Health Insurance Marketplaces

The Patient Protection and Affordable Care Act (ACA) will make shopping and purchasing insurance more consumer friendly by establishing state-based health insurance marketplaces, also known as exchanges. These health insurance marketplaces will make available information about health plan's premiums and copayments, physician and other health care practitioner participation, and benefits, among other important information. The health insurance marketplaces began open enrollment on October 1, 2013. The 2014 open enrollment period will end on March 31, 2014, although special enrollment periods will be available for people experiencing major life events, such as a change in marital status or the birth of a child.

HEALTH INSURANCE MARKETPLACES

People who do not have access to health insurance through their employer must seek insurance on their own in a market that is largely unregulated, expensive, and difficult to navigate. Small businesses often have the same problems, since they do not have the negotiating power of large employers and may face a significant increase in premiums if an employee gets sick.

To help make health insurance plan shopping a less daunting experience for individuals and small businesses, the ACA directs states to establish "health insurance marketplaces" A health insurance marketplace is a virtual marketplace where a person or small business can access objective, easy-to-understand information to help them find health coverage to fit their needs. Exchanges will also help Medicaid- and Children's Health Insurance Program-eligible people enroll.

By 2014, each state will establish a health insurance exchange and eventually, states will have the ability to band together to form regional exchanges. If states fail to establish an exchange that meets the standards outlined in the law, the federal government will create and operate the state's exchange; states may also enter into a partnership with the federal government to share marketplace operation duties. In 2011, states began receiving funding to help establish and operate the exchanges but by 2015 they must be self-sufficient. As of October 2013, 17 marketplaces are operated by states, 27 are run by the federal government, and 7 are partnership marketplaces managed by the state and federal government.

Who is able to purchase insurance through exchanges?

The exchanges are open to:

- Legal residents living in the United States.
- Individuals who are not incarcerated.
- Individuals who receive tax credits to buy coverage through a qualified health plan. Those who do not qualify for premium tax credits may also shop for marketplace-based coverage, provided they live in the United States, are legal residents, and are not incarcerated.
- Small businesses with up to 100 employees who want to purchase qualified health insurance for their employees.
- Starting in 2017, states may permit large employers to buy health insurance through exchanges.

What kind of insurance is available?

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All insurance plans offered through an Exchange must be qualified health plans, meaning they must abide by insurance regulations, copayment and deductible limits, and adhere to a number of other rules that protect consumers. Eventually, the Exchange will rate qualified health plans on the basis of quality and price to help consumers compare plans. Plans offered in the exchange will reflect the four benefit tiers established in the law, from a Bronze plan with higher cost-sharing and lower premiums, to a Platinum plan, which has lower cost-sharing but higher premiums. A catastrophic care plan is available to people under age 30 and some low-income individuals.

- Qualified health plans must provide at least the essential health benefits package (EHB) that includes ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health and substance abuse disorder services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness and chronic disease management, and pediatric services. Health plans established after March 23, 2010 will be required to cover preventive services rated A or B by the United States Preventative Services Task Force without cost-sharing. Immunizations recommended by the Advisory Committee on Immunization Practices and certain recommended preventive services for women and children must also be covered without cost-sharing.
- Initially, states will select an essential health benefit "benchmark plan" on which services in the ten benefit categories will be based. Essential health benefit packages will generally reflect the scope of benefits provided by a typical employer-based health insurance plan.
- Health plans are permitted to cover services in addition to the essential benefit package. States can require coverage of additional services as long as they provide funding.
- The Secretary of HHS is required to give notice to the public regarding decisions relevant to the essential health benefits package and provide for public comment.
- Qualified health plans must also disclose information such as claims payment policy and practices, premium rating practices, claims denials, and policies related to out-of-network cost-sharing.
- Exchange-based health plans must also meet certain marketing requirements, ensure that an adequate number of providers can be accessed by enrollees, and they must meet clinical quality standards.

What else do the Exchanges do?

- Review health plan premium increases.
- Maintain a toll-free hotline to assist customers.
- Apply a rating to health plans reflecting the quality and cost of benefits.
- Make available an online calculator to determine if a person is eligible for premium and cost-sharing assistance.

Exchange-eligible individuals and businesses may also have the option of enrolling in other innovative plans such as:

- *Consumer Oriented and Operated Plan (CO-OP)*: Some people may have access to a CO-OP insurance plan, a member-run, non-profit insurance plan where a board of members decides on issues involving benefits, premiums, and other important plan features. A CO-OP cannot be operated by an existing insurer and any profits must be directed towards lowering premiums and other consumer costs. The ACA distributes grants for the creation of CO-OP plans and grant applicants offering a state-wide qualified health plan, an emphasis on integrated health care, and those that have significant private support will be prioritized. CO-OP programs may offer qualified health plans outside of the Exchange as well. Funding for the CO-OP program was reduced by $2.2 billion in the Fiscal Year 2011 Continuing Resolution budget extension. A regulation on CO-OPs was released in December 2011.

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The American Taxpayer Relief Act of 2012 (H.R. 8), which was signed into law on January 2, 2013, creates a new CO-OP Program Contingency Fund and redirects 10 percent of the unobligated funds provided under the CO-OP Program created by the ACA. This means that funding will no longer be distributed to states to build new CO-OPs; however, existing CO-OPs- established in 24 states so far – will continue to receive financial help from the federal government as it's available.

- *Multi-State Qualified Health Plans (MSQHP)*: Each Exchange will have available at least two MSQHPs, insurance plans made available nationally that are contracted with the Office of Personnel Management (OPM), the same federal entity that administers health insurance for Members of Congress. The implementation of the MSQHP will be phased in, with availability in at least 60 percent of states on January 1, 2014 and the rest of the country in four years. MSQHP will negotiate with OPM on factors such as premiums, the percentage of a premium that is devoted to medical care, and other terms. The benefits package would have to be at least as generous as other QHPs, but states could require additional benefits as long as they provide funding. Of the two plans that must be made available, one is required to be a non-profit insurer and the other cannot provide abortion coverage beyond the services mandated by federal law. The federal government released a proposed regulation on MSQHPs in November 2012 and a finalized regulation in March 2013. In 2014, the number of plans available in states will vary – Alaskans may choose from 36 different plans, while Indianans will be able to choose between 2 plans.

- *Basic Health Plan (BHP):* States have the option of creating a Basic Health Plan for Exchange-eligible people with incomes between $15,856 and $22,980 (based on 2013 figures) for individuals and $32,499 and $47,100 for a family of four. Instead of receiving health coverage through an Exchange-based plan, the federal government would direct credits to the BHP to provide coverage. The Basic Health Plan coverage will be provided through one or more state-contracted health insurance plans (likely health maintenance organizations) that provides at least the minimum benefit package required of Exchange-based plans and adheres to premium and cost-sharing limits. States would negotiate with health plans on premium and cost-sharing levels, care coordination and preventive care availability, and whether the plan would use certain performance and quality measures for physicians and other health practitioners. One of the potential benefits of the BHP is that it can serve as "bridge" coverage for those who may shift between Medicaid and exchange-based plan eligibility, providing more seamless coverage of providers, benefits, and cost-sharing. HHS has delayed implementation of the Basic Health Plan, stating that BHPs will be established starting in 2015.

What is the status of health insurance exchanges?

Open enrollment for all state, federal, and partnership exchanges began on October 1, 2013, although online enrollment in the federally-run small business health exchange commences on November 1 and Spanish-language marketplace enrollment begins in late October. People can now access the exchanges online, via toll-free call center, or through an in-person assister. Individuals and small businesses may now shop, compare, and enroll in the health insurance coverage that best meets their needs. During the early phases of the exchange launch, many persons reported difficulties in shopping and signing up for coverage due to major technical problems with the enrollment and shopping portal, www.healthcare.gov, created by the federal government. The federal government announced plans on October 20 to correct the technical problems but it was unclear at that time how long it would take for the web portal to become fully operational and functional. To help you help your patients determine health insurance choices, as well as to answer questions that you might have, the American College of Physicians has put together a series of documents to address questions about the changes

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in healthcare coverage brought about by the new marketplaces. ACP's *Help Your Patients Enroll in Health Insurance Marketplaces* campaign provides general information on resources that are available to you and your patients, and answers frequently asked questions about insurance enrollment. In addition, ACP has also assembled state-specific resources to tell you more about what is happening in your area and help you provide your patients with accurate contact information.

The campaign can be accessed here.

Additional Resources

- *Healthcare.gov: Health Insurance Marketplace.* The portal to health insurance marketplaces operated by the federal government, links to state-run marketplaces, contact information for community-based health insurance outreach and enrollment entities, and other resources.

  http://www.healthcare.gov/marketplace/index.html

  Spanish-language website:

  https://www.cuidadodesalud.gov/es/

- *National Partnership for Women and Families: Affordable Care Act and Open Enrollment*

  http://www.nationalpartnership.org/issues/health/aca-open-enrollment.html

- *CMS.gov Marketplace website for professionals:* provides media, videos, posters, index cards, fact sheets, and other resources to guide you and your patients through the health insurance marketplaces.

  http://marketplace.cms.gov

- *American College of Physicians Comments to CMS regarding the Proposed Rule on Establishment of Exchanges and Qualified Health Plans*: *Letter to CMS, Department of Health and Human Services.*

  http://www.acponline.org/advocacy/where_we_stand/access/exchange_letter_cms.pdf

- *American College of Physicians Comments to HHS regarding the Bulletin on the essential benefit package.*

  http://www.acponline.org/advocacy/where_we_stand/access/essential_benefits.pdf

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