KANSAS HEALTH INSTITUTE

MEMO

To: Senate Financial Institutions and Insurance Committee

From: Kansas Health Institute

Date: January 18, 2011

Re: Minimum Requirements for Health Insurance Plans Offered through Health Insurance Exchanges under the Affordable Care Act

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Introduction

The Affordable Care Act (ACA) makes significant changes in the regulations governing providers of large, small and non-group health insurance. In addition to the regulatory changes, the ACA also authorizes the creation of new state-based health insurance exchanges designed to provide coverage to both individuals and small groups. Federal subsidies also will be provided through the exchanges to eligible persons.
Certain distinctions will exist between plans offered inside the exchanges and plans offered outside the exchanges; this memo will briefly describe these distinctions.[i]

Requirements for New Plans

With exceptions, by 2014, the following regulations will apply to new individual and small group plans regardless of whether they are offered inside or outside of an exchange. Insurance companies will be:

- Prohibited from imposing lifetime and annual limits (lifetime limit prohibition became effective in 2010).
- Prohibited from cancelling policies – a practice known as rescission –except in cases of fraud (became effective in 2010).
- Required to cover recommended preventive services at no cost to plan beneficiaries (became effective in 2010).
- Required to extend coverage of dependent children to age 26 (became effective in 2010).
- Limited to the use of only four rating factors; age, family composition, geographic location and tobacco use.
- Required to issue and renew coverage to all who apply.
- Required to cover "essential health benefits", a federally defined list of basic benefits.
- Required to adhere to cost-sharing limits defined by the law.
- Required to implement new risk-adjustment strategies and offer standardized plans.[ii]

Requirements for Exchange Plans

In general, for a health insurance plan to be offered through a health insurance exchange it must be certified to be a "Qualified Health Plan" (QHP); note, however, that QHPs may also be offered outside of the exchanges. In order to be a QHP, a plan must do the following:

- Adhere to marketing requirements that do not discourage enrollment of persons with significant health needs.
- Ensure sufficient choice of providers.
- Include "essential community providers" that mainly serve the low-income and medically underserved.
- Implement quality improvement strategies with increased reimbursement or other incentives for goals such as reduction in hospital readmission rates or successful incorporation of health and wellness programs.

Issuers of QHPs must also meet specific requirements such as licensure and good standing in the state, the offer of at least one QHP at both the "silver" and "gold" levels in the exchange, and maintenance of the same premium rate for a plan regardless of whether it is offered through the exchange, directly from the issuer or through an agent.

Lastly, several provisions apply specifically to plans offered through an exchange. Most significantly, those individuals with incomes between 100 and 400 percent of the Federal Poverty Level ($22,050□$88,200 for a family of four in 2010) who do not have access to affordable coverage elsewhere, may be able to receive federally subsidized coverage, but only through plans offered in the health insurance exchanges. Similarly, small employers who qualify for tax credits to offset the costs of coverage will only be able to receive those tax credits when purchasing coverage through an exchange. Some additional rules applicable only to exchange plans (the details of which are to be developed by the Secretary of HHS) include evaluation by a quality rating system and by an enrollee satisfaction system.

Conclusion

While there is substantial overlap between the rules applicable to new individual and small group plans offered either outside or inside of health insurance exchanges, a few critical distinctions exist. Many details have yet to be determined about how both the exchanges and the market outside of the exchanges will operate and much discretion is left to the states in determining how to design the health insurance marketplace.

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[i] Information adapted and summarized from Congressional Research Service Report R41269, *PPACA Requirements for Offering Health Insurance Inside Versus Outside an Exchange*.

[ii] Please note that information in this memo is not intended to be exhaustive and additional rules and regulations may apply to QHPs, issuers of QHPs and QHPs offered through health insurance exchanges.