



CLOSE-UP: Health Insurance Exchanges

June 27, 2011

In conjunction with the mandate requiring most individuals to have health insurance beginning in 2014, the Affordable Care Act (ACA) authorizes states to establish American Health Benefit Exchanges, where health insurance can be purchased. Exchanges are expected to provide access to a health insurance marketplace that better helps consumers shop for coverage by making it easier to compare available plan options based on price, benefits and services, and quality. One of the perceived advantages of exchanges is that they will permit pooling people together, reducing transaction costs, and increasing transparency, thus creating more efficient and competitive markets.

States are required to have exchanges in place by January 1, 2014. Although many states are on their way to establishing their exchanges, details of how provisions in the law will actually be implemented will not be available until regulations are issued by various government agencies, primarily the Department of Health and Human Services (HHS).

Who will have access to an exchange?

Qualified individuals and employers can purchase health insurance on the exchanges. Qualified individuals include U.S. citizens and legal immigrants who are not incarcerated and who do not have access to adequate or affordable employer coverage. The ACA also provides flexibility for states to establish separate Small Business Health Options Program (SHOP) Exchanges through which small businesses can obtain coverage for their employees. Prior to 2016, SHOP exchanges are limited to small businesses with 100 or fewer workers, although states can lower that limit to small businesses with 50 or fewer workers. Beginning in 2017, states can allow businesses with more than 100 employees to purchase coverage through the exchanges.

What are the functions of an exchange?

Exchanges promise to provide one-stop shopping, where individuals and small employers can compare health coverage options, select a plan that meets their needs and enroll. Here is an overview of the functions of an exchange:

1. Permit health plans to be offered and provide information about them

- Certify whether health plans are qualified to be offered on the exchange.
- Require plans to publicly disclose their claims payment policies and practices; periodic financial statements; data on enrollment and disenrollment, denied claims and rating practices; information on cost sharing and payments for out-of-network coverage; and enrollee and participant rights.
- Require plans to provide information about the amount of cost sharing for specific items or services.
- Assign a quality rating to each health plan in the exchange.
- Inform consumers about the eligibility requirements for Medicaid, CHIP or other state or local public programs and coordinate enrollment procedures with them.

2. Make health plan selection and enrollment easier for consumers

- Maintain an Internet website of standardized comparative information about the health plans.

- Establish a Navigator program that will award grants to entities that educate consumers and raise public awareness about exchanges.
- Present benefit plan options in a standardized format.
- Provide an electronic calculator to determine the actual cost of coverage after any premium tax credit and any cost-sharing reduction has been applied*.
- Operate a toll-free telephone assistance hotline.

3. Other requirements

- Consult with stakeholders, such as enrollees, enrollment facilitators, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates, to enroll hard-to-reach populations in performing its assigned functions.
- Grant certifications for individuals who are exempt from the individual responsibility penalty, if there is no affordable qualified health plan available through the exchange or the individual's employer or the individual is otherwise exempt.

How does a plan become certified for the exchange?

For a state to certify a plan for placement on its exchange, the plan must:

- Meet marketing requirements to show that the plan is not discouraging enrollment for those with significant health needs.
- Ensure a sufficient choice of providers, including information on the availability of in-network and out-of-network providers.
- Include in its network, where possible, community providers that serve low income, medically underserved individuals and families.

- Be accredited on clinical quality measures, including consumer assessment surveys.
- Use a standard format for presenting health benefits plan options.
- Use a standard enrollment form.
- Implement a quality improvement strategy.
- Abide by applicable insurance regulations relating to guaranteed issue, premium rating, and prohibitions on pre-existing condition exclusions.

What benefits will the exchanges offer?

The qualified health plans that participate on exchanges will offer uniform benefit packages at one of four predetermined levels of coverage, which is designed to make comparisons among plans easier. The uniform benefits package, known as essential health benefits, must include the following categories of services:

- Ambulatory patient services
- Emergency services
- Hospitalization,
- Maternity and newborn care
- Mental health benefits and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

What are the four levels of benefits coverage?

The four levels of coverage vary depending on how much the plan's benefits are expected to pay in terms of the health care costs incurred by a typical population. The coverage levels and benefits equivalents are:

Level	Benefits equivalent
Bronze	60 percent of full value
Silver	70 percent of full value
Gold	80 percent full value
Platinum	90 percent of full value

Qualified health insurers must offer at least one plan at the silver level and one plan at the gold level in each exchange in which their plans are offered.

What about catastrophic coverage?

Plans may elect to offer catastrophic coverage (less coverage at a lower premium). These plans provide less coverage than the four levels of coverage and are only available to enrollees under the age of 30 or those who would otherwise be exempt from the requirement to purchase coverage due to affordability or hardship reasons. While catastrophic plans cover essential health benefits, they will require enrollees to incur liability for substantial cost-sharing amounts before they begin to pay benefits. Those amounts will be comparable to the annual out-of-pocket amounts that enrollees currently pay today under qualified high deductible plans.

How will exchanges be structured?

A state must establish an exchange as a governmental agency or non-profit entity. States are required to establish exchanges for individuals and small businesses by January 1, 2014. States can choose to establish a single exchange serving both individuals and small businesses, or provide coverage through separately designated exchanges. States may form regional exchanges or allow more than one exchange to operate in a state as long as each subsidiary exchange serves a distinct geographic area.

If a state fails to set up an exchange by January 1, 2014, the HHS Secretary will establish and operate an exchange in that state, either directly or through an agreement with a non-profit entity.

The federal Office of Personnel Management (OPM) is required to contract with insurers to offer at least two multi-state plans that will participate in each exchange, including at least one offered by a non-profit entity. Each multi-state plan must be licensed in each state and must meet the requirements of a qualified health plan.

In addition, federal funds will be made available to create new qualified non-profit, member-run health insurance companies (called Consumer Operated and Oriented Plans, or CO-OPs) that are expected to offer qualified health plans in state exchanges.

In 2017, states can opt out of the requirement to establish exchanges if they can show that they can offer all of their residents a basic health program that is at least as comprehensive and otherwise comparable to the qualified health plans available on the exchange.

How will exchanges be funded?

In September, 2010, HHS awarded \$1 million to each of 48 states and the District of Columbia to begin planning their exchanges. Beginning in January 2011 and continuing for three years, HHS made additional funding available to states that meet certain milestones to use in establishing their exchanges. In January 1, 2015, states must ensure that their exchanges are financially self-sustaining. To generate necessary additional funding, states may allow exchanges to charge assessments or user fees to participating health issuers.

What is the status of the Pennsylvania exchange?

To date there has been no legislative action on exchanges. Pennsylvania lawmakers' current focus is primarily on the state budget, although there are legislative committee hearings underway for lawmakers to discuss and learn more about exchanges. At Highmark, we are very focused on the development of the exchanges, because they will be a new key point of distribution, especially for individuals who qualify

for financial assistance, like premium tax credits and subsidies that reduce cost-sharing, by buying on the exchange.

What is the status of the West Virginia exchange?

In West Virginia, a bill has been passed to create an exchange. West Virginia's law includes the formation of a board that will oversee the exchange. This board will be housed under West Virginia's insurance department. However, the bill is not well detailed, and much of its policy remains to be determined.

Unlike exchange proposals in some other states that prohibit insurer representation, the insurance industry will have representation on West Virginia's oversight board.

*For an explanation of the types of financial assistance available for purchasing insurance on the exchange, see the June 13, 2011 Close-up on Subsidies: Financial Assistance to Purchase Health Coverage.

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Please note that information contained in this Close-Up is based on our understanding of the Patient Protection and Affordable Care Act of 2010, as amended, and guidance as of the date of this publication.