STRATEGIC HEALTH CARE

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KEY PROVIDER ISSUES IN HEALTH CARE REFORM

May 2010 **INSURANCE EXCHANGES & CO-OPS**

The Exchange

A core goal of the health reform law is to provide a means for more consumers to obtain health insurance, allowing them to compare benefits and prices and choose a plan that best suits their needs. The state-based health insurance Exchanges are a key piece of the reform package intended to achieve that goal.

No later than 2014, states are required to implement state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by a governmental agency or non-profit organization. A state may elect to provide only one Exchange for both qualified individuals and qualified small employers, if the Exchange is deemed as adequate to assist such individuals and employers. Plans offered on the Exchange will be issued by private insurers and must meet strict government requirements, including minimum benefits packages, specified levels of allowed cost-sharing through co-payments, deductibles, and overall premium prices.

States have the option to operate the Exchanges either directly or through a contracted entity; enter into agreements with other states to jointly provide an Exchange; or opt for the federal government to run an exchange in their state. Those operating an Exchange will be required to certify plans as "qualified" to sell in the exchange; maintain a website to help consumers compare standardized health plans; assist individuals in determining eligibility for Medicaid, CHIP, or other state public programs; calculate an individual's available tax credits; provide information to the federal government about individuals that are exempt from tax penalties; and establish "Navigator" programs that will provide grants to community-based organizations and other entities to assist with enrollment outreach.

Small Business Health Options Programs (SHOP Exchanges)

No later than 2014, states may set up Small Business Health Options Programs, or SHOP Exchanges, in which small businesses will be able to pool together to buy insurance. Small businesses are defined as those with no more than 100 employees, though states have the option of limiting pools to companies with 50 or fewer employees through 2016; companies that grow beyond the size limit will be grandfathered in**.** Beginning in 2017, states will have the option of allowing large groups to purchase coverage through the SHOP Exchange

Consumer Operated and Oriented Plan (CO-OP)

The law establishes the Consumer Operated and Oriented Plan (CO-OP) program as a way to foster the creation of qualified nonprofit, member-run health insurance issuers for the individual and small group markets. It remains unclear how CO-OPS and Exchanges will function with one another.

A total of six billion dollars was appropriated to implement CO-OP programs. Under the new CO-OP program, the Secretary has the authority to issue loans and grants for eligible entities. Loans can be used to cover start up costs and grants may be awarded to meet state mandated solvency requirements. When awarding loans and grants the Secretary

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will be required to give priority to applicants that offer qualified health plans on a statewide basis, utilize integrated care models, and have significant private support. Funds for the CO-OP program are required to be awarded and distributed by the Secretary no later than July 1, 2013.

To be eligible to receive a loan or grant through the CO-OP program an organization must satisfy the following requirements.

- Be organized as a nonprofit, member company under state law,
- maintain substantial activities related to the issuance of qualified plans in states in which it is licensed to issue such plans,
- have governance subject to a majority vote by its members,
- have governing documents that incorporates ethics and conflict of interest standards protecting against insurance industry involvement and intervention,
- operate with a strong consumer focus,
- use profits to lower premiums, improve benefits, or improve quality of care delivered to its members,
- comply with state insurance laws,
- wait to begin operation until the state has implemented the individual and small group insurance market reforms required under the health reform law,
- be a newly developed organization (not a health insurer on or prior to July 16, 2009 or be previously sponsored by a state or local government or political subdivision).

Qualified Health Plans

The Secretary will be required to establish criteria for the certification of health plans as qualified health plans. Participation in the Exchange and SHOP Exchange require plans to meet standards of a "qualified health plans."

Criteria for qualified health plans will include; meet marketing requirements; ensure a sufficient choice of providers, including providers who serve predominately low-income, medically-underserved individuals; meet clinical quality measures; implement a quality improvement strategy; utilize a uniform enrollment form; maintain a standard format for presenting health benefits plan options; provide information to enrollees and prospective enrollees on quality measures for health plan performance and; report to the Secretary of Health and Human Services (HHS) annually on quality reporting measures.

Plans must also provide an essential package of benefits to participate in the Exchange. When defining the essential benefits package the Secretary will ensure that all benefits are, "equal to the scope of benefits provided under a typical employer plan." The essential benefits package must include at least the following general categories and services within these categories.

1. Ambulatory patient services,
2. Emergency services,
3. Hospitalization,
4. Maternity and newborn care,
5. Mental health and substance use disorder services, including behavioral health treatment,
6. Prescription drugs,
7. Rehabilitative and habilitative services and devices,
8. Laboratory services,
9. Preventive and wellness services and chronic disease management and,
10. Pediatric services, including oral and vision care.

Stand-Alone Dental Benefits— State Exchanges may allow an issuer to offer a limited scope dental benefits plan through the Exchange either separately or in conjunction with a qualified health plan.

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Levels of Coverage – In order to provide services on the Exchange plans must offer the essential benefits package and satisfy bronze, silver, gold or platinum level coverage.

BRONZE LEVEL—Offers coverage that is designed to provide benefits to individuals that is, "actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan."

SILVER LEVEL—Offers coverage that is designed to provide benefits to individuals that is, "actuarially equivalent to 70 percent of the full actuarial value of the benefits provided under the plan."

GOLD LEVEL—Offers coverage that is designed to provide benefits to individuals that is, "actuarially equivalent to 80 percent of the full actuarial value of the benefits provided under the plan."

PLATINUM LEVEL—Offers coverage that is designed to provide benefits to individuals that is, "actuarially equivalent to 90 percent of the full actuarial value of the benefits provided under the plan."

CATASTROPHIC—Plans may offer coverage to individuals under the age of 30 or those exempt from coverage due to financial hardship. Catastrophic coverage plans do not provide bronze, silver, gold, or platinum levels of coverage and are only available in the individual market. This type of plan provides coverage for three primary care visits a year.

Plans may cover benefits that are outside the essential benefit package including abortion services; however, if plans cover abortion services, they must collect a separate premium payment for the coverage and consumers may not use any premium tax credits or other federal funding for abortion services.