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Health-Care Reform: Insurance Exchanges

One of the functions of an Exchange is to grant certifications to individuals who are exempt from the individual health insurance mandate penalty because they are not able to afford a qualified health plan offered through the Exchange, and coverage is not available through the individual's employer.

Starting in 2014, the Patient Protection and Affordable Care Act (ACA) requires the establishment of state-based American Health Benefit Exchanges for individuals and Small Business Health Options Program (SHOP) Exchanges for small employers. The general purpose of these Exchanges is to provide a single resource in each state for consumers and small businesses to compare health plans, get answers to questions, and enroll in a health plan that is both cost effective and meets their health-care needs.

Exchanges are not issuers of health insurance. Rather, they contract with insurance companies who then make their insurance coverage available for examination and purchase through the Exchange. In essence, Exchanges are designed to bring buyers and sellers of health insurance together, with the goal of increasing access to affordable coverage.

A health-insurance Exchange is essentially a one-stop health insurance marketplace. Through an Exchange, you can compare private health plans based on coverage options, deductibles, and cost; get direct answers to questions about coverage options and eligibility for tax credits, cost-sharing reductions, or subsidies; obtain information on a provider's claims payment policies and practices, denied claims history, and cost-sharing and payment policy for out-of-network coverage.

Who can benefit from an Exchange?

Beginning in 2014, most individuals are required to have health insurance (exceptions apply). While the ACA does not require that health insurance be purchased through Exchanges, obtaining coverage through an Exchange can be easier than doing it on your own. This is true especially for individuals who do not have employer-provided health insurance available; individuals who have pre-existing conditions; early retirees who aren't eligible for Medicare; individuals who are unemployed; small businesses (fewer than 100 employees, although beginning in 2017, states may allow larger employers to participate) who want to provide insurance coverage to their employees; and individuals who want to "comparison shop" for health insurance through a single resource. Exchanges also help qualified individuals obtain federally subsidized premium and cost-sharing assistance, and screen individuals for eligibility for certain public insurance programs (e.g., Medicaid, Children's Health Insurance Program).

In order to be eligible to participate in an individual Exchange:

- You must be a U.S. citizen, national, or noncitizen lawfully present in the United States.
- You cannot be incarcerated.
- You must meet applicable state residency standards.

Unauthorized aliens are prohibited from obtaining coverage through an Exchange, without regard to their ability to pay for the cost of coverage.

SHOP Exchanges

The ACA allows states to opt to have one Exchange for both individuals and small businesses or provide coverage through separate Exchanges. SHOPs allow employers to research, compare, and purchase insurance coverage for their eligible employees. An employer and each of its employees who want coverage must submit an application to the SHOP. Once eligibility is determined, qualified employees are enrolled into the qualified health plan (QHP) offered through the SHOP on behalf of the employer.

To be eligible, an employer must offer coverage to all full-time employees (although the employer may elect to include part-time employees). And the SHOP must allow the employer to purchase coverage for employees at any time during the year. However, the plan can't be for a period of less than 12 months. The employer doesn't have to offer all of the SHOP's plans to employees', and the employer isn't required to contribute toward the employee's cost of insurance.

Basic state Exchange functions include access to a toll-free hotline and website for providing information on plans to current or prospective enrollees. Besides plan descriptions, the website also calculates the actual cost of coverage, taking into account eligibility for premium tax credits and cost sharing reductions.

Insurance Exchange particulars

States have the option of running their own state-based Exchange (SBE) or partnering with the federal government to operate a federally facilitated Exchange (FFE). States not making a choice default to a federally run Exchange. The ACA allows for some flexibility in the structure of individual state Exchanges while requiring some universal operating provisions. For instance, state Exchanges may be run by a new or existing state agency, a quasi-governmental agency, or a nonprofit entity. SBEs may elect to license with particular QHPs to actively control plan costs, or SBEs may follow the FFE model of an open marketplace--allowing all plans that meet minimum qualifications to participate.

Qualified health plans

In the past, insurers could deny coverage to individuals with pre-existing conditions, exclude coverage for pre-existing conditions, or offer coverage at higher premiums. Beginning in 2014, individuals seeking insurance through an Exchange can't be denied coverage due to pre-existing conditions, and insurance companies can't impose pre-existing condition exclusions.

The ACA also imposes rating restrictions that limit how much insurers can vary premiums for coverage based on an individual's health. Policies issued through an Exchange can't impose lifetime limits on the dollar value of coverage, nor may insurers place annual limits on the dollar value of coverage. Insurance must also be "guaranteed renewable" and can only be cancelled in cases of fraud.

In addition, Exchanges may only offer QHPs. Generally, QHPs must cover "essential benefits," limit out-of-pocket costs, and provide coverage based on four levels of cost sharing.

Essential benefits include ambulance, emergency, and hospitalization services; maternity and newborn care; mental health and substance abuse treatment; prescription drugs; rehabilitative and laboratory services; pediatric care; and preventive and wellness care management. Exchange plans are limited as to the amount of cost-sharing that may be imposed. Cost-sharing includes co-pays and deductibles for services. For example, Exchange plans can't impose a deductible for preventive health services.

QHPs also offer benefits based on four tiers of cost-sharing. These plans cover different percentages of medical costs, with each successive level contributing more toward the allowed charges. Bronze plans pay 60% of medical costs; Silver plans pay 70% of costs; Gold plans cover 80% of costs; and Platinum plans pay 90% of covered charges. The premium cost for each level of coverage generally increases with the percentage of costs the plan covers, with Platinum plans generally being the most expensive and Bronze plans having the lowest premium for the same individual and benefits package.

Also, Exchanges may also offer:

- Catastrophic coverage, which doesn't count as one of the four levels of coverage (although it must provide essential health benefits). But catastrophic coverage plans have lower premiums, higher cost-sharing, and are available only to individuals under 30 years of age, or individuals exempt from the insurance mandate.
- Dental benefits either in conjunction with a QHP or as a separate benefit.

Exchanges relate to other ACA provisions

The ACA mandates that most individuals maintain minimum health insurance coverage, beginning in 2014 and thereafter (exceptions apply). Failure to comply with this requirement potentially results in a tax penalty. Generally, all plans offered through Exchanges meet the "minimum health insurance coverage" requirement, as do employer-sponsored plans and Medicaid, so enrollment in an Exchange plan is not required to satisfy the mandate.

While employers aren't required to offer health insurance to their employees, certain large employers face a penalty if they don't offer coverage, or if they offer health insurance coverage that has a value less than a Bronze-level plan and at least one full-time worker enrolls in an Exchange and receives a premium credit. Exchanges are also responsible for notifying an employer that an employee has been found eligible for premium credits or cost-sharing subsidies.