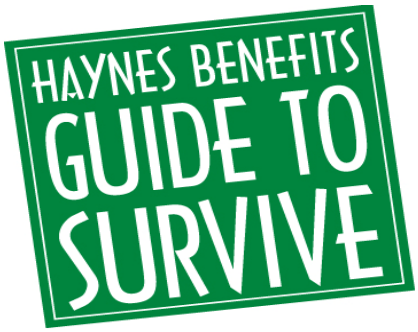

. . . Health Care Reform 2010

Week 4: Exchange Rules Provide a Glimpse of the Future

In this week's alert, we will discuss the basic rules governing exchanges under the Patient Protection and Affordable Care Act ("PPACA" or "the Act").

> *This alert provides a brief overview of the exchange rules because the Act provides only a blueprint for exchanges. The actual regulation is left to the Secretary of Health and Human Services (the "Secretary") and the individual states. And, quite frankly, we believe that many of the rules likely will change between now and 2014, when the exchanges begin operation.*

The basics. As of January 1, 2014, each state must establish an American Health Benefit Exchange ("exchange") that meets the requirements of the Act, make available "qualified health plans" and create a Small Business Health Options Program ("SHOP Exchange").

> *What is an exchange? President Obama said it simply when he referred to exchanges as "Travelocity for insurance." At its basics, an exchange is an internet portal to allow easy shopping for qualified health plans.*

Qualified health plans. The Act requires that qualified health plans provide essential health benefits, limit cost sharing and provide certain levels of coverage.

Essential health benefits. Essential health benefits must include at least the following general categories: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance use disorder services, prescription drugs, rehabilitative and habilitative services, laboratory services, preventive and wellness services, chronic disease management, and pediatric services including oral and vision care. Plans may cover abortion, but federal funds may not be used for non-federally permitted abortions. The Secretary must further define the essential health benefits, which must be at least equal to the covered services under a "typical employer plan."

Cost sharing limits. Qualified health plans must meet the cost sharing limitations discussed in our Week 2 alert.

Levels of coverage. A qualified health plan must offer at least one plan in the silver and gold level, and agree to charge the same premium rate for each qualified health plan regardless of

whether the plan is provided through an exchange. The levels of coverage and respective percentage of the full actuarial value of the benefits provided are: bronze (60%), silver (70%), gold (80%), and platinum (90%). Limited scope dental benefits also are permitted.

Young invincible plans. A qualified health plan may also offer a catastrophic plan in the individual market that provides coverage to those under the age of 30, and provides benefits only after the cost sharing limits described in our week 2 alert are met.

Child only plans. A qualified health plan that offers coverage at any level of coverage must also offer that coverage as a plan in which the only enrollees are individuals under the age of 21.

Timeline. States are to establish the exchanges by January 1, 2014 and open those exchanges to individuals and small employers with 100 or fewer employees. However, prior to 2016, a state may limit exchanges to employers with 50 or fewer employees. In 2017, states may open exchanges to employers of all sizes.

Consumer choice and competition. The Secretary must make grants available to the states to establish exchanges and SHOP exchanges, and to establish criteria to certify qualified health plans. The extensive rules contain numerous requirements, including sufficient choice of providers, quality assurance and improvement strategies, uniform enrollment forms, enrollee satisfaction surveys, market based incentives, quality improvement measures, initial and annual open enrollment periods, and certain special enrollment periods.

Single risk pool. Insurers must consider all enrollees in all individual health plans inside and outside the exchange to be members of a single risk pool. The same rule applies to the small group market. A state law requiring grandfathered plans to be included in the pool will not apply.

> *The only way to avoid the single risk pool rule seems to be to not participate in the exchange.*

State flexibility relating to exchanges. States may require additional benefits in addition to the essential health benefits.

Cooperatives. The Act establishes the Consumer Operated and Oriented Plan (CO-OP) program under which grants and loans may be made to establish CO-OPs, which are to be qualified nonprofit health insurance issuers that will offer qualified health plans in the individual and group markets. CO-OPs cannot be related to an insurer, and will be entitled to tax exempt status.

Navigators. Navigators will conduct public education activities, distribute information and facilitate enrollment. Trade and professional associations are among the entities that may serve as navigators.

Role of brokers. Brokers may serve as navigators, enroll individuals in qualified health plans and assist with tax credits and cost sharing reductions. The Secretary may establish rate schedules for broker commissions.

State flexibility to establish alternative programs. States have flexibility to establish alternative "standard health plans" for low income individuals not eligible for Medicaid which, in the case of a plan offered by a health insurer, has a medical loss ratio of at least 85%. The Act includes specific provisions addressing innovation, health and resource differences, managed care, performance measures and enhanced availability.

We will discuss the rules allowing employee opt out and requiring employer notice of the exchange and vouchers in our Week 5 alert on Employer Responsibility.

Dated: May 25, 2010