Understanding Health Insurance Exchanges

Introduction

On March 23, 2010, the Patient Protection and Affordable Care Act (PPACA) – also known as the ACA - became the nation's health reform law. Consisting of 10 separate legislative Titles, the ACA has several key objectives. The primary objective is to provide coverage for healthcare in which the government, employers and individuals share the responsibility. A second goal is to improve the affordability and quality of healthcare insurance coverage. Furthermore, the ACA aims to bolster primary healthcare access, and improve healthcare value and quality.[i]

The ACA contains several approaches to offer insurance coverage for Americans. The most controversial is the individual mandate. In this mandate, individuals are required to maintain a minimum essential coverage each month or pay a penalty. It also provides for premium credits and cost-sharing subsidies to assist low-income individuals with the cost of health benefits.

Beginning in 2014, anyone who does not have insurance through Medicare, Medicaid or through an employer must purchase insurance or face an annual fine. This mandate has given birth to the health insurance market place which will allow individuals and families without coverage and small business owners to pool their resources and increase their buying power to make insurance more affordable.

The creation of affordable health insurance exchanges sprang from the need for a competitive public health insurance market generated by the ACA. These state-based competitive exchanges will offer Americans and small businesses with a venue to obtain affordable health insurance.

Patient Protection and Affordability Care Act (PPACA)

After Congress passed and the President signed the PPACA in 2010, it became the responsibility of the U.S. Department of Health and Human Services and other federal agencies to implement the law.

How Americans are Protected by the ACA
• Creates the Health Insurance Exchange, a mechanism for individuals, families, and small businesses to obtain health coverage
• Requires insurance companies to cover people with pre-existing health conditions
• Improves access to information to better understand coverage
• Holds insurance companies accountable for rate increases
• Makes it illegal for health insurance companies to arbitrarily cancel your health insurance
• Protects your choice of doctors
• Covers young adults under the age of 26
• Provides free preventive care
• Ends lifetime and yearly dollar limits on coverage of essential health benefits
• Guarantees your right to appeal
Source: https://www.healthcare.gov/how-does-the-health-care-law-protect-me/#part=1

With the passing of this law, considerable transformations will occur within the healthcare industry with the most striking changes scheduled to transpire in 2014. Initially, full implementation of the ACA was to occur on January 1, 2014. On that date, individual and employer responsibility provisions take effect; state Health Insurance Exchanges become operational; Medicaid expansions take effect; and individual and small-employer group subsidies begin.

Recently, the Obama Administration announced that it would delay the requirement that businesses with more than 50 employees must offer health insurance until 2015. Large employers will have an additional year before the employer insurance reporting requirements and penalties take effect under the ACA.

Implementation of ACA is planned over a number of years, with a several portions implemented since 2010. The initial plan and timeline anticipates full implementation will be accomplished by 2015. The Timeline table below highlights the planned key activities and milestones.

Health Reform Implementation Timeline[ii]	
Year	Activity
2010	• States establish exchanges, with technical assistance from HHS • Drug discount program begins for Medicare beneficiaries in the donut hole • Fees on selected health industries begin • HHS issues the first national strategy document on improving health care quality
2011	• New Innovation Center established in Centers for Medicare and Medicaid Services (CMS) to test new payment methods • Small business health insurance tax credit begins • CMS provides access to health risk assessments for Medicare beneficiaries • CMS implements Hospital Value-Based Purchasing Program • CMS implements income-related Part D premiums • CMS implements prohibition on federal payments to states for Medicaid services related to health care acquired conditions
2012	• HHS issues regulations regarding Consumer Operated and Oriented Plan (CO-OP) and provides grants and loans for startup. • As designed, this plan fosters creation of qualified nonprofit health insurance issuers to offer competitive health plans in the individual and small group markets • Accountable Care Organizations (ACO) are eligible to receive incentive bonuses • CMS begins transition to competitive bidding for Medicare Advantage (MA) plans • CMS establishes a system for reducing payments under Medicare to hospitals with high readmission rates
Before 2013	• HHS defines categories of covered services • HHS certifies risk adjustment entities: states implement risk adjustment • States establish insurance rating areas, with review by HHS • Treasury Department implements tax credits to provide for premium assistance; states set up systems to assess eligibility • Treasury Department sets up system for documenting insurance of individual requirement
During 2013	• Insurance market reforms begin and open enrollment starts in March. • Tax Credits for premium assistance go into effect. • Individual requirements to obtain coverage goes into effect. • CMS establishes national pilot program for bundled payments under Medicare. • First report issued by newly established Medicare Commission (September); HHS begins rulemaking to implement Commission proposals. • Excise tax on high cost insurance plans begins.
2013 – 2015	• A system of reinsurance is implemented for all insurers. • Eligibility for Medicaid expands to everyone below 133% of the poverty line (by 2014).

Health Insurance Exchanges under the Affordable Care Act

The ACA facilitates the creation of a competitive, public health insurance market through the creation of health insurance exchanges with the objective of expanding coverage to Americans who are currently uninsured. As planned, these exchanges will provide millions of Americans and small businesses with "one-stop shopping" for affordable health insurance plans tailored to their specific health needs. These exchanges will offer a variety of health insurance plans that meet ACA criteria regarding plan benefits, payments and consumer information.[iii] In this exchange, consumers will be able to compare their options based on price, benefits of health insurance plans and quality. The exchange concept is to provide consumers, both individuals and small business owners with transparency and control while making choices about health insurance. Additionally, enrollment in public programs through the exchange is possible.

Issuers selling health insurance plans through an exchange will have to follow certain rules, such as meeting the private market reform requirements in ACA. While the fundamental purpose of the exchanges will be to facilitate the offer and purchase of health insurance, the law does not prohibit qualified individuals, qualified employers, and insurance carriers from participating in the health insurance market outside of exchanges. Enrollment in exchanges is voluntary and no individual may be compelled to enroll in exchange coverage.

On March 12, 2012, the U.S. Department of Health and Human Services (HHS) released final rules implementing the new insurance exchanges ("Exchanges") under Title I of the ACA. The ACA require states to establish exchanges—the new insurance exchanges for individuals and small businesses beginning in 2014. A state has the option to: (1) operate its own exchange (consistent with federal standards); (2) defer to the federal government; (3) share responsibilities with the federal government in administering the exchange under the

Categories of Health Insurance Exchanges
State Based Exchange • The state operates all exchange activities • Required to establish separate exchanges for individuals and small business employees (Small Business Health Options Program- SHOP)
State Partnership Exchange • A state may elect to work with other states to establish regional exchanges or operate an exchange in partnership with the federal government
Federally-Facilitated Exchange • The Department of Health and Human Services (HHS) operates the exchange
Source: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=84

state-federal partnership model; or (4) partner with other states to establish multi-state or regional exchanges.[iv]

Additionally, private health insurance exchanges are available and are run by a nonprofit or private sector company, which works directly with insurance carriers. They are designed to assist consumers find plans specific to their needs, preferred doctor or hospitals and budget.

The new Health Insurance Exchanges are required to carry out a number of different functions including determining eligibility and enrolling individuals in appropriate plans; conducting plan management activities; assisting consumers; ensuring plan accountability; and providing financial management.[v]

Each state electing to establish a new health insurance exchange must adopt the federal standards in law and rule, and have in effect a state law or regulation that implements these standards. If a state elects not to establish an exchange, the ACA requires the Department of Health and Human Services (HHS) to establish and operate one in that state. This also applies in the event that HHS determines on review that state efforts to establish an exchange have not made sufficient progress to be operational by January 1, 2014.

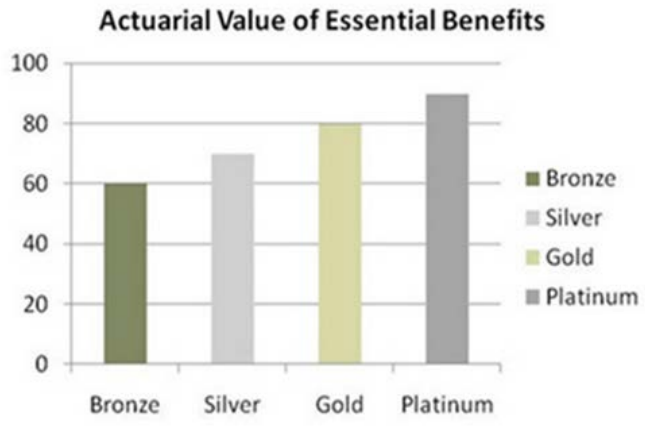
The ACA provides broad authority to the HHS Secretary to establish standards and regulations to implement the statutory requirements related to the exchange. On June 14, 2013, HHS released a Notice of Proposed Rulemaking (NPRM) that proposes a number of policies related to the implementation of the ACA, including provisions regarding Affordable Insurance Exchanges, also known as Health Insurance Marketplaces. Much of the proposed rule focuses on program integrity regarding state exchanges, issuers offering coverage in the federally-facilitated exchange, advance payments of the premium tax credit and cost-sharing reductions, and premium stabilization programs. The overarching goal of the proposed provisions is to safeguard federal funds and to protect consumers by ensuring that issuers, Exchanges, and other entities comply with federal standards meant to ensure consumers have access to quality, affordable health insurance.[vi]

The Exchange Final Rule includes standards for the following:

- The establishment and operation of an exchange
- Health insurance plans that participate in an Exchange
- Determinations of an individual's eligibility to enroll in Exchange health plans and in insurance affordability programs

- Enrollment in health plans through Exchanges

- Employer eligibility for and participation in the Small Business Health Options Program (SHOP) [vii]



Source: CRS Analysis of the Patient Protection and Affordable Care Act.

On April 9, 2013, the Centers for Medicare and Medicaid Services of the Department of Health and Human Services announced the availability of $54 million to fund Navigator programs in states that have federally facilitated or partnership exchanges. This funding is not available for states that operate their own exchanges, which must pay for their own Navigator programs. Navigators are public or private entities or individuals that are qualified and licensed to assist consumers in understanding and making decisions regarding the eligibility and enrollment process. They must meet state licensure or certification requirements.

Exchanges must have in place governance principles, consumer representation, ensure freedom from conflicts of interest and promote ethical and financial disclosure standards.[viii] All plans offered through exchanges will be certified as "qualified health plans" or QHPs. For a state to operate its own exchange beginning January 1, 2014, it must have submitted a Declaration Letter and an Exchange Blueprint application to the Department of Health and Human Services (HHS) prior to December 14, 2012.[ix]

Coverage Offered Through Health Insurance Exchanges

The ACA generally requires Qualified Health Plans (QHP) to provide coverage at one of the following "metal tier" levels: bronze, silver, gold, or platinum. Each coverage level will be based on a specified share of the full actuarial value of the essential health benefits. The actuarial value (AV) is a measure of the percentage of expected health care costs a health plan will cover.

Plans inside and outside the exchange in the individual and small group markets who offer non-grandfathered (plans that were in existence on March 23, 2010 and have basically stayed the same) health plans must offer plans that meet distinct levels of coverage specified in the ACA according to one of these "metal tiers" (and premiums must be the same for QHPs inside and outside of the exchange). Excluding dental-only plans, health insurance issuers must offer a silver plan and a gold plan in the exchange. A health insurance company that offers coverage in any of these four levels will be

required to offer the same level of coverage in a plan specifically designed for individuals under age 21.[x]

The Patient Protection and Affordable Care Act identifies broad benefit categories, but does not clearly list the benefits that include the essential health benefits. As defined in Section 1302 of the Act, essential health benefits include at least the following general categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse disorder services
- Prescription drugs
- Rehabilitative services
- Laboratory services
- Preventative and wellness services
- Pediatric services

Health plans that provide the essential health benefits package must tailor cost sharing to meet one of the four plan levels based on actuarial value. As such, Health Insurance Exchanges will create four general categories of plans:[xi]

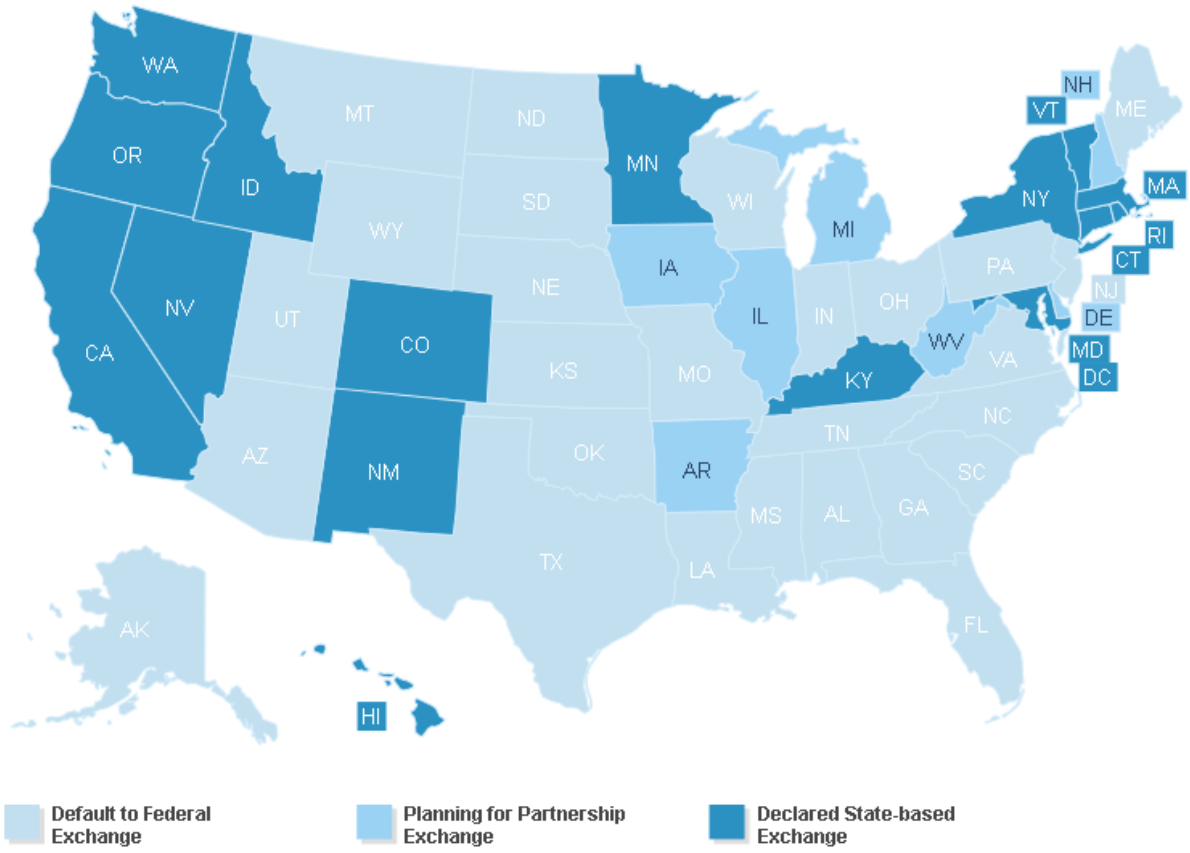
- **Bronze** plan benefit coverage is actuarially equivalent to 60% of the full actuarial value [percent expense paid by the insurer] of the benefit package.
- **Silver** plan benefit coverage is actuarially equivalent to 70% of the full actuarial value [percent expense paid by the insurer] of the benefit package.
- **Gold** plan benefit coverage is actuarially equivalent to 80% of the full actuarial value [percent expense paid by the insurer] of the benefit package.
- **Platinum** plan benefit coverage is actuarially equivalent to 90% of the full actuarial value [percent expense paid by the insurer] of the benefit package. [xii]

The plan levels range from an affordable bronze plan to the highest quality and cost platinum plan. The lower premium plans – bronze and silver – will have the higher

deductibles. Bronze and silver are basic plans with minimal coverage while the platinum plan is the all-encompassing high-end plan.

Health Insurance Exchange Progress to Date

All exchanges must be prepared to begin enrolling consumers into coverage on October 1, 2013, and must be operational on January 1, 2014. States must quickly formulate implementation decisions in light of the approaching deadlines.



State Decisions on Health Insurance Exchanges and the Medicaid Expansion, as of June 20, 2013

Source: The Henry J. Kaiser Family Foundation

As of June 20, 2013, 17 states have declared a State-based Exchange; seven states are planning for a Partnership Exchange; and 27 states are defaulting to a Federally-Facilitated Exchange.

Conclusion

The Patient Protection and Affordable Care Act, signed into law in March 2010, made sweeping changes to the way health insurance will be provided and paid for in the United

States. A major part of the health reform includes improving quality, lowering healthcare costs, improving access to healthcare and enacting new consumer protections.

A new system for purchase of health insurance known as exchanges, which are entities established by states and the Federal government to create a viable arena for offering a choice of plans and providing information to assist consumers with navigating their options. These exchanges are scheduled to be operational January 2014 and support healthcare reform by increasing access, transparency and quality of plans available. Purchasing health coverage will be easier and more affordable as the health insurance exchanges will allow individuals and small businesses to compare health plans, obtain answers to questions regarding coverage and determine if they are eligible for subsidies.

While some provisions of the law have already taken effect, many more provisions will be implemented in the coming years.

Contact Information

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[i] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3001814/#B3

[ii] The Henry J. Kaiser Family Foundation
http://kff.org/health-reform/perspective/pulling-it-together-implementation/

[iii] Joel Bern Teitelbaum, JD, LLM, Sara E. Wilensky, JD, PhD, *Essentials of Health Policy and Law*, Jones & Bartlett Publishers, 2013, page 171

[iv] America's Health Insurance Plans, Summary of Final Rule on Establishment of Exchanges and Standards of Qualified Health Plans, March 12, 2012
http://www.mahp.org/federalreform/ahip/AHIPSUmmaryofExchangerules%283-14-12%29.pdf

[v] National Conference of State Legislatures
http://www.ncsl.org/issues-research/health/american-health-benefit-exchanges.aspx

[vi] CMS.gov
http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/pi-nprm-6-14-2013.html

[vii] Affordable Insurance Exchanges: Choices, Competition and Clout for States, U.S. Department of Health and Human Services, April 29, 2013,
http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011a.html

[viii] Affordable Insurance Exchanges: Choices, Competition and Clout for States, U.S. Department of Health and Human Services, April 29, 2013,
http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011a.html

[ix] §1311(b) of ACA. Instructions for submitting the Declaration Letter and the Exchange Blueprint application http://cciio.cms.gov/resources/files/hie-blueprint-081312.pdf.

[x] National Conference of State Legislatures, Building the Health Insurance Marketplace, June 19, 2013
http://www.ncsl.org/issues-research/health/american-health-benefit-exchanges.aspx#levels%20of%20coverage

[xi] § 1302 of ACA

[xii] American Health Benefit Exchanges, National Conference of State Legislatures, http://www.ncsl.org/issues-research/health/american-health-benefit-exchanges.aspx#building