

Healthcare Re-FORUM

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Updates to Previously Issued Regulations

On November 15, 2010, HHS amended its position on grandfathered group plans and their ability to change insurers. Per HHS... "Under this amendment, all employers have the flexibility to keep their grandfathered plan but change insurance company or third-party administrator." Groups that choose to change insurers are still required to follow other regulations defining what changes are allowed to be made by a group that wants to maintain its grandfathered status. The HHS website provides additional information about this amendment: <http://www.hhs.gov/ociio/regulations/grandfather/factsheet.html>.

CO-OPs and Multi-State Plans on the Exchanges

This issue of *Healthcare Re-Forum* continues our discussion of the provisions pertaining to the state-based American Health Benefit Exchanges (the Exchanges) as designed by the Patient Protection and Affordable Care Act (PPACA). The Exchanges, which will begin in 2014, will offer healthcare consumers different options for obtaining certified coverage through new Consumer Operated and Oriented Plans and Multi-State Plans.

Consumer Operated and Oriented Plans

Consumer Operated and Oriented Plans (CO-OPs) will be member-run, non-profit health insurance issuers that sell qualified health plans (QHPs) in the individual and small group marketplaces on the Exchanges. By July 1, 2013, the Department of Health and Human Services (HHS) will begin distributing \$6 billion in loans and grants for CO-OPs, which must ultimately repay the monies borrowed. The Secretary of HHS will give loan and grant priority to issuers offering statewide provider networks; to those using an integrated care model, such as an accountable care organization; and to those with significant private support. The Secretary will also ensure there is sufficient funding to establish at least one qualified non-profit health insurance issuer in each state and the District of Columbia.

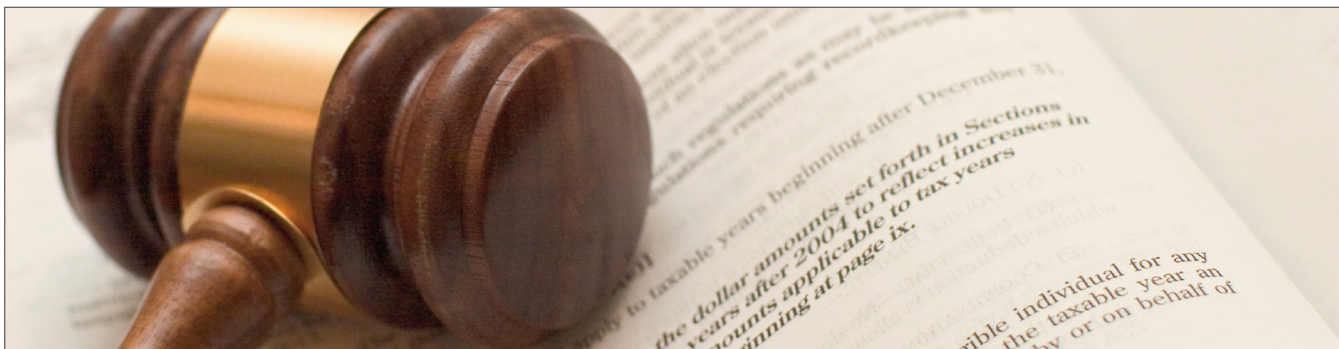
According to the PPACA, any issuer participating in a loan agreement must not use such funds "for carrying on propaganda, or otherwise attempting to influence legislation; or for marketing." In addition, a health insurance issuer who receives a grant or loan through the CO-OP program may qualify for a federal income tax exemption, but only during the period in which the organization is compliant with CO-OP program requirements and with the terms of any CO-OP grant or loan agreement.

CO-OPs have historically functioned effectively in the United States, but have never attracted significant membership. The substantial federal seed money offered by the PPACA could promote considerable growth of both CO-OP plans and their membership, encouraging greater health plan competition in some state and local markets.

To remain in compliance, a CO-OP must:

- Be organized under state law as a non-profit entity
- Be an entity whose primary purpose is to issue QHPs in the individual and small-group market
- Not be sponsored by a state, county or local government
- Have not existed as a health insurance issuer or related entity on July 16, 2009
- Have governing documents that incorporate ethics and conflict of interest standards protecting against involvement and interference in the insurance industry
- Have governance of the organization subject to a majority vote of its members
- Operate with a strong consumer focus
- Use profits to lower premium or improve benefits
- Comply with all appropriate state and federal laws

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Multi-State Plans

The PPACA also requires new multi-state plans be created and overseen by the U.S. Office of Personnel Management (OPM), the agency that also administers the Federal Employees Health Benefits Program (FEHBP). To provide individual and small group coverage, the director of the OPM will contract with health insurance issuers to offer at least two multi-state qualified health plans (MSQHP) through every Exchange in each state. At least one of the carriers must be non-profit. To contract with the OPM, a health insurance issuer must offer the multi-state plan in at least 60 percent of states in the first year, at least 70 percent in the second year, at least 85 percent in the third year, and in all states in the fourth year.

Any individual eligible to purchase insurance through an Exchange may enroll in a MSQHP. Enrollment is voluntary, and individuals may be eligible for premium credits and cost-sharing assistance. Each MSQHP policy must be effective for at least one year and can be automatically renewed if neither the OPM nor the insurance issuer provides notice to terminate. MSQHPs must:

- Meet all QHP requirements, including those related to offering bronze, silver and gold levels of coverage, as well as catastrophic coverage in each state's Exchange (including the identified essential benefits)
- Meet the PPACA's rating requirements, plus any state's defined rating variations that may supersede federal requirements
- Offer plans in all geographic regions and in all states that adopted adjusted community rating prior to March 23, 2010, when the PPACA became law

Health insurance issuers offering MSQHPs must:

- Meet each state's Exchange requirements
- Be licensed in each state and subject to all requirements of each state's laws
- Comply with the minimum standards prescribed for carriers offering health benefit plans under the FEHBP

The director of the OPM will select and implement MSQHPs through negotiations based on issues such as:

- Medical loss ratios
- Profit margins
- Premiums to be charged
- Other terms and conditions of coverage that represent the best interests of those who will be covered

Both the CO-OPs and the multi-state plans are additional options for QHPs to be offered on the Exchanges. The goal of healthcare reform legislation is to not only create an "apples to apples" comparison of different plans offered on the Exchanges, but also to encourage as much competition as possible for increased consumer choice and decreased cost.

Future Topics:

- States' Construction of the Exchanges
- Updates to Previously Issued Regulations