The New Reformed World of Health Insurance Exchanges

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Society of Professional Benefit Administrators
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State Insurance Exchanges are a key component of the health reform legislation
  » Similarity to insurance reform enacted in Massachusetts
What are the Exchanges?
How are they going to work?
Who gets to play?
What impact on benefit administrators?
What role for benefit administrators?
How big is your briefcase?
Exchanges

- Each State must establish by 1/1/2014 an American Health Benefit Exchange that will make insurers’ “qualified health plans” (“QHPs”) available to individuals and small groups.
- Individuals and employers may purchase non-Exchange health plans.
- Employers may self-insure outside any Exchange.
- A State can have a separate Exchange for individual coverage and a distinct Small Business Health Options Program (“SHOP Exchange”) or may merge them into one.
- An Exchange can be a government agency or a non-profit entity “established by” the State.
- States can agree to set up a multi-state Exchange.
- Exchanges can charge insurers assessments or user fees.
Exchange functions

- Certify QHPs for participation
- Determine insurer products to include in Exchange offerings
- Provide ratings of plan premiums and quality
- Internet portal for consumers
- Can contract for administrative support, but not with a health insurer or any entity related to an insurer
Navigators

- Exchanges will award grants to “Navigators,” such as trade and professional associations, consumer organizations, unions, chambers of commerce, insurance agents and brokers, and resource partners of the Small Business Administration.

- Navigators will conduct public education activities, distribute information about QHPs and the availability of premium tax credits and cost-sharing reductions for eligible individuals, facilitate enrollment, provide referrals for enrollees with grievances or complaints or questions about their health plan or coverage or a claim determination.

- Navigators will need to meet standards, and may not be health insurance issuers.
Eligible individuals

- Any person qualifies for individual Exchange QHP coverage if he or she lives in the State, is not incarcerated (except for those awaiting disposition of charges) and is a citizen or an alien anticipated to be lawfully in the country for the entire enrollment period sought.
Small groups

- Any small employer with a group plan covered by ERISA law can participate in the Exchange if it makes all full-time employees eligible for coverage.
- “Small group” means an employer that in the previous year averaged 1 or more employees but not more than 100.
- Until 2016, a State can substitute 50 for 100 in the definition.
- If a small employer is in the Exchange, but gets bigger, it will continue to be treated as small until it leaves the exchange.
Large groups

- Through 2016, large groups may not participate in state Exchanges.
- Starting in 2017, a State may permit health insurance issuers to provide coverage for large employers through the State’s Exchange.
- Law say that states can then “permit” issuers to include large employers in Exchange products, but other language suggests that if does so, and employer elects to buy through Exchange, it cannot be denied participation by an insurer.
The HHS Secretary will set minimum standards Exchanges must use in certifying and recertifying “qualified health plans” for participation.

These will include requirements covering: marketing; network adequacy; inclusion of “essential community providers” willing to accept the “generally applicable payment rates” of the plan; accreditation; quality improvement; uniform enrollment forms; and a standardized benefit presentation format permitting consumer comparisons.
Essential benefits

- Each QHP must offer a core set of “essential health benefits” set by HHS.
- The scope of essential health benefits must equal the scope of benefits provided under a typical employer plan.
- Financial incentives will discourage States from requiring Exchange plans to offer additional benefits.
- If a State imposes a mandate for any additional benefits, it must provide payment to the enrollee, or to the plan on the individual’s behalf, for the incremental premium cost attributable to the extra mandated benefit.
- No impact on state benefit mandates outside Exchange.
Levels of coverage

- Plans will be offered at bronze, silver, gold and platinum levels, representing 60, 70, 80 and 90% actuarial value of the full covered benefits (i.e., if there were no cost sharing provisions).
- Employer contributions to HSAs to count in determining actuarial value of a plan.
- If a qualified plan is offered through the Exchange at any of the four levels, the issuer must also offer it as a separate qualified plan for individuals under the age of 21.
- Catastrophic plan may also be a QHP, but only to under age 30 individuals or those who satisfy hardship or prior uninsured status requirements.
- Employer can choose the level of coverage (e.g., bronze, silver, gold or platinum) to support via contribution.
Deductibles

- Employer small group plans in Exchange may not have deductibles >$2,000 for individual coverage and $4,000 for family.
- These may be increased by employer contributions under flexible spending plans.
- The cap rises by percentage formula for years after 2014 and is then rounded up to the nearest $50 increment.
Massachusetts Exchange – Visiting the “Connector”

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You have options.
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Contact us
Choose the type of plans that will meet your needs.

**Bronze**
- Lower monthly cost
- Higher costs when you receive medical services

Who chooses Bronze plans? 
See Bronze Plans

**Silver**
- Monthly cost can run higher than Bronze
- Lower costs when you receive medical services compared to Bronze

Who chooses Silver plans? 
See Silver Plans

**Gold**
- Highest monthly cost
- Lowest costs when you receive medical services

Who chooses Gold plans? 
See Gold Plans
BROWSE PLANS: 7 benefits packages (What’s a benefits package)? [42 plans]

Show Plans. Then choose up to 3 to compare. Click Continue at bottom.

<table>
<thead>
<tr>
<th>Benefits Package</th>
<th>Monthly Cost</th>
<th>Annual Deductible</th>
<th>Annual Out of Pocket Max.</th>
<th>Doctor Visit</th>
<th>Generic Rx</th>
<th>Emergency Room</th>
<th>Hospital Stay</th>
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Narrow Your Plans by:

- Monthly Cost
  - $301 - $400 (0)
  - $401 - $500 (0)
  - $501 - $600 (0)
  - $601 - $700 (0)
  - $701 - $800 (0)
  - $801 - $900 (3)
  - Greater than $900 (3)

- Annual Deductible
  - None (12)
  - $250 - $500 (6)
  - $500 - $1,000 (5)
  - $1,000 - $2,000 (5)
  - $2,000 - $4,000 (12)

- Insurance Carrier
  - Blue Cross Blue Shield of Massachusetts (7)
  - CeltCare (7)
Premium and rating rules

- Exchange coverage insurers must agree to charge the same premium for each QHP of the issuer whether the plan is offered through an Exchange or offered directly from the issuer or through an agent.
- The Act does not provide further detail on this requirement of uniform pricing both within and outside the Exchange.
- Same community rating type rules apply in Exchange and out.
- Insurers can vary rates within state by “rating area.”
- QHP issuers must put all individual enrollees (other than those in grandfathered health plans), including those who do not enroll through the Exchange, to be members of a single risk pool.
- All an issuer’s small group enrollees in a State are also (other than those in grandfathered plans) to be considered a single risk pool.
- A State may require these individual and small group pools to be combined.
Grandfathered plans

- Grandfathered plans are those in which an individual was enrolled on March 23, 2010. The Act’s requirements for medical loss ratios and uniform coverage documents do apply to grandfathered plans.
- Family members of an individual in a grandfathered plan are permitted to enroll in the plan or coverage if enrollment was permitted under the terms of the plan in effect as of March 23, 2010.
- A group health plan already providing coverage on the date of enactment may also cover new employees and their families.
- Health insurance coverage provided pursuant to one or more collective bargaining agreements is “grandfathered” until the last of the collective bargaining agreements terminates.
“Medical home” plans

- QHPs can provide coverage through a “qualified direct primary care medical home plan” that meets regulatory criteria if the medical home plan services are coordinated with the entity offering the QHP.

- “Medical home” model is mode of care that includes personal physicians for individual enrollee; “whole person orientation”; coordinated and integrated care; evidence-informed medicine; appropriate use of health information technology; continuous quality improvements; expanded access to care; and payment that recognizes added value from additional components of patient-centered care.
CO-OPs

- Up to $6 billion in loan and grant money by 7/1/2013 to seed new non-profit “Consumer Operated and Oriented Plans” (“CO–OPs”) to offer QHPs in the individual and small group markets.
- HHS to ensure that there is enough funding to establish at least one new CO-OP in each State.
- CO-OP cannot be an entity that is already an insurer or that is affiliated with an entity already an insurer as of July 2009.
- CO-OP must be governed by its members and governing documents must protect against insurance industry involvement and interference.
- CO-OPs may form a private purchasing council to do collective purchasing, such as for claims administration, administrative services, and health information technology.
CO-OP may contract with TPA.

No specific rules for contracting set out.

TPA services would need to mesh with CO-OP’s need to to satisfy all qualifications required for QHP issuers.

HHS to give priority to funding CO-OPs that will offer QHPs on a State-wide basis, will utilize integrated care models, and have significant “private support”.
“Basic health programs”

- States can directly offer “basic health program” outside the Exchange.
- Program must offer a defined “standard health plan” for individuals qualifying based on income.
- HMOs, health insurance issuers and “network[s] of health care providers established to offer services under the program” can contract with the state to provide the “standard health plan”
Cross-state “choice” compacts

- States may create “health care choice compacts.”
- QHP could be offered in the individual market in each of the States, but for the most part be subject to the laws and regulations only of the State “in which the plan was written or issued” (i.e., not where it was delivered).
- Each participating State’s laws would continue to apply as regards market conduct, unfair trade practices, network adequacy and consumer protection standards.
- Issuers would either have to be licensed in each participating State, or else submit to the jurisdiction of each State for permitted regulation.
Federal multi-state plan contracts

- Office of Personnel Management ("OPM") to contract with health insurance issuers (which can include Blues) to offer two multi-state qualified health plans through each Exchange. At least one of the contracts shall be with a non-profit entity.
- Federal government will approve rates.
- Approved multi-state plans are deemed certified for Exchange participation.
- By its fourth year, multi-state plan must cover whole country
Subsidy for individual plan risk adjustment reinsurance

- By January 1, 2014 each State to establish or contract with reinsurance entities for a program under which health insurers, and TPAs “on behalf of group health plans,” must make payments, except for plans that have a “grandfather” exception.

- Collected premiums paid out as risk adjustments to participating health insurance issuers that cover “high risk individuals” in the individual market.

- Contributions will proportionally reflect issuer’s fully insured commercial book of business for major medical products and the total value of fees charged by the issuer and the costs of coverage administered by the issuer as a TPA.

- Additional amounts may be assessed to fund the reinsurance entity’s administrative expenses.
TPA interface with customer plans to fund risk adjustment reinsurance payment

- TPA responsible to pay reinsurance contributions “on behalf of” self-insured group health plans
- Law does not establish mechanism for collection or recoupment of funds by TPA from self-insured plans
- For protection TPAs will need to secure funding for payments in advance or in “real time”
HHS will set up a risk corridors for 2014-2016 for QHPs in the individual or small group market based on ratio of allowable costs to the plan’s aggregate premium.

If a plan’s allowable costs for a plan year are more than 103% but not more than 108% of a target amount, HHS will pay the plan 50 percent of the excess in costs over 103% of the target amount. If a plan’s allowable costs are more than 108% of the target, HHS will pay the plan 2.5% of the target amount, plus 80% of the allowable costs exceeding 108% of the target amount.

Plans will pay HHS a portion of savings relative to target amounts. If plan’s allowable costs are less than 97% of target, but not less than 92% of target, plan will pay HHS 50% of the excess of 97% of the target amount over the allowable costs. If plan’s allowable costs are less than 92% of the target amount, plan will pay HHS 2.5% of the target amount, plus 80% of the excess of 92% of the target amount over the allowable costs.
Each State will assess a charge on “low actuarial risk plans” – group health plans and health insurance issuers where the actuarial risk of their enrollees is less than the average actuarial risk for all enrollees in plans or coverage in the State that are not self-insured group health plans.

The State will make a corresponding payment to “high actuarial risk plans” whose enrollments’ actuarial risk is higher than the average.

Risk adjustment program applies to health plans and issuers providing coverage in the individual or small group market in a state.

The risk adjustment provisions do not apply to “grandfathered health plans” or the issuers of a “grandfathered health plan”.

Coverage by private health insurance issuers will not be subject to federal or state laws on a broad range of topics if a QHP under the CO-OP plan or a new Exchange multi-state qualified plan is not subject to the same law. The topics are guaranteed renewal, rating, preexisting conditions, non-discrimination, quality improvement and reporting, fraud and abuse, solvency and financial requirements, market conduct, prompt payment, appeals and grievances, privacy and confidentiality, licensure, and benefit plan materials or information.