Sedgwick LLP

Impact of the PPACA Insurance Exchanges on the Marketplace for Health Coverage

The Patient Protection and Affordable Care Act ("PPACA")[1] creates "insurance exchanges" that will be the enrollment mechanism for Medicaid, the sole source of federally subsidized health coverage, and – possibly – a significant new distribution channel for nonsubsidized individual and small group coverage.

The Exchange Provisions in PPACA

PPACA requires that every state have an insurance "exchange," structured either as a government agency or as a quasi-public/quasi-private entity.[2] The exchange must begin operation by an October 1, 2013 open enrollment period for health coverage with a January 1, 2014 effective date.[3] If a state does not establish an exchange, the federal Department of Health and Human Services ("HHS") will operate a "federally facilitated exchange."[4] In addition, where a state is not prepared to perform all of the exchange functions, HHS and the state can jointly operate a "state partnership exchange."[5]

As of August 2012, 13 states and the District of Columbia had created exchanges either by legislation or executive order: California,[6] Colorado,[7] Connecticut,[8] District of Columbia,[9] Hawaii,[10] Kentucky,[11] Maryland,[12] Nevada,[13] New York,[14] Oregon,[15] Rhode Island,[16] Vermont,[17] Washington[18] and West Virginia.[19] Massachusetts and Utah created exchanges prior to the enactment of PPACA.[20] The Utah exchange is limited to small employers. As of the time of writing, four states – Arkansas, Delaware, Illinois and Michigan – have announced their intention to form partnership exchanges managed jointly by the state and HHS. Eleven states – Alaska, Florida, Louisiana, Kansas, Maine, Missouri, New Hampshire, South Carolina, South Dakota, Texas and Virginia – have stated that they will not form a state exchange or a partnership exchange. In those states, the exchange will be operated solely by HHS. (Some of those states may reverse course and opt for a partnership exchange by the February 2013 deadline; others may file a challenge to the authority of HHS to operate the federal exchange). Twenty states have not yet made a formal decision.

On November 9, 2012, shortly after the reelection of President Obama, HHS Secretary Kathleen Sebelius notified state governors that HHS was extending the deadline for states to file detailed applications for state-operated insurance exchanges from November 16, 2012 to December 14, 2012. HHS will notify states whether their applications to operate a state exchange have been approved by January 1, 2013. HHS also extended the deadline for states to file applications for state partnership exchanges – the hybrid exchanges jointly managed by HHS and a state – to February 15, 2013.[21]

It is likely that a number of states that were sitting on the fence during the pendency of the constitutional challenge to PPACA and the presidential election will now opt for some level of state participation in health insurance exchange mandated by PPACA.[22] The planning path for setting up a state exchange is not short, as web portals have to be designed and built, benefit levels have to be specified (within the constraints of PPACA and the HHS regulations) and participating health plans have to be screened. States that have not made significant progress on developing a state exchange in 2012 are unlikely to be in a position to operate a fully state-based exchange for open enrollment in the fall of 2013 and may utilize the "state partnership" option. States that select the state partnership option for 2014 can convert to a fully state-based exchange in later years.

PPACA gives state exchanges considerable latitude regarding the scope of the exchange's activities. An exchange must offer both individual and small group coverage. States have the option of expanding the exchanges to include large group coverage, defined as groups of more than 50 or 100 employees, depending on the state.

The exchanges will only offer products that provide the "essential health benefits" specified in PPACA.[23] Essential health benefits include coverage for ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.

In December 2011, HHS issued guidance stating that each state can select the specific services that must be included in coverage sold through its exchange based on: one of the three largest small group plans in the state by enrollment; one of

This article appeared in the December 2012 issue of the *ABA Health eSource.*

the three largest state employee health plans by enrollment; one of the three largest federal employee health plan options by enrollment; or the largest HMO plan offered in the state's commercial market by enrollment.[24]

The selection of the "benchmark" plan that will determine the richness of the coverage sold through the exchange involves an inherent trade-off between affordability and comprehensiveness of coverage. As large group plans and government employee plans tend to include more extensive benefits than small group coverage and HMO benefits may not provide a good benchmark for non-HMO plans, the expectation is that most states will base exchange benefits on existing small group coverage. On November 20, 2012, HHS issued a proposed regulation covering the scope of essential health benefits, the actuarial valuation of benefits and the accreditation of health plans authorized to offer coverage through the exchanges.[25] The new regulation confirms that states are to select the benchmark plan and adds that where a state fails to select a benchmark plan, HHS will select the largest small group product in the state as the benchmark.

To participate in the exchanges, a carrier must maintain adequate provider networks, including providers in low-income communities and must offer products that provide specified levels of coverage for "essential health benefits." An exchange may exclude carriers from participation based on a "pattern or practice of excessive or unjustified premium increases."[26]

Some states may allow all carriers with qualified products to participate. Other states may restrict exchange participation to carriers that satisfy additional restrictions imposed by the states. HHS has not indicated whether it will limit participation in federally facilitated exchanges, but it is likely that all carriers will be eligible to participate in the federally managed exchanges.

Exchanges and Government Funded Health Coverage

The exchanges will serve as the intake mechanism for Medicaid and other state health benefits for low-income individuals and families.[27] PPACA mandated that states that did not already provide such benefits must expand Medicaid eligibility to include all individuals with incomes up to 133 percent of the federal poverty line.[28] In its decision on the constitutional challenges to PPACA, the U. S. Supreme Court found the mandatory expansion of Medicaid coverage to be unconstitutional.[29] The Supreme Court's decision creates the significant possibility that in some states there will be individuals and families that will fall into the gap between the Medicaid level and eligibility for federally subsidized coverage.

The exchanges will also be the distribution channel for health coverage for individuals and families that are eligible for federally subsidized insurance premium tax credits starting in 2014. The subsidy, in the form of an insurance premium tax credit, will be available to individuals and families with income between the expanded Medicaid coverage mandated in PPACA and 400 percent of the federal poverty line.[30] The premium tax credit is "advanceable" and functions as a discount to the premium. As a result, eligibility for the premium tax credit must be determined at the time of enrollment.

Impact of the Exchanges on the Marketplace

Given the central role of the exchanges in Medicaid enrollment and the provision of federally subsidized health coverage, it is quite possible that in some states, the exchange may be viewed as part of the government safety net. However, under PPACA, the state exchanges are not limited to government funded coverage and could evolve into a marketing channel for non-subsidized coverage.

Under PPACA, coverage cannot be refused and premium charges cannot vary based on health status or claims history, whether coverage is purchased through an exchange or outside an exchange.[31] PPACA provides that a carrier offering products through an exchange must agree to charge the same premium as it charges for the same product sold outside the exchange.[32] It is currently unclear whether the costs to carriers of exchange products will be higher or lower than comparable non-exchange products. If the less healthy tend to purchase coverage through the exchanges, then adverse selection could result in higher claims costs for exchange products. If the exchanges generate lower overhead costs to insurers than traditional distribution channels (and a serious adverse selection problem does not materialize) then exchange products may be an attractive distribution channel for carriers. Given the wide variety of exchange structures that are likely to be adopted in 2014 and later years, the relative costs of selling health coverage through the exchange and outside the exchange are likely to vary significantly among states.

PPACA and Employer-Based Coverage

The greatest uncertainty regarding the full implementation of PPACA is whether there will be a significant shift from employer-provided coverage to individually purchased coverage. PPACA contains tax credit incentives for small employers to offer healthcare coverage but relatively weak penalties for larger employers that drop coverage.[33] The employer penalties apply if any full-time employee purchases federally subsidized coverage through an exchange. Some larger employers may find it economically advantageous to terminate their health insurance coverage, pay any federal penalties, and pay some or all of the difference in increased salaries to employees (with the idea that they would use the additional money to purchase individual insurance in the marketplace). Until the quality and cost of post-2014

individual health insurance is a known factor, it is difficult to predict whether employers will begin terminating their health plans.

Even if PPACA does trigger a move away from employer-provided coverage, employees with guaranteed access to individual coverage will not necessarily be worse off if they receive higher wages in lieu of healthcare coverage. Whether employees will prefer employers that offer health benefits or employers that offer higher compensation but no health benefits will depend on a wide range of factors and is likely to vary by state, by industry, and by personal preference.

Conclusion

The state, federal and partnership exchanges have to be ready for the open enrollment period that will start on October 1, 2013. In little more than nine months, the states and HHS have to do a tremendous amount to prepare for the full launch of PPACA coverage on January 1, 2014. The work of building the exchanges is likely to continue for several more years after the first open enrollment periods – as the initial exchange designs are refined and as a number of states elect to play a larger role in managing the exchanges.

HHS has chosen to delegate a significant level of exchange design decisions to the states. If this policy continues, over the next few years the various state, federal and partnership exchanges will provide a series of Petri dishes in which for side-by-side experiments that will significantly transform the marketplace for health coverage.

Footnotes

[1] Patient Protection and Affordable Care Act (Pub's. 111-148) as modified by the Health Care and Education Affordability Reconciliation Act (Pub's. 111-152).

[2] Pub. L. No. 111-148 , §1311(d).

[3] Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers 77 Fed. Reg. 18,310 (March 27, 2012). See also Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges (August 14, 2012) http://cciio.cms.gov/resources/other/index.html#hie.

[4] Pub. L. No. 111-148 , §1321(b); Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges (August 14, 2012); http://cciio.cms.gov/resources/other/index.html#hie.

[5] Patient Protection and Affordable Care Act: Establishment of Exchanges and Qualified Health Plans, 76 Fed. Reg. 41,866 (July 15, 2011); Patient Protection and Affordable Care Act: Exchange Functions in the Individual Market: Exchange Standards for Employers, 76 Fed. Reg. 51,202 (July 1, 2011); see http://cciio.cms.gov/programs/exchanges/index.html for HHS guidance on joint federal/state operation of exchanges. See also Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges (August 14, 2012) http://cciio.cms.gov/resources/other/index.html#hie.

[6] California S.B. 900; A.B. 1602 (2010).

[7] Colorado S.B. 11-200 (2011).

[8] Connecticut. S.B. 921 (2011).

[9] District of Columbia, B 19-2 (2012).

[10] Hawaii S.B. 1348 (2011).

[11] Kentucky Executive Order 2012-587 (2012).

[12] Maryland H.B. 166 (2011).

[13] Nevada S.B. 440 (2011).

[14] New York Executive Order 43 (2012).

[15] Oregon S.B. 99 (2011).

[16] Rhode Island Executive Order 11-09 (2011).

[17] Vermont H.B. 202 (2011).

[18] Washington S.B. 5445 (2011).

[19] West Virginia S.B. 408 (2011).

[20] Massachusetts, MGL c. 176Q (2006); Utah, H.B 133 (2008) and H.B. 188 (2009).

[21] Blueprint for Approval of Affordable State-based and State Partnership Insurance Exchanges - Frequently Asked Questions: Blueprint Submission Deadline (November 9, 2012) http://cciio.cms.gov/resources/factsheets/hie-blueprint-states.html

[22] The constitutionality of the PPACA individual mandate was upheld in National Federation of Independent Business v. Sebelius, 567 U. S. __; 132 S.Ct. 2566; 183 L.Ed2d. 450 (2012).

[23] Pub. L. No. 111-148 , §1302(b).

[24] Essential Health Benefits Bulletin: Giving States Additional Flexibility to Implement Health Reform (December 16, 2011); see also Essential Health Benefits Bulletin: Illustrative List of Three Largest Small Group Products by State (January 25, 2012); http://cciio.cms.gov .

[25] Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation, pp. 70643 - 70676 [FR DOC # 2012-28362].

[26] Pub. L. 111-148, §1003 adding PHSA § 2794(b).

[27] Pub. L. No. 111-148, §1413.

[28] Pub. L. No. 111-148, §2001.

[29] Federation of Independent Business v. Sebelius, supra.

[30] Pub. L. No. 111-148, §1401.

[31] Pub. L. No. 111-148 , §1201 (amending the Public Health Services Act (PHSA) to add §2702, to be codified at 42 U.S.C. §300gg-1)).

[32] Pub. L. No. 111-148 , §1301(a).

[32] Pub. L. No. 111-148, §1401 (small employer tax credit); Pub. L. No. 111-148, §1513, as amended by Pub. L. No. 111-152, §1003 (penalties for large employers).

[33] Pub. L. No. 111-148, §1401 (small employer tax credit); Pub. L. No. 111-148, §1513, as amended by Pub. L. No. 111-152, §1003 (penalties for large employers).

Ms. Rowen provides her clients with thoughtful analysis and practical solutions to regulatory problems grounded in a thorough understanding of the business of insurance. She represents property & casualty insurers, health insurers, health plans and life insurers on a broad spectrum of complex regulatory issues.

For further information, please contact:

Hilary N. Rowen
Partner
San Francisco
312.641.9050
hilary.rowen@sedgwicklaw.com