informed on reform

Health Insurance Marketplaces, also known as Health Insurance Exchange FACT SHEET

The Health Insurance Exchange is a Provision of the Patient Protection and Affordable Care Act (PPACA). This Fact Sheet reflects the final regulations as of April 30, 2013.

By 2014, a Health Insurance Marketplace, previously known as a Health Insurance Exchange, is required to be operating in every state as a new option for individuals and small employers to purchase health insurance. States can:

- establish a State-based Marketplace;
- establish/operate a State-partnership Marketplace;
- defer to the Federally Facilitated Marketplace

These new Marketplaces, also known as Exchanges, will offer medical and dental health benefit plans. Individuals purchasing coverage through a Marketplace may be eligible for federal premium assistance, and under certain circumstances a reduction in their out-of-pocket deductible, also known as a cost share subsidy.

There are still many details yet to be clarified by the federal government, and many developments still underway by both federal agencies and state governments. But the main objective of the new Marketplaces is to provide access to affordable health insurance coverage for individuals and small businesses (employing 1-50 employees, in 2016 and beyond small business employing 1-100 employees). In 2017, with approval from Health and Human Services (HHS), states will have an option to open their marketplace to employers with more than 100 employees.

Health Insurance Marketplaces Timeline

2013

10/1/13
Employee Notice of Coverage Options

10/1/13 – 3/31/14
Initial Open Enrollment

2014

1/1/14
Open to Individuals and Small Employers

2015

1/1/15
Marketplaces Financially Self-Sufficient

2016

1/1/16
Small Employer Size Raises to 100

2017

1/1/17
May Open to Large Employers

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High Level Development of Health Insurance Marketplaces

There are several key things to know about the Marketplaces, including:

1. **Governance and Models –** Marketplaces will vary from state to state, but even those run by the federal government must conform to established rules determined by the Department of Health and Human Services (HHS), and any applicable state and federal laws.
2. **Plan Requirements –** Any health plan offered through a Marketplace must be a Qualified Health Plan (QHP) – meeting specific legal requirements set by HHS.
3. **Individuals –** While anyone can purchase coverage through a public Marketplace, those most likely to buy coverage will be those eligible for financial assistance.
4. **Employers –** Small employers, with 1-50 employees, will be the first allowed to purchase group insurance/HMO coverage for their employees on the Small Business Health Options Program (SHOP) Marketplace. All SHOP Marketplaces will expand to groups up to 100 employees in 2016.

1. Governance and Models

States and the federal government have had a number of things to consider as they've developed their Marketplaces. Again, while there will be many differences from state to state, here are some important rules for all:

- Each state must have an individual and a small business Marketplace. States may choose to establish a single Marketplace that performs both functions.
- Small Business Health Options Program (SHOP) Marketplaces are established to assist "small employers" with 1-50 full-time employees. In 2016, employers with 1-100 employees can participate in a SHOP. And after 2017, states may choose to offer large group coverage through the SHOP.
- A state may choose to establish and operate its own state-based Marketplace, a state partnership Marketplace (in collaboration with the federal government), or a federally-facilitated Marketplace model.
- A federally-facilitated Marketplace will be established for those states that have chosen not to build one.

Marketplaces will be operational for open enrollment October 1, 2013. The initial open enrollment of all public Marketplaces for the 2014 plan year for qualified individuals will be between October 1, 2013 and March 31, 2014.

Governance

States have choices regarding the governance of their Marketplaces. Regardless of structure, they must be publicly accountable, transparent, and have technically competent leadership. This ensures health plans offered through the Marketplace are in the interests of eligible individuals and small employers. Marketplaces run by independent agencies or non-profits must have governance principles, include consumer representation, ensure freedom from conflicts of interest, and promote ethical and financial disclosure standards. The governing board must have at least one voting member who is a consumer representative. Governance options include:

- **Public Agency Model:** Governed and administered by a state agency
- **Public Non-profit Model:** Independent non-profit or authority separate from state government
- **Quasi-Governmental Model:** Administered by a state agency and governed by an independent board

Models

Each Marketplace has options with regard to operating and contracting with participating health plan insurers. The models developed could create a variety of consumer experiences from state to state. Depending upon how each Marketplace selects insurers and plans, and how much negotiating and selection they control will determine:

- the level of coverage options available,
- breadth of cost and quality comparisons, and
- the overall consumer "shopping" experience.

2. Plan Requirements and Offerings

Marketplaces will also vary with regard to plan options and requirements. However, the law requires that a plan offered through a Health Insurance Marketplace must be a Qualified Health Plan (QHP). The law defines a QHP as an insurance or HMO plan that is certified by the Marketplace through which it is offered, provides essential health benefits, agrees to charge the same premium for a particular plan whether sold on or off the Marketplace, and meets other requirements.

Marketplace plan requirements

Plans sold through the Marketplace will be categorized in four "metal" groups that represent the percentages of expenses covered by the different plans. A Bronze level plan will cover 60 percent of deductibles, co-insurance and co-pays, while a Platinum level plan will cover 90 percent.

Additionally:

- QHPs must offer at least one silver plan, one gold and a child-only plan to participate on the Marketplace, but a State-based Marketplace may choose to add more requirements.
- Subsidies will be based on the second lowest cost silver plan available. (See individual section.).
- QHPs will need to offer a child-only plan.
- Standalone dental plans may be offered with a QHP.
- QHP networks must offer sufficient choice and include "essential community providers."
- Issuers may provide coverage through direct Primary Care Medical Homes that meet HHS criteria.

Coverage Levels	
Plan	**% of Costs***
Catastrophic (Individual Only)	Up to age 30 or exempt from individual mandate
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

*Plans provide essential health benefits and pay for the noted percentage of actuarial value with the Health Savings (HSA) out-of-pocket limits.

The insurance policies/HMO service agreements offered on a Marketplace must include the following:

- Essential health benefits (see box below)
- Accreditation on clinical quality measures
- No pre-existing conditions for all ages
- No annual dollar limits on essential health benefits
- No lifetime dollar limits on essential health benefits

Essential Health Benefits

Essential Health Benefits are as follows:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- 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

3. Individuals

Beginning in 2014, it is estimated that 25 million people will shop for coverage on the individual Marketplaces. These might include people who currently have individual insurance, are unemployed, self-employed, or work for businesses that either don't offer insurance or whose plan is unaffordable.

Financial Aid

- About 19 million people who purchase coverage through a Marketplace are likely to be eligible for a subsidy called a Federal Premium Assistance Tax Credit (premium subsidy) to help pay the premium for insurance policies purchased through a marketplace.
- The credit is available to individuals and families with incomes between 100% and 400% of the federal poverty level. As of today, 400% is approximately $45,000 for an individual or $92,000 for a family of four.
- The credit amount, determined by the Secretary of Health and Human Services, is based on the amount by which premiums exceed a stated threshold amount. The threshold will be the maximum percentage of income that individuals and families will be required to pay toward the second-lowest cost "silver" plan on the Marketplace.
- The threshold rises from 2% of income for those between 100%-133% of the federal poverty level to 9.5% of income for those between 300%- 400% of the federal poverty level (FPL).

FPL %	Threshold %	FPL $	Maximum Annual Premium $
100%-133%	2%	$23,050 – $30,656	$461 – $613
133.01%	3%	$30,658	$919
150%	4%	$34,575	$1,383
200%	6.3%	$46,100	$2,904
250%	8.05%	$57,625	$4,638
300%-400%	9.5%	$69,150 – $92,200	$6,569 – $8,759

- Individuals eligible for the Federal Premium Assistance Tax Credit may also be eligible for an additional subsidy called the Cost-Share Reduction. Cost-sharing subsidies are meant to protect lower income people from high out-of-pocket costs at the point of service. Individuals with incomes at or below 250% of the federal poverty level will be eligible for this additional subsidy. In 2012, 250% of the federal poverty level was roughly $57,600 for a family of four.

Enrollment

According to the Final Rule:

- The initial open enrollment for qualified individuals will run from October 1, 2013 through March 31, 2014.
- Future open enrollments for qualified individuals will be each year from October 15 through December 7.
- Special enrollment must be granted to individuals with qualifying events between the 1st and 15th of any month, with coverage effective the first day of the following month.
- The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year.

Customer Support

Marketplaces are required to have a number of ways to offer consumers assistance in shopping and applying for health coverage. Every Marketplace must have a website, toll-free call center, and people who are trained and certified to help consumers, including in-person. Insurance brokers and agents may receive special certification to also help consumers shop for plans sold on a Marketplace.

4. Employers

In 2014, small employers sponsoring an insured group health plan may begin using SHOP Marketplaces. These Marketplaces will serve "small employers" with 1-50 full-time employees. For plan years beginning on or after January 1, 2016, the small employer definition will increase to employers with 1-100 employees.

Small Business Health Options Program

The SHOP provides small employers with new ways to offer employee health coverage. Employers with up to 50 employees can offer one or more plans to its employees, as they typically do today. Or, they can select a metal level of coverage from within the SHOP, and allow employees to choose from any qualified health plan within that metal level. The Federal Marketplace will not be ready to support this functionality of "employee choice" until 2015. While not required in 2014, there are state-based Marketplaces that will have the "employee choice" option in 2014. This plan selection includes coverage from multiple insurers. When available, the employer will work through the SHOP as a single billing arrangement.

Employee Notice of Coverage Options

Employers subject to the Fair Labor Standards Act (FLSA), are required to provide a notice to their employees stating whether or not medical coverage is offered to their employees. The notice must also explain information about the Marketplace, including a description of the services it provides and the consumer assistance available. The notice must explain how an employee may be eligible for a premium subsidy available through the Marketplace if the employer plan does not meet certain requirements. The Department of Labor has only issued temporary guidance on this employer requirement. Final guidance is expected late summer or fall, 2013. Until then, employers are not required to distribute the notice.

Employers are required to distribute the notice to all full- and part-time current employees as of October 1, 2013, and to new employees as they are hired, regardless of whether the employee is enrolled in an employer-sponsored medical plan. The Department of Labor has model notices, available in English and Spanish, for employers who do not want to create their own.

Find out more at InformedOnReform.com

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