HEALTH INSURANCE EXCHANGES:
A NEW BEGINNING OR
THE START OF THE END

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The Patient Protection and Affordable Care Act ("ACA") requires the implementation of Health Insurance Exchanges ("Exchanges") beginning January 1, 2014. These Exchanges will provide a new option from which individuals can obtain health insurance coverage and compare health insurance plans. In theory, the new Exchanges will make insurance available at a more cost effective rate for more individuals while expanding the scope of "essential benefits" available to all individuals. The Exchanges are also intended to provide Small Business Health Options Programs ("SHOPs") which are programs under the ACA offering insurance programs for small employers within the state Exchanges.

Although the theory behind the Exchanges is to enhance access to healthcare, control the cost of healthcare and assure that individuals receive "essential health benefits", opponents to the Exchanges believe that Exchanges will be complicated, expensive and will cause confusion in the marketplace. States such as Kansas and Missouri have elected not to implement state based Exchanges. Kansas stated outright that it will not participate in the Exchange program and Missouri passed legislation that states it cannot participate without the legislature's approval. As of the date of this article, Missouri has not passed any implementing legislation so Missouri has also declined the state based Exchanges.

For those states not implementing a state based Exchange, the federal government will implement a “Federally-Facilitated Exchange”. The Federal Exchange is supposed to work closely with the various state governments to implement insurance plans maintaining "essential health benefits" in each state. Essential health benefits include at least ten categories of benefits such as hospitalization, emergency services, maternity and newborn care, prescription drugs, preventative and wellness services, chronic disease management, mental health, substance abuse, behavioral health treatments, rehabilitative devices and services, pediatric services, laboratory services, and ambulatory care. Interestingly, the federal law allows flexibility among the states regarding how each of these types of essential benefits will be provided.

Commercial insurers will assist in developing the actuarial value of Exchange plans which define the proportion of a policy holder's healthcare cost that the plans will cover. Actuarial values are based upon the value of a benchmark plan which is the plan provided by the state's largest health maintenance organization, one of the three largest state employee plans, or one of the three largest small group plans. ACA re-

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quires Exchange based plans to offer four different tiers of coverage that vary based upon each plan’s actuarial value. Depending upon the type of coverage provided, individuals will have different options for cost sharing in the form of co-pays, co-insurance and deductibles. “Bronze” plans must have an actuarial value of 60%; “silver” plans will have an actuarial value of 70%; “gold” plans will have an actuarial value of 80%, and “platinum” plans will be set at 90%.

According to the Centers for Medicare and Medicaid Services (CMS), states that operate Exchanges in 2014 must ensure that their Exchanges are financially self-sustaining by January 1, 2015. There appears to be a variety of grants that states can receive in order to help cover the financial burden of the Exchanges. Those states that have elected not to participate in the state-based Exchange program typically argue that the Exchanges will be very expensive, the guidelines for what should constitute an Exchange are not clear and the federal government should not be interfering with health insurance in each state.

In response, CMS has stated that the Department of Health and Human Services (DHS) will operate the Federally-Facilitated Exchanges in close cooperation with the states and all personnel who work with those Exchanges will be trained in relevant state insurance laws. The federal government will seek to capitalize on existing state policies, capabilities and infrastructure to assist in implementing various components of the Federally-Facilitated Exchanges. According to CMS, a Federally-Facilitated Exchange’s role and authority will be limited to the certification and management of participating qualified health plans. Its role will not extend beyond the Exchange or affect state laws governing which health insurance products may be sold in the individual and small group markets.

According to CMS, the Federally-Facilitated Exchanges will be funded, to a large extent, by participating insurance providers paying a monthly fee. It is anticipated that this rate will be approximately 3.5% of premiums. Exchange user fees will also be implemented to support activities such as consumer outreach, information and assistance activities that health plans currently pay themselves. Interestingly, CMS provides that states will be reimbursed for the costs of assistance they provide to Federally-Facilitated Exchanges in certain circumstances.

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The goal of all the above, according to CMS, is to promote competition based upon quality and cost since consumers will have a new ability to compare similar products from different insurers and will be assured the right to purchase their products, regardless of their health condition. CMS believes that because there will be a number of individuals who will now be eligible for premium tax credits and cost-sharing reductions through the new health exchange program, insurance companies will want to be part of the Exchanges to sell insurance policies to individuals who have not previously acquired health insurance. Opponents to the new law and the Exchanges focus on the lack of pre-existing condition limitations as eligibility criteria for the purchase of health insurance. The argument is that if individuals can purchase insurance who have preexisting health conditions and purchase that insurance at a price that does not take into account their health condition, individuals will buy insurance at those times when they are injured or sick and immediately drop the insurance after the condition has improved. The cost of treatment for that patient could be extremely high during the episode of care and the premiums paid by the individuals might not come close to covering the cost. Therefore, the cost of that care must be shifted to other insureds through increases in other commercial premium rates. The concern is that by implementing the new Exchanges, certain individuals will purchase and maintain coverage on an as needed (short-term) basis but this strategy could dramatically increase the cost of insurance coverage for everyone who buys and keeps in place commercial insurance.

The development and implementation of either state based or Federally-Facilitated Exchanges will be the subject of much discussion and, probably, legislation during 2013. Whether the states drive the Health Insurance Exchanges or the federal government forces the states to accept a Federally-Facilitated Exchange, both parties

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