



## Thirteen Things To Know About Health Care Insurance Exchanges: The New Marketplace

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The primary goals of health reform (the Patient Protection and Affordable Care Act, or "PPACA") were to provide coverage to the uninsured and underinsured, and to bend the curve on spending. One way Congress sought to expand coverage was through the creation of Health Insurance Exchanges. An Exchange is an organized marketplace that offers a choice of health insurance plans and information about the policies, and establishes common rules for benefit design and pricing health insurance. The Exchanges are established on a state or regional foundation, with each state making the decision on how to best implement a program for its residents. The new Exchanges are modeled after the Massachusetts Connector program, one of the first Exchanges in the United States.

**1 Exchange Structure.** The Exchange must be a governmental or non-profit organization that is established by a state. The state may elect to enter into agreements with eligible entities to carry out one or more of its responsibilities; however, such an entity may not be an insurance issuer. States are required to establish separate Exchanges for individuals and small businesses by January 1, 2014.

If the state fails to set up an Exchange by the deadline, or if by 2013 the Secretary of Health and Human Services concludes the state will be unwilling or unable to form its own Exchange, the Secretary will establish and operate an Exchange in the state, either directly or through a qualifying organization.

The state could also choose to form a regional or interstate Exchange with another state or more than one Exchange in a state that serves distinct geographic areas.

**2 Access to Exchanges.** Qualified individuals for coverage in an Exchange include U.S. citizens and legal immigrants who are not incarcerated, and do not have access to affordable employer coverage and are not eligible for Medicaid. The law also provides for separate small business options program (SHOP) Exchanges from which small businesses with up to 100 employees can obtain coverage.

**3 Funding for Exchanges.** On July 29, 2010 the Department of Health and Human Services (HHS) announced the availability of State Planning and Establishment Grants. These funds are meant to assist the states with initial planning activities related to the potential implementation of the Exchanges. While HHS has the flexibility to determine the scope and size of the awards, there is a maximum of \$1 million per state available in this first round of funding, depending on the scope of their request. Each state is only eligible for one grant from this funding opportunity. While the first installment of these planning grants must be awarded no later than March 23, 2011, it is expected that these first awards will be made in September 2010. Federal funding to establish Exchanges will be available to states until January 1, 2015, when the states must ensure that their Exchanges are self-sustaining or provide other means of generating funding.

**4 Functions of Exchanges.** 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;

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## Thirteen Things to Know About Health Care Insurance Exchanges: The New Marketplace

- 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; and 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; and
- establish a Navigator program to award grants to entities to promote public education about and enrollment in Exchanges (discussed below).

**5 Subsidies for Individuals.** To help low-to-moderate income individuals and families purchase coverage through the Exchanges, subsidies for premiums, in the form of refundable and advanceable tax credits, will be available starting in 2014, for those with incomes from 133% to 400% of the federal poverty level.

Generally, subsidies will not be available to people with access to health coverage through an employer. However,

there are exceptions to this if the employer contribution is not adequate or if the employee share of the employer premiums exceeds 9.5% of income. In these cases the employee may enroll in a plan in the Exchange and be eligible for premium and cost sharing subsidies. The availability for subsidies may prove to be a powerful incentive for individuals to seek coverage through the Exchange.

**6 Benefits Offered Through the Exchange.** The health benefit plans that participate in the Exchange will be required to offer a uniform benefits package to be offered at four levels of value. The law requires the HHS to define this uniform benefit package which has to include at least the following services: ambulatory patient services, emergency services, hospitalization, maternity and newborn care, mental health benefits and substance use disorders services, prescription drugs, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services and chronic disease management, and pediatric services. States also have the ability to enhance the core requirements established by HHS for the benefits in their Exchange; however, the state will be responsible for the costs associated with any enhanced benefits.

The scope of the benefits is to be equal to those provided under a typical employer plan. The four levels of coverage vary depending on how much the insurer pays:

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

Plans may also offer catastrophic coverage that doesn't meet one of the four levels of coverage, but only to those individuals under the age of 30 or for limited numbers of individuals exempt from the minimum coverage requirements, mainly due to financial hardship exemptions.

**7 Regulator.** HHS created the Office of Consumer Information and Insurance Oversight (OCIO) to

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## Thirteen Things to Know About Health Care Insurance Exchanges: The New Marketplace

implement provisions of the PPACA that address private health insurance and named former Missouri Insurance Commissioner and consumer advocate Jay Angoff as the director. Within the OCIO, HHS created the Office of Health Insurance Exchanges, which is tasked with developing and implementing policies and rules governing state-based exchanges; establishing and issuing planning grants to states; and overseeing the operation of Exchanges. OCIO has already requested comments on many of the issues confronting the regulators and legislators.

### **8 Enforcement of Health Insurance Exchanges.**

HHS (through OCIO) is required to set standards for the establishment and the operation of the Exchanges. HHS is expected to work with the National Association of Insurance Commissioners (NAIC) and other groups in doing this work. Because of the relatively short time frame, HHS is required to release its regulations as soon as practicable after the date of enactment; hence the request for comments.

If a state already operated an Exchange prior to 2010 (e.g. Massachusetts), it will be assumed that its Exchange meets the standards. However, if it is determined that in fact the Exchange does not meet the established standards, HHS has indicated they will work with them to make the changes necessary.

### **9 Financial Integrity Rules.**

Health Insurance Exchanges are subject to HHS investigations and audits governing their financial activities. Exchanges must keep an accurate accounting of all their activities and expenditures and submit an annual report to the Secretary. The Secretary may implement measures that are aimed at reducing fraud and abuse in Exchange administration. Additionally, payments made by, through, or in connection with an Exchange are subject to the False Claims Act if those payments include any federal funds.

**10 Enrollment Periods.** Exchanges are required to provide for: 1) an initial open enrollment period;

2) annual open enrollment periods; 3) special enrollment periods; and 4) monthly enrollment periods for Indians. The Secretary of HHS is required to provide guidance to Exchanges to implement these periods.

**11 Types of Exchanges.** It is up to each state to organize an Exchange in a manner that best serves its constituency. The options include:

- Exchange solely for individuals
- Small Business Health Options Program (SHOP) - A state may create a separate Exchange for small businesses to purchase health insurance for its employees. A state may merge the SHOP and Exchange for individuals only if the Exchange has enough resources to support both. Initially, a state may allow businesses with up to 100 employees to purchase in the Exchange, but it may expand this number in 2017.
- Regional Exchange – An Exchange may operate in more than one state if each state in which the Exchange operates permits it; and if it is approved by the Secretary.
- Subsidiary Exchanges – A state may establish one or more subsidiary Exchange(s) if: 1) each serves a geographically distinct area; and 2) the area served by each meets certain size requirements
- Federal Exchange – The Secretary of HHS will operate an Exchange in a state that either chooses not to operate an Exchange or that the Secretary determines by January 2013, will not have an Exchange operational by January 2014.

**12 Employer Issues.** Employers of fewer than 101 employees are allowed to purchase insurance for their employees through the Exchange. The small-employer tax credit (for employers with less than 25 full-time employees) will create an incentive for small employers to do so; however to obtain the credit, the employer must contribute at least half of the premium for the coverage. By contrast, all employers with 50 or more employees will be penalized if even one of their full-time employees receives premium or cost sharing

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## Thirteen Things to Know About Health Care Insurance Exchanges: The New Marketplace

subsidies having enrolled in a state Exchange offered plan. Employees who have health benefits through their employers can qualify for subsidies if their share of the premium for their job based policy exceeds 9.5 percent of their household income or if the plan covers less than 60 percent of the total allowed costs of the plan's benefits.

**13 How Plans are Sold.** It is expected that each Exchange will support an internet portal which will assist individuals in determining whether or not they are eligible for the portal as well as facilitating enrollment for those determined to be qualified individuals. In addition to providing an internet portal, the Exchanges must each establish a Navigator program designed to further facilitate education and the growth of the Exchange. Under the Navigator program, the Exchange can award grants to certain trade groups, professional organizations, chambers of commerce, and other similar entities to perform a variety

of tasks on behalf of the Exchange. Insurance agents are eligible to serve as Navigators; however, the role includes additional responsibilities not borne by a typical insurance agent.

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