

# *Health Care Reform: Key Aspects of Exchanges*



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# What is an Exchange?

- **Ambiguous definition, depends who you ask**
  - On-line marketplace structured to enable consumers to make easy, “apple to apples” comparison of health insurance purchases
  - State based infrastructure to support HCR coverage mandate
  - Loosely modeled after Massachusetts “connector”
- **HHS Definition:**
  - *“An Exchange is an organized marketplace to help qualifying individuals and employer groups buy health insurance in a way that permits easy comparison of available plan options based on price, benefits, and quality. The Exchanges will carry out a number of functions required by health care reform, including certifying QHPs (qualified health plans), administering premium tax credits and cost sharing reductions, and responding to customer requests for assistance”*
    - HHS Agency Information Collection Activities, 76 Fed. Reg. 24032 (April 29, 2011)

# Background: Exchange Concept

- Health care reform debate
  - 45 Million uninsured Americans (proponents' number)
  - “Public” option v. maintaining private insurance
  - PPACA compromise: *government organized rather than controlled*
- Pre-PPACA restrictions
  - Preexisting condition exclusion
  - Market driven hurdles to obtaining meaningful individual coverage
- Post-PPACA reforms
  - Individual mandate (weak \$ penalty/legal challenges pending)
  - Phased-in elimination of preexisting condition exclusion
  - Broad insurance market reforms
- Exchange funding
  - Funded with federal grants through 2015, then to become “self-sustaining”
  - Post 2015 Exchanges okay to charge user fees or assessments from insurers
- Will the Exchange concept work?
  - If not, where do 30 million people mandated to obtain coverage go?

# When do the Exchanges go on-line?

- **Exchanges to be established by 2014**
  - Coincides with “pay or play” HCR employer coverage mandate
  - Each State must establish its own Exchange
    - Exchanges may operate under different rules
    - Only required to meet minimum HHS operating standards
  - “Regional” Exchanges okay, with HHS approval
  - State failure to comply by deadline triggers invite to HHS to create a federal version of the Exchange to operate in that State
- **Significant work already underway**
  - HHS launches website with exchange option info (July 1, 2010)
    - <http://www.healthcare.gov/>
  - Users collect response based on criteria (e.g. age, health, smoke)
  - HHS web portal archives previously unavailable data
    - Individual v. family coverage policies by state
    - Percentage of applicants denied coverage
    - Percentage applicants charged more due to health factors

# Who may purchase ?

- (*Eligible*) Individuals
  - Starting in 2014
  - Not eligible for Exchange if Employer offers compliant coverage
  - Individuals may only enroll in a plan through the Exchange of their state of residence (specifically disallows consideration of location of employer)
    - *Exception: If Employer obtains group coverage through Exchange*
  - Only *lawful residents* may obtain Exchange coverage
    - Ten to 15 million undocumented residents ineligible
    - Many will still end up uninsured and obtaining emergency services
- (*Eligible*) Employers
  - Starting in 2014 for small employers only (100 or fewer)
    - States hold “option” through 2016 to limit small ER to 50 or fewer
  - Starting in 2017 states may allow large ERs to buy (101 or more)
- No Direct “Mandate” to use Exchange
  - Eligible employers allowed, but not required to use Exchange
  - If Exchange is used, then must make all FT workers eligible for one or more qualified plans through the Exchange

# Qualified Health Plans (QHPs)

- What is a QHP?
  - Exchange cannot carry any plan not certified as QHP
  - Must offer “essential health benefits” (see next two slides)
  - Insurer must meet qualifications (e.g. licensed, good standing)
  - Must provide coverage at prescribed levels (e.g. gold, silver)
  - Insurer agrees to charge same premium for QHP coverage outside exchange (no discrimination against Exchange coverage plans)
  - Must comply with HHS Exchange regulations + state requirements
    - Special rule: QHP must be subject to state insurance regulations (thereby appears to exclude any self-funded group health plan)
- HHS QHP “certification” conditions (so far)
  - Satisfy federal government’s marketing rules
  - Must offer sufficiently broad provider network
  - Accredited for clinical quality, patient ratings, quality improvement plan
  - Must provide standardized enrollment forms, plan materials, etc.
  - Agrees to publish information about quality standards used to measure performance

# Essential Health Plan Package

- **Exchange plans must deliver compliant coverage**
  - Offer QHPs at four different coverage levels
    - Bronze, silver, gold, and platinum coverage at 60%, 70%, 80%, and 90% benefit payment levels, respectively
    - Provides essential benefits (next slide)
    - Insurers that offer a bronze, silver, gold or platinum levels must also create a corresponding “child only plan” specifically devised for individuals under age 21
- **Essential benefits v. Minimum Essential Coverage**
  - Key distinctions
    - PPACA defines QHP using “essential health benefits”
    - Minimum essential benefit relates to ER mandate for coverage
    - Minimum essential benefit describes coverage ER must provide to avoid the pay or play tax
    - As of now, minimum essential coverage for ERs still undefined except it must be at least as rich as “bronze” level QHP

# Known Essential Health Plan Provisions

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse treatment, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Wellness & preventive services
- Chronic disease management
- Pediatric services (oral and vision care)
- ***HHS regulations could further expand***

# Small Business Health Option

- What is a SHOP Exchange?
  - *Small Business Health Options Program* = SHOP Exchange
  - State entity to assist qualified employers in the state enroll their employees in QHPs offered in the small group market
  - Each state must establish by 2014 (subject to option noted below)
    - Before 2016 States have discretion to define “small” at 50 or 100 EEs
    - Starting in 2016 small employers defined as 100 or fewer
- Compliance option
  - PPACA allows states to provide a single Exchange with combined resources to help individuals + small employers
  - Not allowed to avoid SHOP unless combined resources adequately “robust” to support both groups
  - HHS to monitor Exchanges to gauge adequacy of resources

# Notice of Exchange Coverage

- *What new Notice?*
  - PPACA Amends FLSA to add notice rules about Exchange Coverage
  - Notice to go to all current employees + new hires
  - ***All ERs subject to FLSA must comply – not just ERs under “pay or play”***
- *When does the Notice requirement start?*
  - Disclosure requirement starts on March 1, 2013
    - Nine months ahead of date Exchanges go on-line
  - All workers hired on or after 03-01-2013 must receive notice at time of hiring
  - All Employees working on the effective date must be provided with the new Notice by March 1, 2013
- *What Information must Employers Provide?*
  - Option for coverage in State Exchanges
  - Whether plan is in compliance
  - Explanation to employee of implications of buying Exchange coverage v. using Employer sponsored group health plan
  - Availability of federal tax credit
  - Unclear whether DOL can / will provide model notice
    - Exchanges are state-created and their rules may vary

# States: Option for Exchange “Opt-Out”

- PPACA allows states to “opt-out” of Exchanges after 2017
  - But, states NOT allowed to opt-out without replacement plan
- Law offers states “innovation waivers”
  - HHS will review application for waivers
  - Criteria for waiver hinges on whether replacement plan will deliver protections to state residents that are:
    - Not less comprehensive
    - At least as affordable to participants
    - Protects at least as many residents as HCR
    - Neutral effect on federal deficit
- States must offer adequate evidence to support waiver
  - Actuarial certifications
  - Expert testimony
  - Analytic economic data

# *Will Exchanges Matter to Employers?*

- “Pay or play” concept hinges on mandate to offer coverage (Effective plan years on or after 01-01-2014)
  - Exchanges simultaneously go into effect
- Coverage mandate applies if ER averaged over 50 FT employees on business days in *preceding* calendar year
  - Full-time means **works** on average **30 hours** a week in a month (not *scheduled* to work)
  - Part-timers measured as “full-time equivalents” to reach 50
  - Aggregate (count together employees of) employer groups based on controlled group rules for taxes
- *Will Employees jump to coverage on the Exchange?*
  - Exchange eligibility restrictions
  - Open question, especially since the comprehensive nature of Exchange plans could make such coverage more expensive than expected

# Possible “Pay or play” Penalties

- \$2,000 per employee if fail to offer essential health plan to all full-time employees (and dependents) – nondeductible/annual
  - Calculated on FT workers (not PT or FT equivalents), subtracting 30 from number of employees
  - Annual penalty, but measured on a monthly basis
  - On 1,000 full-time employees, penalty = \$1.94 million
- \$3,000 per each full-time employee that declines employer plan and who also obtains Exchange coverage
- Employee with employer plan eligibility is not entitled to buy coverage from the Exchange, except when:
  - Cost > certain percent of income (roughly 9.5%)
  - Plan offers less than 60% value of benefits

# Individual Mandate

- **Individual mandate starts in 2014**
  - Limited exceptions apply
  - Tax credits may apply (available to \$88K household income/Four person)
- **Must hold compliant health coverage or pay penalty**
  - Fines (assessed as “taxes”) for failure to purchase
    - \$95 in 2014
    - \$325 in 2015
    - \$695 in 2016
  - or*
    - 1.0% of taxable income in 2014
    - 2.0% of taxable income in 2015
    - 2.5% of taxable income in 2016 and thereafter
- **Individual mandate may be fulfilled through**
  - Exchange coverage
  - Employer sponsored group health coverage (if compliant)
  - Privately obtained non-Exchange coverage (if compliant)
  - Government sponsored coverage
    - Medicare, TRICARE, Medicaid, CHIP, etc.
  - Other coverage recognized by HHS

# Exchanges Rely on Employer Data

- Employers may face penalties because of what the government learns from Exchange-collected data
- Employer Reporting Requirement to Government
  - Names, SSNs, Home Address of Employee & Dependents
  - Month-by-Month on Whether Each Person is Covered or Not
  - Reporting rules still unclear
    - *Revised and expanded Form 5500?*
- Exchanges Used for Enforcement Against
  - Individuals
    - IRS will Know if Person is Not on an Employer's Report and Not Enrolled Through an Exchange or Government Program
    - Investigation/Penalty Demand Triggered
  - Employers
    - Individual Enrolls on Exchange with Federal Assistance
    - Exchange will Know Individual's Household Income (IRS Data Check) and Whether Employed (Using IRS Information)
    - Investigation/Penalty Demand Triggered
    - HHS directs State Exchanges to report to Feds

# Employer Data & Enforcement Activities

- “Secondary” Exchange Functions
  - **Exchanges to serve as new compliance “radar gun”?**
  - Expect careful scrutiny of Exchange-collected data
  - Agent to compel HCR Enforcement
  - Both “individual mandate” and “pay or play” closely factor
- CBO: Reform will cost \$1.1 Trillion
  - History of Feds underestimating cost (particularly health costs)
  - Massachusetts red ink
- HCR law contains new and additional taxes and fees
  - New revenue only produces about 50% of CBO budget estimate
- Washington, D.C. is hiring
  - Speculation that hiring will closely relate to enforcement
- Lessons Learned: Medicare Secondary Payer program proves how effective CMS penalties can be at augmenting revenue
- Employers rightly fear HCR compliance will be put under microscope
  - Assessment of fees and penalties will boost revenue

# *Thank You!*



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