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Health Insurance Exchanges In PPACA

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The primary goals of the health care reform that was signed into law in March 2010 were to provide coverage to the uninsured and underinsured, and to bend the curve on spending. One way Congress sought to expand coverage was through the creation of health insurance exchanges. An exchange is an organized marketplace that offers a choice of health insurance plans to consumers, provides information about the plans, and establishes common rules for offering and pricing health insurance.

The Patient Protection and Affordable Care Act (PPACA) requires states to establish American Health Benefit Exchanges for individuals and small groups by January 1, 2014. Additionally, states may choose to implement Small Business Health Options Program Exchanges (SHOP) for small businesses. PPACA sets forth rules for issuers wishing to sell insurance through the exchanges and also sets forth which individuals and small businesses qualify for purchasing through the exchanges. Individuals and businesses may purchase insurance both in and outside the exchange and are not required to purchase in the exchange; however, many are expected to choose the exchange to take advantage of subsidies and tax credits.

To be available in an exchange in 2014, a plan must be certified by an exchange as being a qualified health plan (QHP). Among the basic requirements for an issuer that offers QHPs are the following:

- be "licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance…";
- offer at least one QHP in the silver level and at least one plan in the gold level in an exchange;
- "charge the same premium rate for each qualified health plan of the issuer without regard to whether the plan is offered through an Exchange or whether the plan is offered directly from the issuer or through an agent"; and
- "comply with [other requirements described in greater detail below] and such other requirements as an applicable Exchange may establish."

In order to be certified as a QHP, the following are minimum criteria to be established by the U. S. Secretary of Health and Human Services (i.e., the Secretary may require additional criteria) through regulation (per §1311(c)(1)), which will not be required of nongroup and small group plans that are not QHPs outside an exchange:

- "meet marketing requirements, and not employ marketing practices or benefit designs that have the effect of discouraging the enrollment in such plan by individuals with significant health needs";
- "ensure a sufficient choice of providers … , and provide information to enrollees and prospective enrollees on the availability of in-network and out-of-network providers";
- "include within health insurance plan networks those essential community providers, where available, that serve predominantly low-income, medically underserved individuals";
- "be accredited with respect to local performance on clinical quality measures…";
- implement a quality improvement strategy that provides increased reimbursement or other incentives for the following, per §1311(g)(1):

  - improvement of "health outcomes through the implementation of activities that shall include quality reporting, effective case management, care coordination, chronic disease management, medication and care compliance initiatives, including through the use of the medical home model, for treatment or services under the plan or coverage";
  - "implementation of activities to prevent hospital readmissions";
  - "implementation of activities to improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence based medicine, and health information technology under the plan or coverage";
  - "implementation of wellness and health promotion activities"; and
  - "implementation of activities to reduce health and health care disparities, including through the use of language services, community outreach, and cultural competency trainings."
- use a uniform enrollment form that individuals or employers obtaining or offering coverage through an exchange may use (either electronically or on paper);
- "utilize the standard format established for presenting health benefits plan options;
- "provide information to enrollees and prospective enrollees, and to each Exchange in which the plan is offered, on any quality measures for health plan performance … ; and
- "report to the Secretary at least annually and in such manner as the Secretary shall require, pediatric quality reporting measures consistent with the pediatric quality reporting measures established under section 1139A of the Social Security Act," which was established by the Children's Health Insurance Program Reauthorization Act of 2009 (P.L. 111-3).

Please click here for a detailed chart illustrating certain requirements with which plans must comply when selling inside or outside the exchange.