" plans with limited benefits and low annual caps would be prohibited from being offered in the state exchanges. All other policies would be

offered in the state exchange. Beginning January 1, 2013, all plans offered in the individual and small group market, whether through the exchange or outside of the exchange, would have to comply with the rating reforms and benefit options detailed in the Chairman's Mark.

Legal U.S. residents will be able to obtain insurance through the state exchanges. Parents who are in the country illegally will not be able to buy personal insurance coverage through the state exchange but will be able to buy insurance for their U.S. citizen or lawfully present children.

Functions Performed by Secretary and/or States. The Secretary and/or states would do the following:

1. After consultation with state insurance commissioners, develop a standard enrollment application for eligible individuals and small businesses seeking health insurance through the state exchange, whether done electronically or on paper;
2. Provide a standardized format for presenting insurance options in the state exchange, including benefits, premiums, and provider networks (allowing for customized information so that individuals could sort by factors such as ZIP code or providers);
3. Develop standardized marketing requirements consistent with the NAIC model regulation;
4. Maintain call center support for customer service that includes multilingual assistance — the center would have the ability to mail relevant information to residents based on their inquiry and ZIP code;
5. Enable consumers to enroll in health care plans in local hospitals, schools, Departments of Motor Vehicles, local Social Security offices, and any other offices designated by the state;
6. Develop a model template for a Web portal for use by the states that directs individuals and small businesses to available insurance options in their state, provides a tax credit calculator so individuals and small businesses can determine their true cost of coverage, informs individuals of eligibility for public programs, and presents standardized information related to insurance options, including quality ratings;
7. Conduct eligibility determinations for tax credits and subsidies (as performed by a Federal agency that also reports the information to the Internal Revenue Service (IRS) for end-of-year reconciliation) and enable enrollment of individuals and small businesses;
8. Establish procedures for granting an annual certification upon request of a resident who has sought health insurance coverage through the state exchange, attesting that, for the purposes of enforcing the individual requirement, no health benefit plan which meets the definition of creditable coverage was deemed affordable by the exchange for that individual—and maintain a list of individuals for whom certificates have been granted