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Healthcare re-FORUM

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Types of Plans Sold On the Exchanges

***Healthcare Re-Forum: Issue 29 — An Overview of the American Health Benefit Exchanges* — provided an overview of the guidelines established for the formation of the state-based American Health Benefit Exchanges (the Exchanges), effective January 1, 2014. The Exchanges will be overseen during both implementation and operation by the Department of Health and Human Services (HHS) Office of Consumer Information and Insurance Oversight (OCIIO). This HHS subsidiary, also created by the reform legislation, will implement all private insurance reforms enacted by the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (HCERA).**

Beginning January 1, 2014, all citizens and legal residents of the United States will be required to have qualifying health coverage. Those without appropriate coverage at this time will be assessed a tax penalty, which, by 2016, will be the greater of $695 per year for an individual (or up to three times that amount, $2,085, per family), or 2.5 percent of household income. Health plans in effect on March 23, 2010, are grandfathered under the law and will fulfill the mandate for "qualified coverage."

When the state-based Exchanges are operating, it will be important to note:

- The PPACA does not require insurers to participate in an Exchange, but does stipulate requirements for plans sold on the Exchange.
- Qualified health plans sold on an Exchange must agree to charge the same premium whether the plan is sold through the Exchange or outside of the Exchange; this "same price" requirement applies only to insurers that choose to sell products both within and outside of an Exchange.
- The Exchanges must be self-sustaining by 2015 and may therefore charge assessments or user fees to participating issuers who sell plans on the Exchanges.
- Tax credits and cost-sharing subsidies are only available to individuals who purchase their healthcare coverage through an Exchange.
- The PPACA restricts employees of small businesses to a choice of options at one tier as selected by the employer.

Individuals and families with income between 133 percent and 400 percent of the federal poverty level will be eligible for premium tax credits and cost-sharing subsidies if they purchase plans on the Exchanges.

Qualified Health Plans

A qualified health plan (QHP) is a health insurance policy sold through an Exchange. The PPACA requires Exchanges to certify that QHPs meet minimum standards contained in the law, such as the requirements for an essential benefits package. Rules applicable to QHPs include:

- Defined categories of essential benefits must be included in a QHP; the essential benefits requirements are yet to be fully clarified by HHS
- Grandfathered and self-insured plans do not need to comply with the essential benefits requirement
- Essential benefits currently include: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services (including behavioral health treatments), prescription drugs, rehabilitative and habilitative services and devices, lab services, preventive and wellness services, chronic disease management, and pediatric services, including oral and vision care
- Out-of-pocket cost-sharing limits are $5,950 per individual and $11,900 per family; deductible limits are $2,000 per person or $4,000 per family

[over]

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- QHPs must meet one of four benefit categories created by PPACA; insurers participating in an Exchange must offer at least one plan at the Silver level and one plan at the Gold level (see descriptions below)
- Exchanges must provide for the certification, recertification and decertification of QHPs, consistent with guidelines developed by HHS
- Plan issuers must offer any QHP as a "child-only" plan to individuals under the age of 21
- Exchanges may not sell plans that are not QHPs, other than stand-alone dental plans if they offer pediatric dental benefits meeting the requirements of the PPACA (stand-alone dental plans are considered to be an "excepted benefit" and are not subject to the rules for QHPs)
- Insurers offering individual or small group plans can only base premium rates on four factors: whether the plan or coverage is offered to an individual or family, age (3:1 ratio), tobacco use (1.5:1 ratio) and geographic area based on rating areas as defined by state insurance commissioners

Please note: plans offered outside of an Exchange must also comply with the essential benefits requirements.

Tiered QHPs

QHPs will provide different levels of coverage and will be tiered as follows, with the indicated cost-sharing requirements (up to the out-of-pocket limits noted above):

- **Bronze plans** will provide coverage that is actuarially equivalent[1] to 60 percent of the defined package of essential benefits, with a 40 percent cost share for the beneficiary
- **Silver plans** will provide coverage that is actuarially equivalent to 70 percent of the defined package of essential benefits, with a 30 percent cost share for the beneficiary
- **Gold plans** will provide coverage that is actuarially equivalent to 80 percent of the defined package of essential benefits, with a 20 percent cost share for the beneficiary
- **Platinum plans** will provide coverage that is actuarially equivalent to 90 percent of the defined package of essential benefits, with a 10 percent cost share for the beneficiary

Individuals who are under the age of 30, or who are exempt from the individual mandate because no affordable plan is available to them or they have a hardship exception, may purchase **Catastrophic Coverage**, which will provide the essential benefits package with a cost-share limit in 2014 of $5,950 for an individual or $11,900 for a family. The beneficiaries of this plan will qualify for first-dollar coverage of at least three primary care visits before the high deductible is met. Catastrophic coverage may only be offered in the individual market and will be available on the Exchanges.

The National Association of Insurance Commissioners (NAIC) published Frequently Asked Questions on its website on November 11, 2010. One of the questions addresses the ability to maintain a Health Savings Account and notes "… nothing in the legislation would infringe upon the ability of an individual to contribute to a Health Savings Account (HSA), or discourage an individual from doing so. The minimum level of coverage required to meet the individual mandate was specifically designed to allow for the purchase of a qualified high deductible [health] plan that would complement the HSA."

There is potential for significant variance in the states' regulation of QHPs on the Exchanges due to the political and philosophical differences that exist within the state governments who must establish and operate the Exchanges within their respective states.

Future Topics:
- The Insurance Marketplace On and Off the Exchanges
- Co-ops and Multi-State Plans

[1]Actuarial value of a plan is the portion of the total cost of covered benefits that is paid by a health insurance plan.