

HEALTH INSURANCE EXCHANGE FACT SHEET

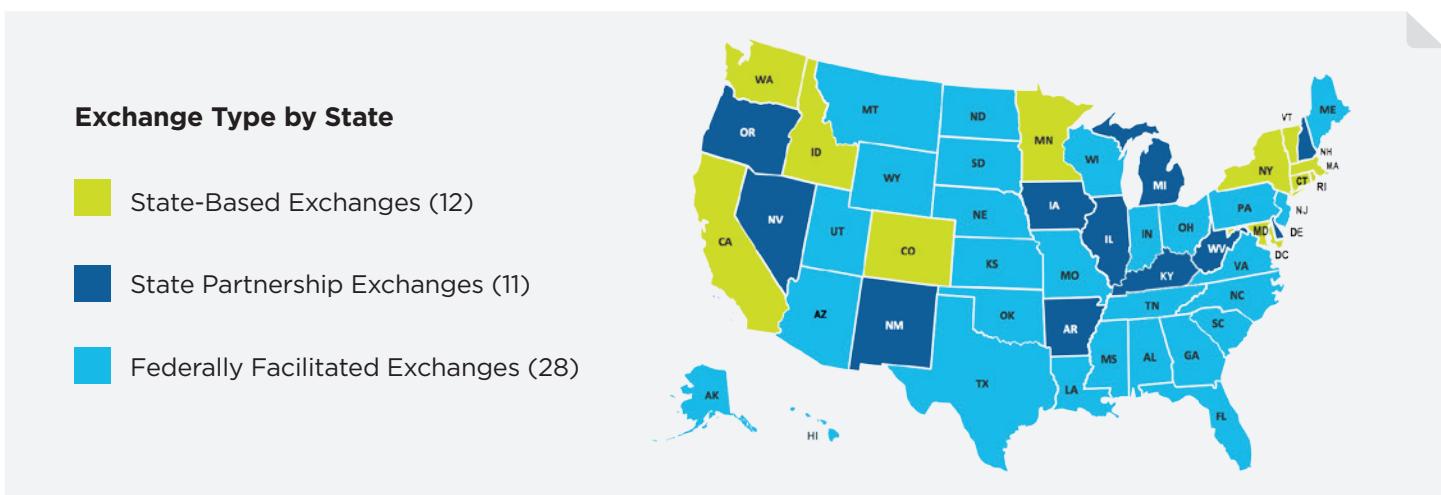


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Overview

A Health Insurance Exchange, also known as a Health Insurance Marketplace, is available in every state as a public option for individuals and small employers to purchase medical and dental insurance. A state may choose to establish and operate its own state-based Exchange, operate a state partnership Exchange (in collaboration with the federal government), or defer to the Federally Facilitated Exchange.

The main objective of public Health Insurance Exchanges is to provide access to affordable health insurance coverage for individuals and small businesses (employing 1-50 total employees unless a state has defined small group differently).



General rules of health insurance exchanges

There are specific rules and general guidance on development and administration of all government-run Exchanges, including:

- 1. Governance and models** - Exchanges will vary from state to state. They all 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 an Exchange must be a Qualified Health Plan (QHP), and meet specific legal requirements set by HHS. People who purchase a QHP through an Exchange have minimum essential coverage.*
- 3. Individuals** - Any American can purchase coverage through a public Exchange. Individuals purchasing coverage through an Exchange may be eligible for federal premium assistance, and under certain circumstances a reduction in their deductible.
- 4. Employers** - Small employers with 1-50 employees, unless small group is defined differently by a state, are allowed to purchase group insurance/HMO coverage for their employees on the Small Business Health Options Program (SHOP) Exchange.

* Having insurance that qualifies as minimum essential coverage was required under the individual mandate; however, the Tax Cuts and Jobs Act included permanent effective repeal of the individual mandate by zeroing out the penalty effective January 1, 2019.

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1. Public vs. Private Exchanges

It is important to understand that the rules and structure of public vs. private exchanges are very different. While private exchanges aren't subject to the same rigorous rules as public exchanges, they also offer more controls over the options available to employees. Employers help structure and define the options made available to their employees on a private exchange, depending on capabilities and service models.

	STATE HEALTH BENEFIT EXCHANGES	PRIVATE EXCHANGES
Oversight	• Government Agency, quasi-governmental agency or not for profit	• Privately owned and operated
Objectives	• Assist individuals, families and small employers in purchasing health insurance • Provide assistance to those who qualify for enrollment in state Medicaid programs	• Offer services to the various individuals and groups in the purchase of health care coverage • Defined contribution
Subsidy Availability	• Yes, for those individuals and families between 100-400% of the federal poverty level (FPL)	• No
Eligibility	• Intended for individuals and small employers looking to purchase health care coverage	• Employers choosing to participate and their eligible employees
Rate Negotiation	• Individual and small employer focus; very strict rating regulations	• Negotiated with private exchange (similar to historic insurance negotiations)
Employer Size	• Small employers are 1-50 total employees unless defined differently by a state	• Any size employer
Example	• Federally Facilitated Exchange • State-based Exchange • State Partnership Exchange	• Third-party exchange partnerships • Single-carrier and multi-carrier options

Models

Each Exchange has different options with regard to operating and contracting with participating health plan insurers, which creates a variety of consumer experiences from state to state. There is an open enrollment period for each plan year. These open enrollment periods are determined by the Department of Health and Human Services (HHS) for the Federally Facilitated Exchange, or the states for state-based Exchanges. People with qualifying events may enroll in coverage throughout a plan year.

How each Exchange selects insurers and plans, and how much negotiating and selection they control determines:

- The level of coverage options available
- Breadth of cost and quality comparisons
- The overall consumer “shopping” experience

2. Plan requirements and offerings

Exchanges also vary with regard to plan options and requirements. However, the law requires that a plan offered through a Health Insurance Exchange must be a Qualified Health Plan (QHP).

QHPs are insurance plans that:

- Are certified by the Health Insurance Exchange through which they are offered
- Provide essential health benefits (EHBs)
- Offer “tiered” coverage levels with at least one Silver Plan, one Gold Plan, and a Child-Only Plan
- Charge the same premium for a particular plan whether sold on or off the Exchange
- Meet other requirements as mandated by the state

Coverage levels

Plans sold through the Exchange offer coverage at different percentages of coverage from 60-90%. Like any other insurance plan, when the percentage of coverage is higher, the premium and other associated expenses increase.

PLAN	% OF COSTS**
Catastrophic (individual only)	Up to age 30 or exempt from individual mandate*
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

*The Tax Cuts and Jobs Act included permanent effective repeal of the individual mandate by zeroing out the penalty effective January 1, 2019. Most individuals were still required to maintain coverage in 2018 or pay a penalty when they file their 2018 federal income tax return in 2019.

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

The insurance policies/HMO service agreements offered on an Exchange must include the following:

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

Essential health benefits

Essential health benefits are further defined by each state, but the ten broad categories are as follows:

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| <ul style="list-style-type: none">➢ Ambulatory patient services➢ Emergency services➢ Hospitalization➢ Maternity and newborn care➢ Mental health and substance use disorder services, including behavioral health treatment | <ul style="list-style-type: none">➢ 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 |
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3. Individuals

People most likely to shop for health coverage through an Exchange are those who currently have private individual insurance, are unemployed, self-employed, or work for businesses that either do not offer insurance or whose plan is unaffordable.

Financial aid

Millions of people who purchase coverage through an Exchange 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 an Exchange.

The Federal Premium Assistance Tax Credit subsidy is available to individuals and families with low-to-moderate incomes between 100% and 400% of the FPL. The credit amount for purchased coverage is based on the amount by which the premiums exceed a threshold amount. The threshold amounts rise in correlation with the FPL. The FPL varies for individuals and by family size.

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 are eligible for this additional subsidy.

Enrollment

- Open enrollment takes place each fall on dates determined by HHS.
- Special enrollment is available to people with qualifying events between the first and 15th of any month, with coverage effective the first day of the following month. There is typically a 60-day enrollment window from the date of a triggering event to select an Exchange plan.
- The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year.

Customer support

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

4. Employers

Small employers sponsoring an insured group health plan may use SHOP Exchanges. These Exchanges will serve “small employers” with 1-50 full-time employees unless small group is defined differently by a state.

Small Business Health Options Program (SHOP)

The SHOP provides small employers a way to offer employee health coverage. Participating employers can offer one or more plans to their employees, as they typically do in the private sector. Or, employers can participate in an “employee choice” option by selecting a “plan category” (also known as a metal level) of coverage from within the SHOP, and allowing employees to choose from any qualified health plan within that category. This plan selection includes coverage from multiple insurers, but 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 one-time notice to all full- and part-time employees stating whether or not medical coverage is offered to their employees. The notice must give information about the Exchange, 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 Exchange if they are not eligible for an employer-sponsored plan or the employer plan does not meet certain requirements.

These requirements took effect in October 2013, and most employers with established businesses now only need to provide this notice of coverage options during the new hire process. If an employer newly enters the market for offering health benefits, they will have to provide this notice to all employees upon entering the market. The Department of Labor has model notices, available in English and Spanish.



*** If the federal government ceases reimbursement payments of cost-sharing reductions (CSRs) to insurers, it does not eliminate the availability of CSRs. Insurers are required by law to offer them to qualified individuals.

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