

Healthcare re-FORUM

Healthcare Re-Forum : 2010 Issue No. 29

An Overview of the American Health Benefit Exchanges

The Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA) direct the states to establish health insurance exchanges, known as the American Health Benefit Exchanges (the Exchanges), as a new mechanism for individuals and small employers to purchase health insurance coverage beginning January 1, 2014. To assist in the implementation of the state-based Exchanges, federal funding will be available beginning in 2011 and will phase out by 2015, at which time the Exchanges must be self-sustaining.



The PPACA also requires the federal Office of Personnel Management (OPM) to contract with health plan issuers to offer a minimum of two multi-state plans in each Exchange, at least one of which must be non-profit. These multi-state plans will have separate risk pools and will be separate entities from the Federal Employees Health Benefit Program, which the OPM also administers. The Exchanges will also be responsible for offering a co-op, which will be funded nationally by a \$6 billion grant.

At a minimum, the PPACA and HCERA authorize each state to create Exchanges through which individuals and small employers* can purchase health insurance coverage. States will have four options to consider as they set up their Exchanges:

- Establish an Exchange to supervise coverage options for both individuals and small employer groups with up to 100 employees
- Establish an Exchange for individuals and a separate Small Business Health Options Program (SHOP) to serve small employer groups with up to 100 employees

- Establish an Exchange allowing multiple states to jointly offer increased coverage options
- Establish multiple Exchanges that serve distinct geographic regions within a state

If a state fails to create an Exchange, or to adequately comply with Exchange regulations set by the Department of Health and Human Services (HHS), HHS will set up and operate the Exchange within that state.

Participation by individuals and employers in an Exchange will be completely voluntary. Employers and individuals may continue to obtain coverage through the non-Exchange health insurance marketplace.

The PPACA requires the state-based Exchanges to:

- Certify health plans as “qualified” before they are offered in the Exchange
- Develop a rating system to classify qualified health plans based on relative quality and price
- Notify the public about eligibility for enrollment in Medicaid, Children’s Health Insurance Programs (CHIP) and other similar state programs, as well as coordinate the enrollment process for each
- Use a standard enrollment form and uniform format for presenting understandable health benefit plan options

*Please note, for purposes of the Exchanges, a small employer is an employer with 100 or fewer employees. States have the option of defining small employers as those with 50 or fewer employees until 2016, when all states will need to comply with the Exchange definition of small group as 100 or fewer. Beginning in 2017, states may choose to allow employers with more than 100 employees to offer coverage for their employees through an Exchange.

[over]

- Create and maintain a website for consumers to find pricing and other plan information, and include an online calculator to determine the actual cost of a plan's coverage after subsidies
- Operate a toll-free telephone hotline to assist consumers and employers
- Publicly disclose all claims payment policies and practices, finances, enrollment data, denied claims and rating practices
- Publish cost sharing and out-of-network payment information for each plan
- The Exchanges will offer four levels of QHPs, each including mandated essential benefits (which are not yet fully defined)

The next issue of *Healthcare Re-Forum* will discuss in detail the plans that will be sold on the Exchanges.

Exchanges will employ Navigators, who will provide consumer guidance in the Exchanges' plan options, offer culturally and linguistically appropriate information about enrolling in the plans and provide information about available subsidies. They will also provide referrals for complaints.

By 2014, many new federal standards will apply to all insurers offering new coverage in the individual and small group markets, regardless of whether the coverage is purchased through an Exchange. Insurers who offer coverage through an Exchange will also be subject to additional requirements, such as adequacy of provider networks, reporting requirements, grievance procedures and marketing practices, which could make some insurers less willing to sell through an Exchange.

Two states currently operate Exchanges—Massachusetts and Utah. Washington (state) is anticipating a January 1, 2011, launch for its Exchange.

On the other hand, Exchanges may be attractive to insurers due to the large pool of prospective customers. Billions of dollars in premium tax credit subsidies and cost-sharing subsidies will be available to individuals within a defined income range. For example, individuals whose income levels fall between 133 percent and 400 percent of the federal poverty level will be eligible for subsidies on a sliding scale basis, but can only apply the subsidies to plans purchased on an Exchange. Of the roughly 35 million individuals that the Congressional Budget Office projects will be enrolled in individual coverage in 2009 (including grandfathered coverage), 24 million are expected to have purchased that coverage through an Exchange. Of that 24 million, it is anticipated that 20 million will receive premium credits or cost-sharing subsidies.

Health insurance plans offered through the Exchanges will be referred to as qualified health plans (QHP). While full regulations have yet to be released by the Secretary of HHS, the following requirements are known:

- A QHP must satisfy a minimum threshold of coverage defined by HHS
- A QHP must be offered by a licensed insurer and cannot be a self-insured plan sponsored by an employer and exempt from state regulation under ERISA's preemption rules
- QHPs will vary in cost from least expensive to most expensive: bronze, silver, gold and platinum
- To be included on an Exchange, carriers must agree to offer at least one silver and one gold plan
- Exchanges will be prohibited from setting premiums for plans. However, they can ask insurers to justify rate hikes, and if they are dissatisfied with the answer, can use price as a reason to drop a particular plan from their list of qualified offerings

Future Topics:

- Types of Plans Sold On the Exchanges
- The Insurance Marketplace On and Off the Exchanges
- Co-ops and Multi-State Plans