FOCUS on Health Reform

THE HENRY J. KAISER FAMILY FOUNDATION

APRIL 2010

EXPLAINING HEALTH CARE REFORM: Questions About Health Insurance Exchanges

The Patient Protection and Affordable Care Act (PPACA), signed into law in March 2010, made broad changes to the way health insurance will be provided and paid for in the United States. PPACA created a new mechanism for purchasing coverage called Exchanges, which are entities that will be set up in states to create a more organized and competitive market for health insurance by offering a choice of health plans, establishing common rules regarding the offering and pricing of insurance, and providing information to help consumers better understand the options available to them. Initially Exchanges will serve primarily individuals purchasing insurance on their own and smaller employers; states will have the option of opening Exchanges to larger employers a few years after implementation.

This summary provides responses to questions about the purpose and function of Exchanges and how they relate to regulation of the insurance market. Certain 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 (DHHS).

Who will have access to Exchanges?

PPACA requires most individuals to have health insurance beginning in 2014. It authorizes entities known as American Health Benefit Exchanges, which states will establish by January 1, 2014, to make plans available to qualified individuals and employers. Qualified individuals include U.S. citizens and legal immigrants who are not incarcerated, and who do not have access to affordable employer coverage. PPACA also provides for separate Small Business Health Options Program (SHOP) Exchanges from which small businesses with up to 100 employees can obtain coverage for their employees. Prior to 2016, states can limit Exchanges to businesses with 50 or fewer workers, and, beginning in 2017, states can allow businesses with more than 100 employees to purchase coverage from an Exchange.

The Congressional Budget Office estimated that in 2019, approximately 24 million people would purchase their own coverage through the Exchanges, plus an additional 5 million people whose employers allow all their workers to choose among the plans in the Exchanges.

How will Exchanges be structured?

An Exchange must be a governmental agency or nonprofit entity that is established by a state. States are required to establish separate exchanges for individuals (American Health Benefit Exchanges) and small business employees (Small Business Health Options Program, or SHOP, Exchanges) by January 1, 2014. States can choose to establish a single Exchange serving both individuals and small businesses, or provide coverage through separate entities. States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area.

If a state fails to set up an Exchange by January 1, 2014, the DHHS Secretary will establish and operate an Exchange in the state, either directly or through an agreement with a nonprofit entity.

Funding to establish Exchanges will be available to states from within one year of enactment (i.e., 2011) until January 1, 2015, when states must ensure that their Exchanges are self-sustaining. States are required to allow Exchanges to charge assessments or user fees to participating health insurance issuers or to provide other means of generating funding.

The federal Office of Personnel Management (OPM) is required to contract with insurers to offer at least two multi-state plans 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. These multi-state plans will be offered separately from the Federal Employees Health Benefits Program (which OPM administers) and will have a separate risk pool.

In addition, federal funds will be made available to establish non-profit, member-run health insurance companies (called Consumer Operated and Oriented Plans, or CO-OPs) in each state.

What functions will Exchanges perform?

The law requires that, at a minimum, Exchanges will:

- certify whether health plans are qualified to be offered in the Exchange, including examining their premium increases;
- require of plans and make public disclosure of the following information in plain language: claims payment policies and practices; periodic financial disclosures; data on enrollment, denied claims, and rating practices; information on cost sharing and payments for out-of-network coverage; and enrollee and participant rights;
- require qualified health plans to make available timely information about the amount of cost sharing for specific items or services;
- operate a toll-free telephone assistance hotline;
- maintain an Internet website where enrollees can obtain standardized comparative information about the health plans;
- assign a rating to each health plan in the Exchange based on the relative quality and price of their benefits;
- use a uniform enrollment form and a standardized format for presenting health benefits plan options;
- inform people about the eligibility requirements for the Medicaid, CHIP or other State or local public programs and coordinate enrollment procedures with them;
- make available an electronic calculator to determine the actual cost of coverage after any premium tax credit and any cost-sharing reduction has been applied;
- 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;
- establish a Navigator program to award grants to entities to promote public education about and enrollment in Exchanges.

In order to be certified by the Exchange as a qualified health plan, plans must meet marketing requirements (to assure that they will not discourage enrollment of those with significant health needs), ensure a sufficient choice of providers, include essential community providers that serve the low income, be accredited on clinical quality measures including consumer assessment surveys, and use a standard format for presenting health benefits plan options. In addition, qualified plans in the Exchanges must abide by insurance market regulations relating to guaranteed issue, premium rating, and prohibitions on pre-existing condition exclusions.

In carrying out their activities, Exchanges are to consult with stakeholders such as enrollees, enrollment facilitators, representatives of small businesses and self-employed individuals, State Medicaid offices, and advocates for enrolling hard-to-reach populations.

What subsidies will be available to Exchange participants?

To help low to moderate income individuals purchase coverage through the Exchanges, subsidies for premiums, in the form of refundable and advanceable tax credits, will be available starting in 2014 for individuals and families without access to other coverage and with incomes from 100% to 400% of the federal poverty level (FPL). The premium credits will be tied to the second lowest cost Silver plan in the area and will be set on a sliding scale so that the premium contributions are limited to percentages of income for specified income levels (e.g., for incomes up to 133% FPL, the premium contribution will be limited to 2% of income). (The poverty level is $22,050 for a family of four in 2009 and early 2010. See "What benefits will be offered through the Exchanges," below, for information about the Silver coverage level. See also the Kaiser Family Foundation report on *Explaining Health Care Reform: Questions About Health Insurance Subsidies*.)

Generally, subsidies will not be available to people with access to health coverage through an employer. If, however, an employer health plan does not have an actuarial value of at least 60%—meaning that the plan covers at least 60% of the cost of covered benefits in the aggregate for a standard population—or if an employee's share of the employer premium exceeds 9.5% of income, the employee may enroll in a plan in the Exchange and be eligible for premium and cost-sharing subsidies. Employers offering minimum essential coverage will be required to provide "free choice vouchers" to employees with incomes less than 400% FPL and whose contribution for the employer coverage exceeds 8% but does not exceed 9.8% of their income, which they can use to enroll in an Exchange.

Beginning in 2014, PPACA also provides for reduced cost sharing for families with incomes at or below 250% of poverty by making them eligible to enroll in health plans with higher actuarial values (a higher actuarial value means that the insurer, on average, pays a larger share of covered expenses[1]). PPACA also specifies reduced out-of-pocket limits for people with incomes at or below 400% of poverty (see the Kaiser Family Foundation report *Explaining Health Care Reform: Questions About Health Insurance Subsidies*).

What benefits will be offered through the Exchanges?

The qualified plans that participate in the Exchanges will be required to offer a uniform benefits package which would be offered at four levels of value, making comparisons across plans easier. The law requires the DHHS Secretary to define this uniform benefit package, referred to as the essential health benefits, which must include at least the following general 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, and pediatric services including oral and vision care. States may require qualified health plans to offer additional benefits, but PPACA says that the State must defray the cost of any additional benefits by making payments either to the enrollee or to the health plan.

The scope of these benefits must be equal to the scope of benefits provided under a typical employer plan, as determined by the DHHS Secretary. The four levels of coverage, which vary depending on how much the insurer pays, include:

- Bronze: benefits equivalent to 60% of the full actuarial value of plan benefits,
- Silver: benefits actuarially equivalent to 70% of full value,
- Gold: benefits actuarially equivalent to 80% full value, and
- Platinum: benefits actuarially equivalent to 90% 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.

Plans may offer catastrophic coverage that doesn't meet one of the four levels of coverage, but only to enrollees under the age of 30 or those who would otherwise be exempt from the requirement to purchase coverage because the premium exceeds 8% of their income. These plans would offer less coverage but at a lower premium—their coverage level would be set at the HSA current law levels except that prevention benefits and coverage for three primary care visits would be exempt from the deductible.

Qualified plans in the Exchanges are not allowed to design benefits or reimbursement in a way that discriminates against individuals because of their age, disability, or expected length of life. Exchanges must allow the offering of limited scope dental benefits for adults, either separately or in conjunction with a qualified health plan, if the plans provide pediatric dental benefits meeting certain requirements.

States can also create a Basic Health Plan for uninsured individuals with incomes between 133% and 200% of poverty in lieu of those individuals receiving premium subsidies to purchase coverage in the Exchanges, effective January 1, 2014. States that offer the Basic Health Plan must ensure that the benefits are at least equivalent to the essential health benefits and premiums are not higher than those in the Exchanges.

States are allowed to prohibit abortion coverage in qualified health plans offered through an Exchange if the state enacts a law to do so. Plans that do provide abortion coverage beyond that permitted with federal funds (to save the life of the woman and in cases of rape or incest) must create allocation accounts to segregate subsidies for premium payments and cost-sharing amounts for abortion services from premium and cost-sharing subsidies for all other services so that no federal premium or cost-sharing subsidies are used to pay for abortion coverage. At least one of the multi-state health plans in an Exchange is required to not provide abortion services beyond those permitted with federal funds.

[1] See the Kaiser Family Foundation *Glossary of Key Terms in Health Reform* at www.kff.org/healthreform/upload/7909.pdf.

Conclusion

The Exchanges established by PPACA are designed to be settings in which qualified individuals and families and small businesses can purchase health insurance coverage that meets certain rules relating to affordability, required benefits, and market standards. People who do not have access to employer or public coverage will find choices in the Exchanges, with standardized benefit options that make comparisons easier. Premium and cost-sharing subsidies will be available to help low- and modest-income people finance their coverage. The Exchanges also will provide settings in which insurers and plans can be monitored to assure that they conform to consumer protection rules that go beyond current insurance market regulations.

Resources

Alliance for Health Reform/Commonwealth Fund – Health Insurance Exchanges: See How They Run. Webcast provided by kaisernetwork.org: www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=3134

Center on Budget and Policy Priorities – Health Insurance "Connectors" Should Be Designed to Supplement Public Coverage, Not Replace It: www.cbpp.org/1-29-07health.htm

Community Catalyst – Revisiting Massachusetts Health Reform: 18 Months Later: www.communitycatalyst.org/doc_store/publications/revisiting_MA_health_reform_dec07.pdf

Congressional Budget Office, Letter to Honorable Nancy Pelosi, March 20, 2010: www.cbo.gov/doc.cfm?index=11379&zzz=40593

Heritage Foundation – The Significance of Massachusetts Health Reform: www.heritage.org/research/healthcare/wm1035.cfm

Institute for Health Policy Solutions – What Health Insurance Exchanges or Choice Pools Can and Can't Do About Risks and Costs: http://allhealth.org/briefingmaterials/WhatHealthInsuranceExchangesorChoicePoolsCanandCantDoAboutRisksandCosts-1459.pdf

Kaiser Commission on Medicaid and the Uninsured – President Obama's Campaign Position on Health Reform and Other Health Care Issues: www.kff.org/uninsured/kcmu112508oth.cfm

Kaiser Family Foundation – Health Reform documents including summary of the law, implementation timeline, premium subsidy calculator, other reports: http://healthreform.kff.org/

Kaiser Family Foundation – How Private Health Coverage Works: www.kff.org/insurance/7766.cfm

Kaiser Family Foundation/National Governors Association – Webcast, Creating a Marketplace for Expanding Coverage: www.kaisernetwork.org/health_cast/hcast_index.cfm?display=detail&hc=2063

Kaiser Family Foundation – State Health Facts (State Insurance Rules): www.statehealthfacts.org/comparecat.jsp?cat=7

Massachusetts Connector: www.mahealthconnector.org/portal/site/connector/

The Patient Protection and Affordable Care Act, and the Health Care and Education Reconciliation Act, full text and summaries from the Democratic Policy Committee: http://dpc.senate.gov/dpcdoc-sen_health_care_bill.cfm

Urban Institute – Health Insurance Exchanges: Organizing Health Insurance Marketplaces to Promote Health Reform Goals: www.urban.org/UploadedPDF/411875_health_insurance_marketplaces.pdf

This publication (#7908-02) is available on the Kaiser Family Foundation's website at www.kff.org.

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