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Health Care Reform Management Alert Series

Multi-State Plan Program Guidance and Expatriate Plan Transition Relief Issued

Issue 59

This is the fifty-ninth issue in our series of alerts for employers on selected topics on health care reform. (Click here to access our general summary of health care reform and other issues in this series.) This series of Health Care Reform Management Alerts is designed to provide an in depth analysis of certain aspects of health care reform and how it will impact your employer-sponsored plans.

The Office of Personnel Management ("OPM") issued final regulations in the *March 11th Federal Register* regarding the establishment of the Multi-State Plan Program. The Multi-State Plan Program introduces Multi-State Plans in the individual and small group health insurance markets on the Affordable Insurance Exchanges ("Exchanges") in order to foster competition. The final regulations describe how OPM will manage the Multi-State Plan Program, the requirements for a health insurer to contract with OPM to offer a Multi-State Plan, and the required plan features of a Multi-State Plan.

MULTI-STATE PLAN PROGRAM

Background

ACA requires the establishment of Exchanges in each State (and the District of Columbia) to create a regulated marketplace where individuals and small businesses can purchase health plans directly from private health insurers. The purpose of the Exchanges is to create a market for individual and small group health plans by: (1) providing a choice of health insurance plans to individuals and small employers; and (2) pooling individuals and small businesses that participate in the Exchange.

In order to facilitate competition in the Exchanges, ACA requires OPM to create the Multi-State Plan Program where certain plans will be allowed to market specified health insurance products in each Exchange (called a Multi-State Plan or "MSP"). In order for a private health insurer to contract with OPM and offer an MSP in the Multi-State Plan Program, the insurer and the MSP that it offers must meet several requirements.

Requirements for Health Insurers Participating in the Multi-State Plan Program

The final regulations outline the requirements that a health insurer must meet in order to contract with OPM and offer an MSP in the Multi-State Program. Below are highlights of the requirements:

- **Licensing:** The health insurer must be licensed in each State where it offers coverage. By the fourth year that a health insurer offers an MSP, the final regulations require that the insurer offer an MSP in all 50 States and the District of Columbia. Thus, the insurer must be licensed in all States or have the ability to become licensed in all States by the fourth year it offers an MSP.

TRANSITION RELIEF FOR INSURED EXPATRIATE PLANS

On March 8, 2013, the Departments of Labor, Health and Human Services, and Treasury ("Departments") issued an additional Frequently Asked Question regarding the applicability of the Affordable Care Act ("ACA") to expatriate health plans. According to the guidance, insured group health plans that limit coverage to individuals who reside outside of their home country for at least six months of the plan year ("Expatriate Plans") have transition relief. For plan years ending on or before December 31, 2015, the Departments will consider an Expatriate Plan to comply with Group Market Reform provisions of ACA to the extent that it complies with the pre-ACA version of Title XXII of the Public Services Act, including the HIPAA nondiscrimination provisions, and the mental health parity requirements, claim procedure requirements, and ERISA reporting and disclosure obligations.

Until May 8, 2013, the Departments will accept comments regarding the challenges that Expatriate Plans face in complying with ACA.

- **Required Levels of Coverage:** The health insurer must offer at least one MSP at the silver level of coverage (*i.e.,* providing benefits actuarially equivalent to 70% full value) and at least one MSP at the gold level of coverage (*i.e.*, providing 80%) on each Exchange. The bronze and platinum levels of coverage may be offered by the health insurer as well. In addition, the insurer must offer a "child-only" plan for individuals who are under 21 years old.
- **Phased Expansion:** As mentioned above, by the fourth year that an insurer contracts with OPM to offer an MSP, the health insurer must offer an MSP in all 50 States and the District of Columbia. In the first year, the health insurer must offer an MSP in at least 31 States, then at least 36 States and 44 States in the second and third years, respectively.
- **Network Adequacy:** The health insurer must offer a network of providers that are large and sophisticated to ensure that services are accessible without unreasonable delay and include essential community providers.
- **User Fees:** Beginning in 2015, OPM may assess user fees on the health insurance issuers to participate in the Multi-State Plan Program.
- **Accreditation:** The health insurance issuer's MSP will need to be accredited like Qualified Health Plans that wish to participate in the Exchange.

Required Plan Features for an MSP

The MSP that a health insurer offers must contain several plan features to ensure that the coverage is as good if not better than the qualified health plans competing in the Exchange. Below are highlights of the requirements:

- **Essential Health Benefits ("EHB"):** Each MSP must have essential health benefits equal to the benchmark plan in the applicable State or the EHB-benchmark plan selected by OPM. For more information on essential health benefits, see *Issue 46*.
- **Cost-Sharing Limits:** The MSP must have cost-sharing limits, including deductibles, co-payments, and co-insurance that comply with ACA as well as any other standards set by OPM.
- **Rating:** For the insurance premium rates, the health insurer will need to comply with the rating factors and the medical loss ratio requirements under ACA, see *Issue 32*.
- **Other ACA Requirements:** In order to ensure a level playing field, the MSP must generally provide coverage that is consistent with the Individual and Group Market Reform provisions of ACA, including not imposing any pre-existing condition exclusions and the availability of external review of claims (to be conducted by OPM).

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