Part X: State Insurance Exchanges (Marketplaces)

State, State-federal Partnerships, and Federally Facilitated Exchanges (FFEs)

417. What are the state health insurance exchanges or marketplaces?

A centerpiece of healthcare reform is the state insurance exchanges, which the federal government more recently has labeled marketplaces. Healthcare reform requires states and certain other governmental entities[[1]](#footnote-1) to create exchanges, a competitive marketplace for individuals and small businesses to purchase insurance. Exchanges, for the calendar year beginning January 1, 2014 and thereafter, will be the main way that people gain insurance coverage when they do not receive it from their employer. (Initial enrollment began Oct. 1, 2013.) While the exchanges will be a major avenue to health insurance, it is likely that the majority of people will continue to obtain coverage from their employers.

As discussed below, there are three types of state exchanges:

* those created by a state
* state-federal partnership exchanges, and
* federally facilitated exchanges (FFEs) in those states that do not create or operate their own exchange

Exchanges will provide individuals and small business owners with a "one stop shop" to compare and buy health insurance. The purpose is to provide consumers with more control and greater transparency for making choices about health insurance. People can also enroll in public programs, such as Medicaid and CHIP (for children), through exchanges. Exchanges are intended to use the power of a large insurance pool, made up of individuals and small businesses, to generate competition among insurers to offer better quality plans at a lower cost.

 Terminology Politicized. Opponents of the federal healthcare reform law tend to refer to the exchanges that were set up by the Department of Health and Services as “federal exchanges” because they were established by the federal government, albeit on a state-by-state basis. As will be discussed later, opponents of the federal healthcare reform law contend that no one who lives in a state with a “federal exchange” can receive a premium tax credit or subsidy for their exchange purchased health insurance, even if their income is low enough. When this book refers to a state exchange or marketplace, the reference typically includes all three types of exchanges described above.

417.1 What is the status of the exchanges and healthcare reform in the five US territories?

By letter dated July 16, 2014,[[2]](#footnote-2) HHS has reversed its position that healthcare reform required insurers in five US territories to comply with the law’s major market reforms, i.e., guaranteed coverage, mandated benefits, and limits on insurers’ profits. Healthcare reform does not require residents in Puerto Rico, the U.S. Virgin Islands, American Samoa, Guam and the Northern Mariana Islands to get coverage nor does it provide subsidies like those on the states’ exchanges to help lower income persons afford coverage. In 2014 HHS determined, contrary to its prior position, that the definition of “state” in the Public Health Service Act, which is the law that imposes the insurance mandates, indicates that the ACA market rules do not apply to the territories. The territories are exempt from guaranteed coverage, community rating, single risk pools, rate review, the medical loss ratio, essential health benefits requirements, and the rules limiting the profits of insurers. However, group health plans in the territories must still comply with other requirements, such as the prohibition on lifetime and annual limits (PHS Act section 2711), the prohibition on rescissions (PHS Act section 2712), coverage of preventive health services (PHS Act section 2713), and the internal and external appeals process (PHS Act section 2719).

418. What is the relationship between the exchanges for individuals and small businesses?

Healthcare reform created two kinds of exchanges: health insurance exchanges for individuals and Small Business Health Options Program (SHOP) exchanges for small business owners.

The law delegates primary responsibility for governing and operating the exchanges to the states, with the federal government (primarily HHS) setting minimum standards. States have the option to merge the individual and SHOP exchanges, collaborate with other states to form multi-state regional exchanges, or to form multiple exchanges within their state if each one serves a geographically distinct area.

Beginning in 2014, however, purchasing employer-provided health coverage for employees through a SHOP will be the only way for qualified employers to obtain a small business health care tax credit.

HHS will issue rules allowing a state that has already received conditional approval to operate a state-based exchange for 2014 to request permission to operate a SHOP-only Exchange instead while the individual market operates under an FFE.[[3]](#footnote-3) For years after 2014, HHS will provide rules requiring states to request approval to operate a SHOP-only Exchange using a special application. The FAQs also clarify that a SHOP-only Exchange must have a state-run navigator program, but it may be limited to consumer outreach and education activities, while the FFE would operate its own navigator program in the individual market.[[4]](#footnote-4)

419. What is the biggest loophole in the law as to exchange purchased health insurance?

This loophole is an intentional attempt to assist those who temporarily cannot afford the exchange health insurance they purchased. The result is that insureds receiving subsidies for their health insurance purchased on an exchange need only pay premiums for nine months for twelve months of health insurance coverage. As a result providers may inadvertently give uncompensated care for up to two months per year for such insureds. Under the law,[[5]](#footnote-5) families who obtain subsidized health plan coverage through an exchange and fail to pay their premiums have a three-month grace period to pay the premiums[[6]](#footnote-6) due before the policy is cancelled.[[7]](#footnote-7)

Thus, doctors and hospitals who treat patients with such subsidized exchange health insurance could find themselves liable for uncompensated treatment costs due to the healthcare reform law. The three-month grace period was meant to ensure continuity of care for low-income families who might be between jobs and could not afford to pay their premiums for a few weeks. However, it also creates a loophole for insureds who want to game the system. Insurers are responsible only for paying claims during the first month of this three-month grace period. During months two and three, families are asked to pay their hospital and doctor's bills (or their delinquent insurance premium) if they seek health care services. However, if they do not pay either bill, providers will not be paid for the cost of the treatment.[[8]](#footnote-8)

Providers might be unable to avoid treating exchange patients, even if they discover they will not be paid if the delinquent premiums are not paid. Contracts by providers with large health insurers often include an "all-products" clause, which requires that doctors treat any patients covered under the health plan. Doctors have legal and ethical obligations not to abandon their patients during course of treatment.

In a notice published in the Federal Register,[[9]](#footnote-9) HHS acknowledged that nonpayment of premiums for subsidized exchange policies would "increase uncertainty for providers and increase the burden of uncompensated care." HHS officials said that the agency will "monitor this issue moving forward and will continue to work on the development of policies to prevent misuse of the grace period."

Persons who have delinquent exchange insurance premiums would face tax penalties for any advance payment of premium tax credits paid on their behalf when the individual did not pay for coverage, but they would not receive a fine, a premium rate increase, or a repayment order. They could also enroll in another subsidized exchange policy the next year even if they never pay all or a part of the three months of missed premiums.

Here is how this three-month grace period works, according to examples #2 and 3 in the summary of the regulations[[10]](#footnote-10)

**Example #2:** Individual misses $50 payment that is due February 28 for March coverage and misses $50 payment that is due March 31st for April coverage. Individual pays $150 on April 30 for March, April and May coverage.

* Issuer adjudicates claims for March
* Coverage continues for April and May (second and third months of the grace period), but:
* Providers are notified of the potential for a denied claim
* Issuer pends claims for services performed in April and May until individual pays outstanding premiums
* Individual has paid full premium for March, April, and May as is eligible for premium tax credit for March, April, and May

**Example #3:** Same facts as Example #1 except that individual does not pay enrollee's share of premium for March, April, or May.

* Coverage terminated retroactively to March 31
* Issuer can deny claims for services rendered during April and May. Providers could then seek payment directly from the individual for any services provided during that time
* Individual may have additional tax liability attributable to the $450 for the advance payment of the premium tax credit paid on his or her behalf for March's coverage. The exact amount of additional tax liability would be determined in accordance with the rules for tax credit reconciliation under section 36B of the Code.

420. What if a state elects not to create its own exchange?

If a state decides not to run its own exchange or does not meet minimum federal standards, HHS can create a federal exchange in that state or find a not-for-profit entity to run it. Sixteen states are setting up their own exchanges. Eight additional states are collaborating with HHS to set up exchanges. These are called state-federal exchanges. In the rest of the states, HHS is required to set up the state marketplaces, which are called federally facilitated exchanges (FFEs). In June 2013, GAO reported that it "cannot yet be determined" if the exchange marketplaces will be ready for enrollment in all states.

HHS has also provided for a federally facilitated SHOP (FF-SHOP) in states that do not establish a state-based Exchange.[[11]](#footnote-11)

See Q 50.

421. When can individuals and businesses purchase insurance on the exchanges?

HHS announced that the initial open enrollment period will run from October 1, 2013, through March 31, 2014.[[12]](#footnote-12) The annual enrollment period for 2015 and subsequent years will begin October 15 and extend through December 7 of the preceding calendar year.[[13]](#footnote-13)

Additionally, exchanges must offer special enrollment periods.[[14]](#footnote-14) Under final exchange regulations, the exchanges must allow qualified individuals and enrollees to enroll in a QHP or change from one to another because of the following triggering events:[[15]](#footnote-15)

* A qualified individual or dependent loses minimum essential coverage. Loss of minimum essential coverage does not include termination or loss due to failure to pay premiums on a timely basis (including COBRA premiums prior to expiration of COBRA coverage) or certain situations allowing for rescission.[[16]](#footnote-16)
* A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption
* An individual, who was not previously a citizen, national, or lawfully present individual gains such status
* A qualified individual’s enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of the exchange or HHS
* An enrollee adequately demonstrates to the exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee
* An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. (The exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer’s upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan)
* A qualified individual or enrollee gains access to new QHPs as a result of a permanent move
* An individual may enroll in a QHP or change from one to another one time per month; and
* A qualified individual or enrollee demonstrates to the exchange that the individual meets other exceptional circumstances (as defined by the exchange).

The special enrollment period generally is 60 days from the date of the triggering event.[[17]](#footnote-17) Coverage must be effective as of the first day of the following month for elections made by the 15th of the preceding month and on the first day of the second following month for elections made between the 16th and the last day of a month (but coverage must be effective on the date of birth, adoption, or placement for adoption, when that is the special enrollment triggering event).

422. What levels of health insurance are available on the exchanges?

There will be health insurance offerings at bronze, silver, gold, or platinum level coverage (benefits that are actuarially equivalent to 60 percent, 70 percent, 80 percent, or 90 percent of the full actuarial benefits provided under the plan[[18]](#footnote-18) or a catastrophic plan (also known as “young invincibles” coverage).[[19]](#footnote-19)

Insurers can offer a catastrophic plan to two types of insureds on an exchange. A catastrophic plan is one that provides coverage for essential health benefits and provides no benefit for any plan year until the individual has incurred cost-sharing expenses equal to the overall cost-sharing limit ($5,000 deductible for single coverage and $10,000 deductible for family coverage) for the plan year.[[20]](#footnote-20) The deductible cannot apply to at least three primary care visits. A catastrophic plan is permitted only in the individual market and only for (a) young adults who are under age thirty before the plan year begins (called the “young invincibles” because they are more likely not to purchase insurance), and (b) persons exempt from the individual mandate because affordable coverage is not available or they have an HHS hardship exemption.[[21]](#footnote-21)

423. What subsidies are available for individuals purchasing health insurance on an exchange?

Subsidies are provided for individuals earning less than 400 percent of the federal poverty level. The lower a person’s income, the greater the subsidy will be. However, as discussed in the next question, the law is not clear as to whether a subsidy is available in the majority of the exchanges, i.e., the exchanges established by HHS in thirty-six states.

423.01 What have the courts said about the ability of those purchasing insurance on a stated exchange established by the federal government to qualify for a subsidy?

 This issue is being litigated in many courts. More decisions are to come. Two federal Circuit Courts have issued conflicting rulings on whether the federal government can subsidize health insurance premiums for people in thirty-six that use an insurance exchange run by the federal government. Due to this split in the Circuits and the importance of the issue, it seems very likely that the U.S. Supreme Court will rule on this issue, perhaps in its term that begins in the fall of 2014. However, that could be mooted if the entire DC panel issues a contrary decision, and the administration plans to ask for a decision by a full panel of the DC Circuit, a so called en banc review, which triggers an automatic stay of the effect of this decision. However, since the issue is also being litigated in other circuits, and there are decent arguments for both sides, it is likely that this issue will eventually reach the US Supreme Court.

The Fourth Circuit in *King v. Burwell[[22]](#footnote-22)* unanimously upheld the subsidies, saying that the regulations issued by the IRS saying that the eligible (by income below set thresholds) residents of all states are eligible for the subsidies was “a permissible exercise of the agency’s discretion.” The DC Circuit ruled 2-1 in *Halbig v. Burwell[[23]](#footnote-23)*that the federal government could not subsidize insurance for people in states whose exchanges were established by HHS and vacated the IRS regulations under IRC § 36B. The IRS interpreted section 36B broadly to authorize the subsidy also for insurance purchased on one of the thirty-six exchanges established by the federal government.[[24]](#footnote-24) For some of those exchanges, the states in question assisted the federal government in creating the exchange for that state. Initially, fourteen states and the District of Columbia established their own exchanges.

The key language in dispute is the provision that the tax subsidies are available to eligible taxpayers “enrolled in through an Exchange established by the State. “[[25]](#footnote-25) In essence, those who argue that all exchanges qualify argue that all exchanges are state exchanges, including those states where the exchange was established for that state by HHS or by HHS in cooperation with that state and that the purpose of the law would be frustrated if those only in state created state exchanges would qualify for the tax subsidies. Those arguing that the tax subsidies should only be given to lower income taxpayers in states in which the state itself established the exchange point to the literal language of the law, arguing that its purpose was to encourage states to create their own exchanges so that their residents could enjoy the tax subsidies.

The ultimate outcome of this issue is extremely important, as more than half of those persons purchasing health insurance on an exchange receive a subsidy. No doubt, many if most of those would not purchase the insurance without the subsidy, frustrating on of healthcare reform’s purposes to expand health insurance coverage.

In addition, the employer mandate is not triggered by the mere purchase of insurance bv an employee on an exchange, but rather it is triggered by the subsidized purchase of health insurance on an exchange. If residents of thirty six states are not eligible for subsidies, the impact of and revenues from the employer mandate tax would decline dramatically.

**423.02 Can pharmaceutical companies help pay for copays and deductibles for prescription drugs for exchange-purchased insurance; Can hospitals and other healthcare providers make premium payments for individuals with exchange health insurance?**

Pharmaceutical companies can help cover the cost of copayments on brand-name drugs for patients who get insurance through qualified health plans sold on the insurance exchanges (marketplaces) through coupons and other methods. While drug companies cannot pay any copayments for drugs paid by Medicare (such payments would be an illegal kickback for benefits paid by a federal program), HHS has determined that health insurance offered on the exchanges is not a “federal health care program,” whether state run or federally assisted.[[26]](#footnote-26)

However, HHS says that hospitals, other healthcare providers, and other “commercial entities” should not make premium payments to health insurance issuers for qualified health plans purchased on an exchange. HHS states that this practice could skew the insurance risk pool and create an uneven field in the exchanges (marketplaces). “HHS discourages this practice and encourages issuers to reject such third party payments. HHS intends to monitor this practice and to take appropriate action, if necessary.”[[27]](#footnote-27)

However, despite this CMS this statement, seemingly a hospital could assist an uninsured patient with the purchase of exchange insurance. A tax exempt hospital should consider the relationship of any premium assistance to its mission and charitable purposes and structure such assistance to avoid private benefit issues. Premium assistance provided to patients may also result in tax liabilities for the patients, and providers may be required to report each patient’s premium assistance amounts on a Form 1099-MISC.

The IRS has already indicated that “employer payment plans” cannot reimburse exchange or privately purchased health insurance with pre-tax dollars. An employer payment plan is one that reimburses an employee for individually purchased health insurance, including but not limited to exchange purchased health insurance, on a pre-tax basis.[[28]](#footnote-28) This practice is not permitted for plan years beginning on and after Jan. 1, 2014, although employer reimbursements on an after-tax basis are permitted. An employer payment plan fails to comply with the annual dollar limit prohibition and no-cost preventive services rule because an employer payment plan

(1) imposes an annual limit equal to the cost of the individual coverage purchased through the arrangement,

(2) does not provide preventive services without cost sharing in all instances, and

(3) cannot be integrated with any individual health insurance policy.[[29]](#footnote-29)

The only premium reimbursement plans that may be offered (where an employer reimburses employees for their share of health insurance premiums on a pre-tax basis) are one of the following arrangements:

* POPs: a premium only plan, as defined in Treas. Reg. section 1.125-1(a)(5), "is a cafeteria plan that offers as its sole benefit an election between cash (for example, salary) and payment of the employee share of the employer-provided accident and health insurance premium (excludible from the employee's gross income under section 106)."
* SHOP Premium Reimbursement Plans: These plans must be offered under a Code section 125 cafeteria plan. Note that the cafeteria plan would generally be prohibited from offering a health FSA since that coverage could be in compliance (and be an excepted benefit) only if the employer offers other group health coverage.
* Retiree-only HRA plans (these are excepted benefits and would therefore not be subject to health care reform rules).

Further, individual policies available on the public exchanges could prohibit employer funding of the premiums (as is common in the individual marketplace now). However, an employer can always choose to raise an employee's taxable pay based upon the premiums they are paying for individual (or other) insurance, in effect reimbursing some or all of the premium with after-tax dollars.

424. What consumer consumer-assistance tools must exchanges provide?

Each state health insurance exchange (marketplace) must provide a variety of consumer-assistance tool, including the following:

* Information on the certifying, recertifying, and decertifying of qualified health plans (QHPs);
* The assigning of relative quality and price ratings to each QHP offered through the exchange;
* Toll-free call centers to address the needs of those seeking assistance
* Internet websites providing a variety of features, including comparative information on available QHPs, certain financial information, and information about the navigator and call center
* An exchange calculator to facilitate comparisons of QHPs that takes into consideration the premium tax credit and any cost-sharing reductions
* A consumer-assistance function, including the navigator program discussed subsequently in this Part; and
* Outreach and education activities[[30]](#footnote-30)

425. What are some of the problems and complexities experienced in setting up and operating the exchanges?

Comparing the various offerings on the exchanges will not be simple, especially the first time one uses an exchange, and thus the need for the specially trained navigators. Americans insist on choice among insurance products, enabling them to find coverage they believe will fit their personal needs. That choice comes at a stiff price. First, it adds considerably to the costs of administrative functions, which in the United States run about twice per capita what they are in other countries. Making the choice of what policy to purchase will take significant time due to the complexity.

The health insurance exchanges or marketplaces must perform several tasks and coordinate with other government programs and organizations. The state-based exchanges must coordinate with the Internal Revenue Service to determine eligibility for subsidies and their magnitude. The exchanges must also work with small employers as well as the state-administered Medicaid programs to determine whether an applicant on the exchanges should be referred to Medicaid or other government programs, such as CHIP. Additionally, some exchanges will negotiate premiums with insurers. While the Affordable Care Act specifies the basic benefits that must be covered, which each state can translate into its own basic benchmark package, some variation of covered services around the state benchmark package is possible within the same policy actuarial value, adding some complexity.[[31]](#footnote-31)

Exchange Navigators

426. What is the role of the exchange navigators?

Healthcare reform requires each state exchange to establish a navigator program, under which it awards grants to public or private entities to carry out certain navigator functions.[[32]](#footnote-32) HHS regulations set forth the eligibility requirements for navigators and the duties they are expected to perform. To be eligible, an entity must demonstrate that it has existing relationships or could readily establish relationships with employers, employees, consumers, or self-employed individuals likely to be eligible for enrollment in a qualified health plan (QHP); must meet licensing, certification, or other standards imposed by the state or exchange; and must not have a conflict of interest.

Exchanges are required to include entities from at least two of a variety of categories, including community and consumer-focused not-for-profit groups; unions; trade, industry, and professional associations; and licensed agents and brokers. However, a navigator must not be a health insurer or receive any direct or indirect consideration from a health insurer.[[33]](#footnote-33)

The five duties of a navigator are:

(1) maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness of the exchanges

(2) provide information and services in a fair, accurate, and impartial manner

(3) facilitate enrollment in QHPs

(4) provide referrals to any applicable consumer-assistance program or ombudsman in the case of grievances, complaints, or questions about health plans or coverage; and

(5) provide information in a culturally and linguistically appropriate manner for the needs of the population being served by the exchange[[34]](#footnote-34)

427. What standards must navigators and non-navigator assistance personnel meet?

HHS regulations create standards for navigators and non-navigator assistance personnel in federally facilitated exchanges (FFEs) (including state-federal partnership exchanges) and for federally funded non-navigator assistance personnel in state-based exchanges.[[35]](#footnote-35) State-based exchanges may, but need not, also establish non-navigator consumer assistance programs, which are funded by exchange establishment grants rather than navigator grants, to help provide outreach, education, and assistance to consumers. FFEs, other than certain state-federal partnership exchanges, likely will not include non-navigator assistance programs.

Navigators must have expertise in eligibility and enrollment rules and procedures but may not actually make eligibility determinations and may not select qualified health plans (QHPs) for consumers or enroll applicants into QHPs.[[36]](#footnote-36)

States and exchanges cannot prescribe licensing or certification standards for navigators that would conflict with healthcare reform; e.g., they cannot require navigators to be licensed agents or brokers or obtain errors and omissions insurance.[[37]](#footnote-37) There are detailed conflict of interest standards applicable to navigator and non-navigator personnel.[[38]](#footnote-38) State-based exchanges are not required to adopt these standards for their navigators or for non-navigator assistance personnel that are not federally funded, such as enrollment assisters, certified application counselors, and producers (insurance agents and brokers).

428. What is the role of health insurance agents and brokers on the exchanges?

States may allow health insurance agents or brokers to (1) enroll individuals and small employers in qualified health plans on an exchange and (2) assist individuals in applying for premium tax credits and cost-sharing reductions in exchanges.[[39]](#footnote-39) In states where a federally-facilitated or state-federal partnership exchange marketplace is operating, all agents and brokers must register with CMS so that they may assist qualified individuals for individual marketplace coverage.[[40]](#footnote-40)

Although agents and brokers may help qualified individuals enroll in a QHP through the exchange, they cannot perform eligibility determinations. Eligibility determinations must be made through the exchange, and the information collected cannot be accessed by insurers, agents, and brokers.[[41]](#footnote-41) Agents and brokers are also permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions.[[42]](#footnote-42)

Agent and Broker Roles

429. What additional guidance has HHS issued about health insurance agents and brokers as to their role vis-à-vis the exchanges?

HHS has issued a memo focusing on the role of agents and brokers in FFEs and state-federal partnership FFEs. It also addresses certain questions related to state-based Exchanges.[[43]](#footnote-43) It addresses, among others, the following issues.

Registration. In states where a federally-facilitated or state-federal partnership marketplace is operating, all agents and brokers must register with CMS so that they may assist qualified individuals for individual marketplace coverage. Agents and brokers will continue to be appointed by insurers that will check licensure status and verify the agent’s or broker’s registration with exchanges. In states with an FFE or state-federal partnership FFE, all agents and brokers must register with HHS and complete an online training course to assist with individual coverage beginning in the summer of 2013.[[44]](#footnote-44) Agents and brokers working exclusively with employers in federally facilitated SHOP (FF-SHOP) exchanges (which may be combined with the regular exchange for individuals) are encouraged, but not required, to register and complete the training.

Two Website Pathways. Agents and brokers in FFEs and state-federal partnership FFEs will be permitted to assist individuals and employers through two internet “pathways”: (a) an insurer-based pathway that redirects to an exchange website; or (b) an exchange-based pathway that directly accesses an exchange website. Both pathways will allow agents and brokers to assist individuals and employers to receive eligibility determinations, compare plans, and enroll in coverage, and will transmit agent and broker identifying information to the appropriate insurer to facilitate payment.[[45]](#footnote-45) The individual will create a username and password on the exchange website and should not disclose this information to anyone.

Disclosure of All Available QHPs. HHS does not require agents and brokers to display all QHPs or to facilitate enrollment in all QHPs, but state-based exchanges may require agents and brokers to do so. HHS expects agents or brokers using the FFE insurer-based pathway to inform individuals when they are providing information for QHPs with which they have a business relationship, and that other choices and information can be directly accessed through the exchange website. The FFE exchange-based pathway will display all QHPs.

Broker/Agent Compensation. State-based exchanges may establish their own rules for compensation of agents or brokers, including parameters for direct compensation from an exchange or through insurer-paid commissions. HHS also notes that, if insurers will be paying commissions to agents or broker, it has encouraged state-based exchanges to consider providing information to insurers (agent or broker identifying information) to facilitate these transactions. FFEs and state-federal partnership FFEs will not establish a commission schedule or pay commissions directly to agents or brokers. The amount and terms of commissions will be negotiated by the insurer and the agent or broker. The QHP certification standards require QHP insurers to pay the same agent and broker compensation for enrollment in similar health plans offered inside and outside of FFEs and state-partnership FFEs. However, agents and brokers acting as navigators may not receive compensation from insurers.[[46]](#footnote-46)

Web-Brokers. This HHS memo also addresses the role of web-brokers (i.e., agents or brokers who enroll individuals through public websites). State-based exchanges are permitted to work with web-brokers and that, with respect to FFEs, HHS is developing the ability to support integration between a web-broker’s website and the FFE website to allow individuals to start shopping on the web-broker’s website, connect to the FFE website to complete eligibility applications, and return to the web-broker’s site to shop for QHPs. The HHS memo also includes information on how QHPs may be displayed on a web-broker’s website and certain other relevant issues.

430. What other existing organizations will assist individuals on the exchanges?

State Health Insurance Assistance Programs (often called SHIPs) help Medicare beneficiaries understand their Medicare plan options and enroll. Government agencies, such as those that administer the Medicaid and Children’s Health Insurance Programs (CHIP), help people sign up for those benefits, and community-based organizations also assist with Medicaid and CHIP enrollment. These entities will also help applicants who don’t qualify for Medicaid or CHIP get coverage and premium assistance through the exchange.

1. . PPACA § 1311(b)(1) (2010). “State” means the 50 states of the U.S., the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, American Samoa, and the Northern Mariana Islands. PPACA § 1551; PHSA § 2791(d)(14). [↑](#footnote-ref-1)
2. See letter from HHS to US territory insurance commissioners at <http://www.cms.gov/CCIIO/Resources/Letters/Downloads/letter-to-Ilagan.pdf>. [↑](#footnote-ref-2)
3. . Small Business Health Options Program (SHOP)-Only Marketplace FAQs, Q/A-1 at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/shop-marketplace-5-10-2013.pdf. [↑](#footnote-ref-3)
4. . Small Business Health Options Program (SHOP)-Only Marketplace FAQs, Q/A-4 at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/shop-marketplace-5-10-2013.pdf. [↑](#footnote-ref-4)
5. . PPACA § 1412(c)(2)(B)(iv)(II). [↑](#footnote-ref-5)
6. . 45 CFR §§ 156.270(d). [↑](#footnote-ref-6)
7. . 76 Fed. Reg. 41866; 45 CFR §§ 155.400, 155.430 & 156.270 available at https://www.federalregister.gov/articles/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans#h-165. [↑](#footnote-ref-7)
8. . 45 CFR §§ 156.270(d)(3) provides that QHP issuers notify providers who submit claims for services rendered during the second and third months of the premium grace period that any such claims will be pended, and potentially not reimbursed by the QHP issuer if the individual does not settle outstanding premium payments. [↑](#footnote-ref-8)
9. . Id. [↑](#footnote-ref-9)
10. . Summary, Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310 at 18427 (March 27, 2012) et seq. at https://www.federalregister.gov/articles/2012/03/27/2012-6125/patient-protection-and-affordable-care-act-establishment-of-exchanges-and-qualified-health-plans#h-166. [↑](#footnote-ref-10)
11. . General Guidance on Federally-facilitated Exchanges (May 16, 2012); Fact Sheet: Affordable Insurance Exchanges (May 16, 2012) at http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/ffe-guidance-05-16-2012.pdf. [↑](#footnote-ref-11)
12. . 45 CFR § 155.410(b). [↑](#footnote-ref-12)
13. . 45 CFR § 155.410(e). [↑](#footnote-ref-13)
14. . PPACA § 1311(c)(6) (2010). Special enrollment periods include those specified in Code § 9801, other special enrollments under circumstances similar to such periods under part D of title XVIII of the Social Security Act, and “special monthly enrollment periods for Indians (as defined in section 4 of the Indian Health Care Improvement Act).” [↑](#footnote-ref-14)
15. . 45 CFR § 155.420(d). [↑](#footnote-ref-15)
16. . 45 CFR § 155.420(e). [↑](#footnote-ref-16)
17. . 45 CFR § 155.420(c). [↑](#footnote-ref-17)
18. . PPACA § 1302(d). [↑](#footnote-ref-18)
19. . PPACA § 1302(e). [↑](#footnote-ref-19)
20. . PPACA § 1302(c)(1) and (e); Code § 223(c)(2)(A)(ii). [↑](#footnote-ref-20)
21. . PPACA § 1302(c)(1) and (e). [↑](#footnote-ref-21)
22. No. 14-1158 (4th Cir. July 22, 2014). [↑](#footnote-ref-22)
23. No. 14-5018 (D.C. Cir. July 22, 2014), [↑](#footnote-ref-23)
24. Treas. Reg.. § 1.36B-2(a)(1). [↑](#footnote-ref-24)
25. IRC § 36B(2)(A). [↑](#footnote-ref-25)
26. HHS Secretary Kathleen Sebelius letter to Rep. Jim McDermott, ranking minority member of the House Ways and Means Health subcommittee ((ct. 30, 2013), at [http://op.bna.com/hl.nsf/id/etor-9czj72/$File/case.pdf](http://op.bna.com/hl.nsf/id/etor-9czj72/%24File/case.pdf). [↑](#footnote-ref-26)
27. See Third Party Payments of Premiums for Qualified Health Plans in the Marketplaces (Nov. 4, 2013) at <http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/third-party-qa-11-04-2013.pdf>. However, the IRS permits these payments if made with after tax dollars. See [↑](#footnote-ref-27)
28. IRS Notice 2013-54. II.B. [↑](#footnote-ref-28)
29. See IRS Notice 2013-54, Q&As 1 and 3. [↑](#footnote-ref-29)
30. . 45 CFR § 155.205. [↑](#footnote-ref-30)
31. . Uwe E. Reinhardt, What Makes U.S. Health Insurance Exchanges So Complicated (July 19, 2013), at http://economix.blogs.nytimes.com/2013/07/19/what-makes-u-s-health-insurance-exchanges-so-complicated/?ref=policy. [↑](#footnote-ref-31)
32. . PPACA § 1311(i). [↑](#footnote-ref-32)
33. . 45 CFR § 155.210. [↑](#footnote-ref-33)
34. . 45 CFR § 155.210(e). [↑](#footnote-ref-34)
35. . PPACA; exchange Functions: Standards for Navigators and Non-navigator Assistance Personnel, 45 CFR Part 155, 78 Fed. Reg. 20581 (Apr. 5, 2013). [↑](#footnote-ref-35)
36. . Prop. HHS Reg. § 155.310(d); PPACA; exchange Functions: Standards for Navigators and Non-navigator Assistance Personnel, 45 CFR Part 155, 78 Fed. Reg. 20581, 20583 (Apr. 5, 2013). [↑](#footnote-ref-36)
37. . Prop. HHS Reg. § 155.210(c)(2); PPACA; exchange Functions: Standards for Navigators and Non-navigator Assistance Personnel, 45 CFR Part 155, 78 Fed. Reg. 20581, 20585 (Apr. 5, 2013). [↑](#footnote-ref-37)
38. . Prop. HHS Reg. § 155.215. [↑](#footnote-ref-38)
39. . PPACA § 1312; 45 CFR § 155.220. [↑](#footnote-ref-39)
40. . HHS Memo: Role of Agents, Brokers, and Web-Brokers in Health Insurance Marketplaces, I.A (May 1, 2013) at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/agent-broker-5-1-2013.pdf. [↑](#footnote-ref-40)
41. . PPACA; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, 77 Fed. Reg. 18310, 18425 (Mar. 27, 2012). [↑](#footnote-ref-41)
42. . 45 CFR § 155.220(a)(3). [↑](#footnote-ref-42)
43. . HHS Memo: Role of Agents, Brokers, and Web-Brokers in Health Insurance Marketplaces (May 1, 2013) at http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/agent-broker-5-1-2013.pdf. [↑](#footnote-ref-43)
44. . Id. [↑](#footnote-ref-44)
45. . Id. at I and its Appendix. [↑](#footnote-ref-45)
46. . Id. [↑](#footnote-ref-46)