Kansas Legislative Research Department

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Health Reform

M-2 Health Insurance Marketplaces/Market Reforms/ Implementation

This article outlines the insurance marketplace reforms included in the Affordable Care Act, related changes in Kansas law, and the interaction of the market and Exchange and available options following the June 2012 U.S. Supreme Court decision and the remaining implementation time line, as established by the Act.

Market Reforms – September 23, 2010, Policy Requirements

Under the Affordable Care Act (ACA), a number of significant market reforms became effective for most group and individual health insurance policies with plan years beginning on or after September 23, 2010. Under the ACA, most health benefit plans in Kansas were affected by these provisions, including self-funded Employment Retirement Income Security Act (ERISA) plans excluded from state regulation. The following provisions, with notation of relevant action by the Kansas Legislature, are the health insurance market reforms for plan years beginning on or after September 23, 2010[1]:

- **No annual or lifetime limits.** Health plans are not permitted to impose lifetime dollar limits on key benefits. Annual dollar limits on insurance coverage also are restricted and are not allowed to be less than $750,000 unless the health plan receives a waiver.
- **Prohibition on rescissions.** Rescissions of health insurance coverage are prohibited, except in instances of fraud or intentional misrepresentation.
- **Coverage of preventive health services.** Qualified health plans (QHPs) are required to provide, at a minimum, coverage without cost-sharing for: preventive services rated A or B by the U.S. Preventive Services Task Force; recommended immunizations; preventive care for infants, children, and adolescents; and additional preventive care and screenings for women.
- **Extension of adult dependent coverage.** Health plans that offer dependent coverage must provide coverage for adult children up to the age of 26 for all individual and group policies.

1 Some of the provisions will not apply to health plans that were in existence prior to March 23, 2010, and have complied with the requirements necessary to maintain a "grandfathered" status.

- **Prohibition of preexisting condition exclusion, children under age 19.** Health plans may not deny coverage or apply pre-existing condition exclusions to coverage for children under age 19. Under the law, a high-risk pool separate from the state pool already in place was created to cover certain individuals with pre-existing medical conditions – this pre-existing conditions pool remains effective until January 1, 2014.
    - The Kansas Legislature enacted legislation (2011 HB 2075) that amended law governing the existing State High Risk Pool law to accept children under the age of 19, if no coverage is available under an individual health insurance policy in the area in which the child lives. The law also increased the statutory lifetime limit from $2.0 million to $3.0 million. The 2013 Legislature increased this limit to $4.0 million (2013 HB 2107.)
- **Appeals process.** The ACA requires a group health and health insurers in the group or individual markets to implement an effective appeals process for coverage determination and claims. This process must, at minimum, include: having an internal claims appeals process; providing notice to plan enrollees of available internal and external appeals processes and the availability of any applicable assistance; and allowing an enrollee to review his or her files, present evidence and testimony, and to receive continued coverage pending the outcome of the appeal.
    - The Kansas Legislature enacted updates to four provisions in the external review statutes (2011 HB 2075) to comply with the Uniform Health Carrier External Review Model Act (new rules adopted on July 23, 2010). The Legislature previously has enacted provisions granting insureds certain appeal rights for adverse health care decisions made through a utilization review process (internal review rights, 2006 H. Sub. for SB 522).
- **Prohibition on discrimination based on salary.** Group health plans (other than those self-insured plans) may not establish rules relating to the health insurance eligibility of any full-time employee that are based on the total hourly or annual salary of the employee. The eligibility rules cannot discriminate in favor of higher wage employees.
- **Other patient protections.** Health plans in the group market or insurers in the individual market may not require referrals for in-network pediatrician and ob-gyn care. Additionally, if the plan or health insurance issuer covers services in a hospital ER, the plan or issuer is required to cover those services without the need for prior authorization. If the ER services are provided out-of-network, the cost-sharing requirement will be the same as the in-network requirement.

Among other insurance reforms instituted in 2010, the law required health plans to report their proportional spending of premium dollars spent on clinical services, quality, and other costs and, subsequently, provide rebates to consumers for the amount of the premium expended that is less than 85 percent for plans in the large group market and 80 percent for plans in the individual and small group markets (aka Medical Loss Ratio [MLR]).

January 1, 2014, ACA Insurance Marketplace Provisions in the ACA

In addition to market reforms that became effective in late 2010, the ACA provides a number of marketplace reforms that become effective on January 1, 2014, including:

- **Elimination of pre-existing condition exclusions**—individuals and families purchasing insurance in the individual market will be guaranteed coverage for pre-existing conditions.
- **Guaranteed issue and renewability of coverage**—guaranteed issue and renewability will be required.

- **Rating factors limited to age (3:1 band), tobacco use, geography, and family size**—rating variation only will be allowed based on age [limited to 3:1 ratio], premium rating area, family composition, and tobacco use [limited to 1.5:1 ratio] in the individual and small group market and the Exchanges.
- **Limits on out-of-pocket costs in qualified health plans**—deductibles for plans in the small group market are limited to $2,000 for individuals and $4,000 for families unless contributions are offered that offset deductible amounts above these limits. Out-of-pocket limits also would be reduced for persons with incomes up to 400 percent of the federal poverty level (FPL) (three tiers).
- **Mandatory coverage of "essential health benefits"**—the ACA creates an essential health benefits package requirement—which provides for a comprehensive set of services, covers at least 60 percent of the actuarial value of the covered benefits [the "bronze" level of coverage], limits the annual cost-sharing to the current law Health Savings Accounts (HSAs) limits [$5,950/individual and $11,900/family in 2010], and is not more extensive than the typical employer plan.
- **Uniform explanation of benefits and standardized definitions**—requires qualified health plans to meet new operating standards and reporting requirements.

Additional options for coverage. States would be allowed to create a Basic Health Plan for uninsured individuals with incomes between 133-200 percent of FPL who would otherwise be eligible to receive premium subsidies in the Exchange. States also would be permitted the option of merging the individual and small group markets.

January 1, 2014, also represents the first day of operation (open enrollment commenced in October 2013) of a health insurance exchange in the states. The ACA allows states an option to create state-based American Health Benefit Exchanges and Small Business Health Options Program (SHOP) Exchanges, administered by either a governmental agency or non-profit organization, through which individuals and small businesses (up to 100 employees) may purchase health insurance coverage. This article does not address the individual mandate or phase-in tax penalty for those without qualifying health insurance coverage. The remaining section addresses the options available for states, following the recent decision, NFIB v. Secretary Sebelius, Department of Health and Human Services.

Exchange Options—State Discussion and Decision

Following the June 2012 U.S. Supreme Court decision, discussions began anew about the Exchange options available to the State of Kansas.

With the operational requirement of January 1, 2014, it was unlikely a state-based Exchange could be implemented in Kansas. The decision to opt-in for a state-based exchange would have to be submitted and certified by the U.S. Department of Health and Human Services (HHS) for approval or conditional approval by January 1, 2013 [for the 2014 coverage year]. The Kansas Legislature convened its 2013 Session on January 14, 2013. The legislation addressing the operational issues associated with the Marketplace, including its governance, was introduced during the session.

Review of State Options

The 2011 Interim Special Committee on Financial Institutions and Insurance received a briefing on Exchange options available to the states; options, in lieu of the establishment of a state-based Exchange, include: a State-Federal Partnership Exchange and a Federally-Facilitated Exchange.

In September 2011, HHS outlined the structure for a **Federally-Facilitated Exchange (FFE) and State-Federal Partnership Exchange** options. Five "core" functions of an exchange were identified:

- Consumer Assistance

  - Activities include consumer education and outreach; development and management of the Navigator program; call center operations; and website management.
  - If a state opts to maintain its consumer assistance function, the state would provide in-person assistance, Navigator management, and outreach and education.
- Plan Management
  - Decision-making includes those decisions relating to the operation of the Exchange (active purchaser or an open marketplace) and the rules and requirements for insurers participating on the Exchange and plans offered.
  - Plan management functions include plan selection; collection and analysis of plan rate and benefit package information; ongoing issuer account management; and plan monitoring, oversight, data collection, and quality analysis.
- Eligibility. The process of determining which individuals will be eligible for Children's Health Insurance Program (CHIP) and Medicaid programs and those persons eligible for tax credits and subsidies applicable to the purchase of private health insurance coverage.
- Enrollment. This process includes the enrollment of individuals in public programs or private plans based on the person's eligibility and the on-going involvement with private health plans (enrollments and payment of premium subsidies).
- Financial Management. Responsibilities include premium processing, the development and management of the funding mechanism for the operation of the Exchange, and the risk adjustment and reinsurance programs that will be required to ensure the operation of the health insurance marketplace (the market will include new, previously uninsured, enrollees).

State-Federal Partnership Options. Partnerships are Exchanges where both the federal HHS and the state operate functions of the insurance exchange. States entering into a Partnership would be required to agree, under the terms of their grants, to ensure the state's insurance department, Medicaid and CHIP cooperation to coordinate business processes, systems, data and information, and enforcement. As part of this agreement, a state could choose to operate plan management functions [see above Core Functions] and some or all consumer services, using available Exchange grant funding to establish functionality. Including these options in the agreement could allow for an easier transition to a future state-based Exchange.

The three options for operating an Exchange available to the states under the Partnership are:

- Option 1: Plan management functions;
- Option 2: Selected consumer assistance functions; and
- Option 3: Both selected consumer assistance and plan management functions.

All other core functions would be performed by the HHS under these options.

FFE Option. As State officials did not certify a Partnership [declaration letter] by November 16, 2012, for a state-based exchange[2] an FFE is being implemented in Kansas. The operation of an FFE in Kansas means:

2 On November 9, HHS Secretary Sebelius extended the deadline for submission of the Exchange Blueprint from the original date of November 16, 2012 to December 14, 2012. HHS is required to approve or conditionally approve a State-based Exchange for 2014 according to the statutory deadline of January 1, 2013. On November 8, 2012, Governor Brownback notified the Insurance Commissioner he would not support the state-federal partnership Exchange application. [Media Release, 11/08/2012]

- The FFE will perform the core functions comparable to State-based Exchanges, including consultation with stakeholders.
- The FFE will make decisions where Exchanges have flexibility, including network adequacy and marketing.
- The FFE will work with local stakeholders through the Navigator program and other outreach to educate consumers and small businesses about available options in 2014.
- HHS is permitted to charge issuers (of health plans and policies) user fees to run the FFE.
- FFEs will determine eligibility for QHPs, tax credits, cost sharing reductions, and Medicaid and state CHIP eligibility based on modified adjusted gross income (MAGI). The FFE will provide eligibility information to the applicable State agency to enroll these individuals in coverage.

The FFE will have standardized rules, and input from the states will be part of this process to implement Exchanges. Further, HHS will administer these functions in a manner consistent with the Exchange final rule, which established minimum Federal standards for major Exchange business areas "while leaving much flexibility and discretion to Exchanges to design processes and procedures that reflect local market dynamics." [General Guidance on Federally-facilitated Exchanges, Center for Consumer Information and Insurance Oversight (CCIIO), CMS, May 16, 2012]

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