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Will Proposed Health Insurance Exchanges Work?

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Beginning in 2014, the state health insurance exchanges have the potential to become one of the most significant industry changes under the Patient Protection and Affordable Care Act (PPACA). Conversely, there also is the possibility that the lack of participation by both insurance providers and participants could undermine these marketplaces, making this part of health care reform nearly moot shortly after implementation. This update, the second in a series, looks at the specific requirements for the state exchanges, how PPACA encourages their use, and, finally, what insurers should consider when preparing for implementation of the exchanges.

Exchanges – Exchange Basics

Under PPACA, each state must establish, as a governmental agency or nonprofit entity, an American Health Benefit Exchange (Exchange) that facilitates the purchase of qualified health plans. The Exchanges also must provide for the establishment of a Small Business Health Options Program to assist businesses with fewer than 100 employees with enrolling their employees in small group qualified health benefits plans. States may choose to establish a single Exchange that performs both functions. Furthermore, if a state refuses to implement an Exchange, the Department of Health and Human Services will implement the Exchange for the state, either directly or through a contract with a nonprofit organization.

The Exchanges will initially be open only to individuals who work at companies no more than 100 employees or that do not provide insurance, the self-employed and unemployed, non-Medicare-covered retirees, and small businesses. In addition, multi-state exchanges are allowed, which would result in a larger pool of potential insureds for those states with relatively small populations. Conversely, in larger states, the government is allowed to operate multiple Exchanges, with each Exchange based on separate geographic areas. Starting in 2017, the states also can allow employers with more than 100 employees to participate.

Plan Requirements

Under PPACA, all plans offered through the Exchanges must be "qualified plans" and provide coverage for "essential benefits." (For more information on essential benefits, see our April 6, 2010 Legal News Alert at http://www.foley.com/publications/pub_detail.aspx?pubid=6997). These qualified plans are classified into four groups based on the percentage of costs covered by the insurer: Bronze (60 percent cost share), Silver (70 percent cost share), Gold (80 percent cost share), and Platinum (90 percent cost share). In addition, each Exchange must offer at least two health plans that are available in two or more states. At least one of these health plans must be a nonprofit organization. Furthermore, all plans offered through the Exchanges also must meet PPACA's universal requirements for all health insurance plans in 2014, including but not limited to the requirements relating to preexisting conditions, rescissions, renewability (as discussed in our April 6, 2010 Legal News Alert), and variations in ratings (based on age, tobacco use, and so forth). Despite these requirements, PPACA does not grant the states the authority to set the premiums for plans offered through the Exchanges. Although states cannot set premiums for the plans in the Exchange, PPACA does require that insurance companies justify any rate increases and prices to the state regulators. If the state regulators are not satisfied with an insurer's justification, the regulators may exclude the company from participating in the Exchange.

However, and perhaps most important, nothing in

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PPACA prohibits an insurer from offering insurance outside of the Exchanges or eligible individuals and employers from purchasing coverage outside the Exchanges. In other words, although there will be an individual mandate in 2014, no individual or employer shall be compelled to purchase coverage through the Exchanges. Nonetheless, as discussed below, PPACA provides powerful financial incentives for the use of such Exchanges.

Incentives to Use the Exchanges

PPACA provides two direct incentives for individuals and families to buy health insurance through the Exchanges.

Premium Credits

For individuals and families whose income is up to four times the federal poverty level (currently, up to $43,420 for individuals and $88,200 for families), tax credits will be available for purchasing insurance through the Exchanges. The amount of the credit is determined on a sliding scale and will be paid directly to the insurer to obtain coverage through the Exchange, while the individual or family pays the difference in the cost of coverage.

Free Choice Vouchers

In addition, employers who offer their employees health insurance coverage also must provide employees who would qualify for the premium credit discussed above and who spend between 8 and 9.8 percent of their income on premiums a "free choice voucher." The voucher amount would be equal to what the employer would have paid to provide coverage to the employee under the employer's plan. The voucher only can be used if the employee chooses not to enroll in the employer's existing plan, and then can only be used to enroll in a plan in an Exchange. Employees who use a voucher would be ineligible for the premium credit discussed above.

Impact of Incentives

In theory, these inducements will create a large pool of potential insurance purchasers that will be highly attractive to insurers, providing them with a significant incentive to offer coverage through the Exchanges. This, in turn, would give state regulators a powerful weapon to combat premium increases in the form of their ability to exclude insurers from the Exchanges based on "unjustified" rate increases. However, many industry experts believe the Exchanges may have a "critical mass" problem. That is, the Exchanges may not initially begin with enough selection of health insurance plans due to industry concerns related to the pools that will actually access coverage through the Exchanges (i.e., whether adverse selection and other factors will have a tendency to effectively turn the Exchanges into high-risk pools of insureds). This would then lead healthier individuals to purchase insurance outside the Exchanges, which will lead to even fewer insurance companies in the Exchange, and so forth, quickly accelerating into a death spiral for the Exchanges. At the end of the day, no one is sure whether either of these scenarios will play out. The answer may well lie somewhere in the middle, with the Exchanges resulting in a viable, albeit not huge, marketplace for health insurance.

Why Should Insurance Companies Care About the Exchanges in 2010?

With the Exchanges not going into effect until 2014, it is reasonable that much of the insurance industry is preoccupied with those portions of PPACA that are set to impact the industry much earlier.

However, insurance providers should realize that regulators will begin collecting information relating to premium increases starting with the 2010 plan year. This will be part of the data used to determine whether an insurance company should be allowed to participate in an Exchange. Therefore, any insurance company even considering participating in the Exchanges should be cognizant that decisions made this year regarding premiums will impact the company's options in 2014.

In addition, and only to a slightly lesser extent, insurance companies that expect to participate in the Exchanges should likely begin developing their specific health insurance plans this year, as such plans will need to be approved by state regulators before being allowed into the Exchange. Since PPACA requires that the Exchanges be open by January 1, 2014, the first plans on the Exchanges must be approved in 2013. Since there is typically a benefit to being among the first products in any given market, insurance companies that wish to reap this reward have barely more than two-and-half years to develop their products and gain approval before the Exchanges open.