



HEALTH CARE REFORM update



BlueCross BlueShield
of Kansas City

An Independent Licensee of the
Blue Cross and Blue Shield Association

Summary of Provisions on Exchanges

On Tuesday, March 23, President Obama signed into law the “Patient Protection and Affordable Care Act” (PPACA). A reconciliation bill making changes to the Act was signed by the President on March 30. The PPACA as amended by the reconciliation bill is collectively referred to as the Act in this summary. This summary provides an overview of the provisions on Exchanges.

Summary

The Act requires each state to create an American Health Benefit Exchange by January 1, 2014. The Exchanges are a marketplace for individuals and small employers to purchase “qualified health plans” meeting product design requirements under the Act. Beginning in 2017, states can expand participation to large employers. Purchasing through the Exchange is voluntary, but it is the only vehicle for individuals to receive the premium or cost-sharing subsidies (See BlueKC’s Federal Healthcare Reform: Individual Mandate & Subsidy fact sheet). Health insurance products can continue to be sold outside of the Exchange, but such products must still meet the product design requirements established under the Act. (See Blue KC’s *Federal Healthcare Reform: Product Design Mandates* fact sheet for more information.)

Key Dates

- By July 1, 2010, the Dept. of Health and Human Services (HHS), in consultation with states, will establish an Internet portal for coverage information.
- By March 23, 2011, states begin to receive Exchange planning grants.
- By January 1, 2013, states must show sufficient progress towards implementing an Exchange or HHS may implement the Exchange for that state.
- By January 1, 2014, a state is to establish an Exchange.
- Starting January 1, 2015, a qualified health plan may only contract with hospitals and other providers meeting enumerated quality standards.
- Beginning in 2017, a state may open its Exchange to large employers.

HHS Internet Portal

The Act requires HHS to establish an Internet portal by July 1, 2010. The portal is a tool through which residents of a state can find health insurance, including commercial coverage (individual and small group), Medicaid, and high risk pools, in that state. A uniform format for insurers to use to present information on the website will be issued by HHS by May 23, 2010.

Grants & Funding

By March 23, 2011, the Secretary will disburse grant funding to states in order to facilitate the establishment of Exchanges. The grant funds can be used for activities such as planning, related to establishing the Exchange in the state. The amount of money available will be determined by the Secretary. The grant funds are renewable until January 2015 as long as the state is making progress toward establishing the Exchange, implementing the reforms required by the Act, and meeting benchmarks that the Secretary may establish. After that time the Exchange must be self-sustaining.

Establishing the Exchange

Each state is required to establish an Exchange by January 1, 2014. The Exchange will:

- Facilitate the purchase of qualified health plans (QHPs); and
- Establish a Small Business Health Options Program to assist qualified small employers in enrolling employees in QHPs.

The state may elect to merge the individual and small group Exchanges into a single Exchange. The Act provides flexibility to states to establish regional or interstate Exchanges, subject to the approval of each state involved and HHS. If a state does not establish an Exchange by January 1, 2014, the federal government will step in to do so.

Who can purchase through the Exchange (Consumer Choice)

The Exchange will offer QHPs, as further described below, and stand-alone dental plans to qualified individuals and qualified employers.

- A qualified individual means an individual who is seeking to enroll in the individual market and resides in the state that established the Exchange.
- A qualified employer is a small employer that elects to make all full-time employees eligible for one or more QHPs offered through the Exchange (as of 2014, this includes employers with up to 100 employees, although a state may elect to maintain the size of small groups to 50 employees until 2016). In 2017, the term could include large groups (those over 100) at the state's election. The employer may select a level of coverage (e.g. bronze, silver, gold or platinum) and each employee may choose to enroll in any QHP (regardless of insurer) at that level. It is unclear whether an employer may select a specific QHP for its employees.

Presumably the Exchange in the state of the employer is used by an employee regardless of the state in which he or she resides, as the "residence" rule appears to apply to enrollment in the individual market and not for groups. This may be clarified by regulation. It appears that the insurer will be paid directly by the individual or the employer for coverage purchased through the Exchange.

Qualified Health Plans

In order to be available through the Exchange, a product must be offered by a health insurer licensed in the state where the Exchange is established and must be a Qualified Health Plan (QHP). HHS will set the criteria for QHPs. At a minimum a QHP must:

- Meet marketing fairness and network adequacy requirements;
- Be accredited on quality measures such as HEDIS, CAHPS, patient experience ratings, and other criteria measured by an entity recognized by HHS for the accreditation of health insurers or plans (the period for receiving accreditation will be established by the Exchange);
- Contain enumerated quality improvement strategies identified in the Act and provide information on quality measures;

- Utilize a uniform enrollment form for individuals and employers and a standard format for presenting plan options;
- Beginning in 2015, only contract with hospitals and providers who satisfy certain quality procedures.

HHS may establish additional requirements by regulation. The Exchange will determine if a plan meets the HHS requirements for a QHP. QHPs will be rated based on quality and price.

Benefits/Coverage through the Exchange

- The QHPs must provide, at a minimum, the following benefits:
- Coverage for mental health and substance abuse in accordance with the Mental Health Parity and Addiction Equity Act and implementing regulations:
- “Essential health benefits” including:
 - Ambulatory patient services, emergency services, hospitalization, maternity/newborn care, mental health and substance abuse disorder services including behavioral health treatment, prescription drugs, rehabilitative and habilitative services and devices, lab services, preventative and wellness services and chronic disease management, and pediatric services, including oral and vision care;
 - Cost-sharing limited to the HDHP limits (indexed annually after 2014);
 - For small group plans, the annual deductibles are generally limited to \$2,000/\$4,000 (indexed annually after 2014); and
 - Meet one of four actuarial value tiers (determined by standard population, not plan’s actual population): Bronze (60 percent actuarial value); Silver (70 percent); Gold (80 percent); and Platinum (90 percent). An employer’s HSA contributions may be taken into account in determining the actuarial value.
- HHS is to ensure that the essential health benefits package is equal to a typical employer plan. HHS may further define essential benefits.
- All other benefit requirements under the Act (e.g. coverage for preventive services, dependent to age 26, emergency services, etc.) (See Blue KC’s Federal Healthcare Reform: Product Design Mandates and Federal Healthcare Reform: Dependent Coverage fact sheets for more information.);
- A catastrophic plan, meeting certain requirements, can be offered in the individual market to individuals under age 30 or meeting a hardship exemption;
- States can require that the plans offer additional benefits (mandates) but must defray the cost of the premium tax credit and cost-sharing subsidies incurred by an individual for that benefit. (See Blue KC’s Federal Healthcare Reform: Individual Mandate & Subsidy fact sheet.)

Impact on Delivery System

There are several provisions relating to QHPs that are geared toward improving quality and the delivery system. These include:

Requirements that QHPs provide, implement and report on quality improvement strategy through a payment structure that provides increased reimbursement and incentives to providers to:

- Improve outcomes through quality reporting, case management, care coordination, chronic disease management, including the use of the medical home model;
- Prevent hospital readmissions through programs for discharges;
- Improve patient safety and reducing errors through use of best clinical practices, evidence based management, and health information technology; and
- Implement wellness and health activities.

- Beginning in 2015, QHPs cannot contract with hospitals with more than 50 beds unless such hospitals utilize patient safety evaluation systems and to implement discharge processes.
- Beginning in 2015, QHPs cannot contract with providers unless such providers implement healthcare quality improvements to be defined by HHS.

State Functions

Each state has the following responsibilities:

- Establish Exchange within a governmental agency or as a non-profit entity;
- Authorize the Exchange to contract with an eligible entity for any of the functions; the eligible entity can either be the state Medicaid agency or can be an entity that has experience in the individual and small markets but may not be a health insurer;
- Review mandates beyond the federal requirements to determine if they should be maintained and, if so, the cost; and
- Determine if the individual and small group markets are to be merged.

HHS Obligations

In addition to the obligations discussed throughout this fact sheet, HHS is charged with:

- Providing technical assistance to states;
- Establishing criteria for QHPs, including a rating system for QHPs to be rated based on quality and price;
- Continuing to operate the Internet portal and to assist states in developing their own;
- Developing a model Internet tool that directs individuals and employers to plans, assists them in determining if they are eligible to participate in the Exchange, and for tax credits or subsidies;
- Define and periodically review essential health benefits;
- Developing guidelines for the quality improvement mechanisms that QHPs are required to implement; and
- Establishing procedures under which a state can allow for broker involvement, including the establishment of rate schedules for broker commissions paid by QHPs.

Additional Insurer Obligations

In addition to the obligations discussed elsewhere in this fact sheet, insurers are subject to the following requirements:

- Pooling – individuals purchasing through the Exchange or outside of it are to be considered as part of a single risk pool (except for those through grandfathered plans). A similar rule applies for small groups (See Blue KC's *Federal Healthcare Reform: Rating Reforms* fact sheet for more information.);
- Offer at least one QHP in the silver and gold level in the Exchange;
- Offer any QHP as a "child-only" plan to individuals under the age of 21.
- Charge the same premium for a QHP whether purchased through an Exchange directly or through a broker.

Navigators

Exchanges may award grants, out of Exchange operating funds and not federal funds, to entities that will increase public awareness and education about QHP choices (in an impartial manner). Navigators may be trade, industry or professional associations, community groups, chambers of commerce, unions, and licensed insurance brokers that can demonstrate existing relationships with employers and consumers that are likely to be eligible for coverage through the Exchange. Navigators will be responsible for conducting public education activities, distributing fair and impartial information about QHPs and subsidies, facilitating enrollment through the Exchange, referring individuals to state agencies for assistance, etc. Navigators cannot be insurers or receive consideration from any health insurer in connection with enrollment of qualified individuals or employees of a qualified employer. HHS will establish criteria for Navigator programs.

Relevant PPACA Sections

- §1103 – HHS Internet Portal
- §§1311 & 1312 – The Exchange & Consumer Choice
- §§1301 & 1302 – Qualified Health Plans
- §1321 – State Operation & HHS oversight

Additional sections interacting with the Exchange

- §1001 adding §2715 to the PHSA relating to uniform coverage documents (See Blue KC's *Federal Healthcare Reform: Uniform Coverage Documents & Standardized Definitions* fact sheet for more information.)
- §1003 adding § 2794(b)(1) to the PHSA relating to state review of premiums (See Blue KC's *Federal Healthcare Reform: Rating Reforms* fact sheet for more information.)
- §1302 – Essential Health Benefits (See Blue KC's *Federal Healthcare Reform: Product Design Mandates* fact sheet for more information.)
- §3015 creating §399JJ of the PHSA establishing data collection and public reporting requirements.

This summary is provided for informational purposes only and is not intended as legal advice. This summary does not reflect any guidance or federal regulations that may have been issued after the passage of PPACA. Please consult your legal advisor for additional information.

References

PPACA: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf

Reconciliation: http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872pcs.txt.pdfhttp://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872pcs.txt.pdfhttp://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872pcs.txt.pdf