Overview of the ACA Marketplace

I. Marketplace

A. BACKGROUND: Beginning in 2014, each state is required to create an exchange (a governmental agency or nonprofit organization, established by the state) to facilitate the sale of qualified health plans (QHPs), including federally administered multistate plans and nonprofit cooperative plans. The law requires HHS to create an exchange in states that do not set up their own exchanges. However, the Patient Protection and Affordable Care Act (PPACA) does not provide the federal government with adequate funding to set up or operate federal health insurance exchanges.

States can create either one exchange to serve both small group and individual markets or separate exchanges for these pools. One goal is to facilitate a comparison of available health insurance options by purchasers. Standards for qualified coverage must include:

- Mandated essential coverage
- Cost-sharing requirements (deductibles, copayments, and coinsurance)
- Catastrophic coverage for purchasers aged thirty and younger in the individual market.

States must also create Small Business Health Option Programs, or “SHOP Exchanges,” for small employers to purchase coverage. The states can expand the programs to include large employers beginning in 2017.

B. As the nation and the industry prepares for the exchanges to open, here are the answers to ten critical questions:

1. **How do employers use exchanges?** There is rolling enrollment for employers, but, upon enrollment, the employer is locked into the plan for one-year periods. The plan premiums are also locked in for the same amount of time. Once the employer enrolls in a state exchange:

   - The employer must offer Exchange coverage to all employees.
   - The Exchange must provide an aggregate bill to the employer for all employees.
   - Employers must notify the Exchange about any employee change of status, for example, adding dependents or terminating employment.
   - Employers with multiple worksites can offer access to a single Exchange or to state Exchanges where employees are located.

2. **Are there any operating state exchanges?** Massachusetts and Utah have operating exchanges, but neither one has produced lower costs. Massachusetts has some of highest insurance rates in the United States, and Utah’s exchange rates are higher than purchasing outside the exchange.
One study, conducted for the Ohio Department of Insurance, has predicted that the likely cost increases for health insurance in Ohio will be a total of 55 percent to 85 percent for several reasons, including:

◆ The law’s requirements for commercial, employer-sponsored, small group, and individual health insurance markets, both inside and outside the exchanges, including guaranteed issue of insurance coverage regardless of preexisting medical conditions or health status,

◆ Adjusted community rating with premium rate variations only for benefit plan design, geographic location, age rating (limited to ratio of 3:1), family status, and tobacco usage (limited to ratio of 1.5:1),

◆ Premium rate consistency inside and outside the exchanges, and,

◆ Requirements for essential health benefits.

In addition, the study noted that:

- Although the percentage of Ohio residents with coverage could rise by about 7.9 percent, the price of individual health insurance coverage might rise by about 55 percent to 85 percent, excluding the impact of medical inflation, Milliman Consulting predicts. These increases will be 8 percent to 12 percent higher than adjusted small group rates. This is primarily driven by the estimated health status of the new individual health insurance market and the expansion of covered benefits.

- The small group market (from 2 to 100 individuals) is expected to see increases of 5 percent to 15 percent.

- Due to community ratings, some groups could see an increase of 150 percent while others could receive a decrease of up to 38 percent.

- Employers with age fifty-five and older demographics are likely to see the decreases.

- The highest rate increases are expected in companies with two to nine employees.

- Large groups are expected to see an increase of 0 percent to 5 percent.

- None of these increases take into account the increase in medical inflation, which for 2012 is estimated to be 7 percent to 8 percent.
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- One important factor for cost increases in group plans is the pass-through fees resulting from increased taxes on insurance companies and medical manufacturers.

3. **What are the functions of the state health insurance exchanges?** The exchange functions and responsibilities include the following:

- Certification, re-certification, and decertification of health insurance options as qualified,
- Operation of a toll-free hotline,
- Maintenance of a website for providing information on plans to current and prospective enrollees,
- Assignment of a price and quality rating to plans,
- Presentation of plan benefit options in a standardized format,
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs, as well as eligibility for the refundable income tax credit,
- Provision of an electronic calculator to determine the actual cost of coverage, taking into account eligibility for premium tax credits and cost sharing reductions,
- Certification of individuals exempt from the individual responsibility requirement, Provision of information to certain individuals and to employers, and
- Establishment of a “navigator” program that provides grants to entities assisting consumers.

4. **What are the areas over which HHS has responsibility for the state health insurance exchanges?** HHS is responsible for regulatory standards in five areas that insurers must meet in order to be certified as qualified health plans (QHPs) by an exchange:

- marketing,
- network adequacy,
- accreditation for performance measures,
5. **What are the primary federal requirements for state exchanges?** Only lawful U.S. residents may obtain coverage in an exchange. Exchanges must comply with federal regulatory standards in the following areas:

- Information on the availability of in-network and out-of-network providers, including provider directories and availability of essential community providers;
- Consideration of plan patterns and practices with respect to past premium increases and a submission of the plan justifications for current premium increases;
- Public disclosure of specific plan data, including claims-handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out-of-network coverage, and other information identified by HHS;
- Timely information for consumers requesting their amount of cost sharing for specific services from specified providers;
- Establishment of "navigators" to assist consumers in selecting their health insurance;
- Information for participants in group health plans;
- Information on plan quality-improvement activities;
- Presentation of enrollee satisfaction-survey results; and
- Publication of data on the Exchange’s administrative costs.

Additionally, exchanges must meet detailed requirements for call centers and an Internet web site.

6. **What is a Qualified Health Plan (QHP)?** A qualified health plan (QHP) is health insurance certified by a state Exchange that offers “essential health benefits.” A QHP must be offered by an insurer that:

(a) Is licensed and in good standing to offer health insurance coverage in each state in which it offers health coverage;
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(b) Agrees to offer at least one QHP in the silver level and at least one QHP in the gold level in each Exchange;

(c) Agrees to charge the same premium rate for each QHP, whether offered through an Exchange or offered directly from the insurer or through an agent; and

(d) Complies with regulations to be issued by HHS and any requirements established by an applicable Exchange.

However, a QHP may vary premiums by rating area.

For QHP purposes, the term health plan includes “health insurance coverage” and a “group health plan.” Health insurance coverage means benefits consisting of medical care (provided directly, through insurance or reimbursement, or otherwise, and including items and services paid for as medical care) under any hospital or medical service policy or certificate, hospital or medical service plan contract, or health maintenance organization contract offered by a health insurer.

A “group health plan” is an ERISA welfare benefit plan that provides medical care. Health plans must be subject to state regulation; therefore, the term “health plan” does not include a group health plan or multiple employer welfare arrangement (MEWA) not subject to state insurance regulation under ERISA Section 514. Thus, self-insured group health plans cannot qualify as QHPs.

Health insurance plans must:

- Meet certain marketing requirements;
- Ensure a sufficient provider choice and include, where available, providers that serve low-income and medically underserved individuals;
- Be accredited for clinical quality, patient experience, consumer access, and quality assurances, and implement a quality improvement strategy;
- Use a uniform enrollment form and a standard format for presenting plan options;
- Provide information on quality standards used to measure plan performance.

The U.S. Office of Personnel Management (OPM) must enter into contracts with health insurers to offer at least two multistate QHPs through each Exchange in each state.

7. How are state health insurance exchanges regulated? PPACA includes two federal requirements for state health insurance exchanges:

- Minimum functions that Exchanges must perform directly or by contract, and,
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◆ Oversight responsibilities Exchanges must exercise in certifying and monitoring the performance of Health Plans.

Plans participating in the exchanges also must comply with state insurance laws and federal requirements in the Public Health Service Act.

The final regulations set “standards for establishing exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an exchange, certifying health plans for participation in the exchange,” and establishing “a streamlined, web-based system for consumers to apply for and enroll in qualified health plans and insurance affordability programs.” HHS has also issued questions and answers on federally facilitated Exchanges, including for instance, how the Exchanges will interact with state departments of insurance.

State exchanges are to be operational in 2014. A change in the final rule gives more flexibility to states that are not able to show "complete readiness" to operate an exchange on January 1, 2013. HHS may conditionally approve a state-based exchange upon demonstration that it is likely to be fully operationally ready by October 1, 2013. Applications of a state's Exchange Blueprint were required to be submitted 30 business days before January 1, 2013, or by November 16, 2012.

Individuals and small businesses will be able to purchase private health insurance via these exchanges. Starting in 2014, exchanges are intended to:

◆ Facilitate the comparison by individuals and small businesses of health plans,

◆ Provide answers to questions,

◆ Determine eligibility for tax credits for private insurance or health programs like the Children's Health Insurance Program (CHIP), and,

◆ Allow enrollment by individuals and small employers in a Qualified Health Plan (QHP).

8. **How should states set up health insurance exchanges?** The U.S. Department of Health and Human Services (HHS) issued final regulations that provide a framework to assist states in building health insurance exchanges, state-based competitive marketplaces authorized by the 2010 federal health care reform law. These rules set minimum standards for exchanges and give states some flexibility to design the exchanges to fit their insurance markets, subject to HHS approval. The regulations propose rules and guidance on how to structure the exchanges in two areas:

◆ Setting standards for establishing exchanges, setting up a Small Business Health Options Program (SHOP), performing the basic functions of an exchange, and
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certifying health plans for participation in an exchange; and,

◆ Ensuring premium stability for the exchanges, especially in the first three years.

According to HHS, forty-eight states and the District of Columbia have been awarded grants to help plan and operate exchanges. However, by August 2012, only approximately 30 percent of the states had taken action beyond receiving a planning grant, such as passing legislation or taking administrative action, to begin creating exchanges.

The rules allow states to decide:

- Whether their exchanges should be local, regional, or operated by a nonprofit organization,
- How to select plans to participate, and
- Whether to collaborate with HHS for the work.

However, HHS must approve each exchange and the criteria for its insurance policies. In 2014, exchanges will initially be available only to individuals and small employers, but states may expand them in 2017 to be available to large employers as well.

Using the standards and processes in the regulations to approve exchanges, HHS must determine by January 1, 2013, whether an exchange will be operational by 2014, which means it must begin open enrollment on October 1, 2013. In states that do not obtain this HHS approval (or decide not to establish an Exchange), a federally facilitated exchange would be implemented for 2014.

**Initial open enrollment.** The initial open-enrollment period is proposed to extend from October 1, 2013, through March 31 2014. Only those enrolling in a qualified health plan (QHP) on or before December 22, 2013, would be ensured coverage effective January 1, 2014. Special enrollment periods are also provided in the regulations. The annual enrollment period for 2015 and subsequent years will begin on October 15 and end after December 7.

**Eligibility and consumer assistance.** Exchanges would make eligibility determinations and provide consumer assistance tools, including a toll-free call center, a website with comparative information about available qualified health plans (QHPs), and a “navigator” program that facilitates enrollment and provides other information and services. Navigators cannot be insurers but can be agents or brokers. They cannot receive direct or indirect compensation from an insurer for enrolling eligible individuals, employers, or employees in a QHP.
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Each exchange must provide the following:

- A toll-free call center to address the needs of those seeking assistance;
- An Internet website providing a variety of features, including comparative information on available QHPs, certain financial information, and information about the Navigator and call center;
- An Exchange calculator to facilitate comparisons of QHPs that takes into consideration the premium tax credit and any cost-sharing reductions;
- A consumer-assistance function, including the Navigator program discussed below; and
- Outreach and education activities.

**Small Business Health Options Program (SHOP).** Each state will establish insurance options for qualifying small businesses through a SHOP, and participation by small employers will be voluntary. SHOP is intended to give small employers the same purchasing power that large employers have and to allow them to offer employees a choice of plans for a single monthly payment. For 2014 through 2016, only employers with fewer than 100 employees or fewer than fifty employees (states have the option of choosing either) will be granted access to the SHOP exchange. Certain small employers will be eligible to receive a small business tax credit for up to 50 percent of the contributions they make toward employees’ premiums for two consecutive years if certain tax rules are met.

**QHP certification.** Exchanges must establish procedures, which must be approved by HHS, for certification, recertification, and decertification of qualified health plans (QHPs). The regulations do not require exchanges to accept all eligible QHPs, although that is allowed. Alternatively, exchanges could limit QHP participation to those plans that meet the state’s selection criteria. The regulations include minimum standards for QHPs and QHP issuers. States may impose additional requirements, if approved by HHS.

An Exchange is required to allow the insurer of a plan that provides certain limited-scope dental benefits to offer the plan through the Exchange (either separately or in conjunction with a QHP) if the plan provides pediatric dental benefits.

Reinsurance, 3-Year Risk Corridor Program, and Risk Adjustment. The HHS regulations outline standards for various programs required by healthcare reform that are intended, beginning in 2014, to mitigate the impact of adverse selection and stabilize premiums in the individual and small group markets. Standards are established for the transitional reinsurance program, which is a required state-based program that reduces uncertainty for insurers during the first three years the exchange is in operation by making payments for high-cost cases. A temporary risk corridor program from 2014 through 2016 will protect against
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uncertainty in setting rates within the exchanges by limiting the extent of insurer losses and gains.

The proposed regulations also include standards for a risk adjustment program, which is an optional program that a state may establish inside or outside of an exchange, after 2014. The program is intended to provide stability in the individual and small group markets by transferring funds from insurers of lower-risk enrollees to insurers of higher-risk enrollees.

9. **What is the Employer Exchange Notice requirement?** The 2010 health reform law amends the Fair Labor Standards Act (FLSA) to require that employers provide all new hires and current employees with a written notice (Employer Exchange Notice) about the exchange and some of the consequences if an employee decides to purchase a qualified health plan through the exchange in lieu of employer-sponsored coverage. Regulations implementing the Employer Exchange Notice requirement will be issued and enforced by the Department of Labor.

The Employer Exchange Notice requirement was effective on March 1, 2013. Employees hired on or after the effective date must be provided with the notice when they are hired. All employees already employed on the effective date must be provided with the notice no later than the effective date (i.e., no later than March 1, 2013).

The Employer Exchange Notice rule applies to employers that are subject to the FLSA. The FLSA’s minimum wage and maximum hour provisions apply to entities that are engaged in interstate commerce and have a gross annual volume of sales that is not less than $500,000 (enterprises engaged in commerce or in the production of goods for commerce). However, the Employer Exchange Notice requirement does not have the same limitation. As a result, it seemingly applies to “any person acting directly or indirectly in the interest of an employer in relation to an employee.”

The Employer Exchange Notice must include the following information:

- Employees must be informed of the existence of an Exchange, given a description of the services provided by the Exchange, and told how to contact the Exchange to request assistance.
- Employees must be informed that they may be eligible for a premium tax credit (under Code Section 36B) or a cost-sharing reduction (under PPACA Section 1402) through the Exchange if the employer’s plan share of the total cost of benefits under the plan is less than 60 percent.
Employees must be informed that:

- If they purchase a qualified health plan through the Exchange, they may lose any employer contribution toward the cost of employer-provided coverage; and
- All or a portion of the employer’s contributions to employer-provided coverage may be excludable for federal income tax purposes.

10. **What is the role of health insurance brokers or agents in the state health insurance exchanges?** The final regulation contains welcome news for agents and brokers of health insurance. HHS, in the final regulation, permits states to allow an agent or broker to enroll individuals, employers or employees in qualified health plans (QHPs), in a manner that constitutes “enrollment through the exchange,” on their own website. It is up to each state to determine whether its exchange can list approved insurance agents and brokers. [However, navigators need not be agents or brokers.] An individual can be enrolled in a QHP through an exchange with the assistance of an agent or broker only if the agent or broker ensures that the individual receives an eligibility determination through the state’s Exchange website.

If the consumer would be eligible for a refundable federal income tax credit for a QHP purchased on the exchange’s website, the consumer may access the tax credit for purchases through the broker or agent’s private Web portal.

The regulation sets out a series of requirements brokers or agents must meet in order for their clients to be able to access the tax credits for purchases through their Web sites. For consumers to do this, brokers and agents must be registered with the Exchange. This means that the state (or the federal government in the case of a federally facilitated exchange (FFE)), controls whether their exchange remains the exclusive market for the tax credit or whether brokers and agents can assist eligible individuals and families in obtaining the subsidies.

Additionally, all QHPs must be available for purchase through the website, and the agents and brokers assisting the customer must be trained on all QHP options. Thus, a single-carrier exchange will not meet the qualifications for a purchaser to access the tax credit. The private websites must present all QHPs and all QHP data in a manner that meets HHS standards and must not use financial incentives, such as rebates or free prizes, to lure customers to one QHP instead of another. Consumers may withdraw from this process at any time and use the exchange website. Any private web portal must be compliant with exchange privacy and security standards. Of course, state laws related to the qualifications and conduct of agents and brokers continue to apply.

Interestingly, the private web portals, unlike the state or federally facilitated exchanges, do not have restrictions on selling products other than QHPs. Thus,
brokers and agents can use their existing web portals to sell other products as well as QHPs, as long as the requirements noted previously in this section are met.

Thus, if permitted to use an agent or broker, consumers never have to go to the state exchange website to buy a product and access the refundable tax credit. All of the information transfers between the private broker site, the exchange, and the insurance carriers can be invisible to the consumer.

This aspect of the final regulation indicates that HHS believes that private distribution of exchange health insurance will help to stimulate the use of exchanges. For agents, brokers, and private exchanges, the shift presents a new opportunity to access the exchange population. For consumers, it is likely that more will look into whether or not they qualify for a tax credit while shopping for insurance, which could increase QHP sales.

NOTE: The Ten Things to Know About Exchanges appeared in LifeHealthPro (online) June 24, 2013. This was excerpted from: Health Care Reform Facts, Alson R. Martin, J.D., LL.M.