Health Insurance Exchanges

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A key piece of the expansion of private health insurance through the 2010 Patient Protection and Affordable Care Act (ACA) was the creation of health insurance exchanges (HIX). This brief outlines state opportunities and challenges related to exchanges and examines implications from the June 2012 Supreme Court Ruling related to the ACA.

What is a Health Insurance Exchange?

A health insurance exchange (HIX) is an organization that attempts to create a more organized, competitive, and transparent marketplace for buying health insurance[1]. Exchange-like entities have been around in some states at least since 1993 and have achieved varying levels of success in maintaining strong pools of enrollees.

The ACA created two types of exchanges: the American Health Benefits Exchange (AHBE) for individuals, and the Small Business Health Options Program (SHOP). States can: (1) choose to operate the two types of exchanges together or separately; (2) create multiple exchanges of each type within a state as long as they serve separate geographic areas; (3) join with other states to create regional exchanges; or (4) choose to not create an exchange. If a state opts not to create an exchange, the federal government will create it in order to meet the law's requirement that every state have an operational exchange by January 1, 2014. Exchanges that are established and run by the states are referred to as State-Based Exchanges (SBE), while those that are established and operated in whole or in part by the federal government are referred to as Federally Facilitated Exchanges (FFE) and Partnership Exchanges respectively[2].

Table 1: What does a Health Insurance Exchange Do?
Both the AHBE and the SHOP perform the same general functions. They are required by the ACA to:
• Certify whether health plans are qualified to be offered in the exchange;
• Require plans 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 its 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, Children's Health Insurance Program (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 to 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[3]; and
• Adjust premiums among plans so that plans enrolling the sickest populations receive supplements from plans that enroll healthy populations (risk adjustment).

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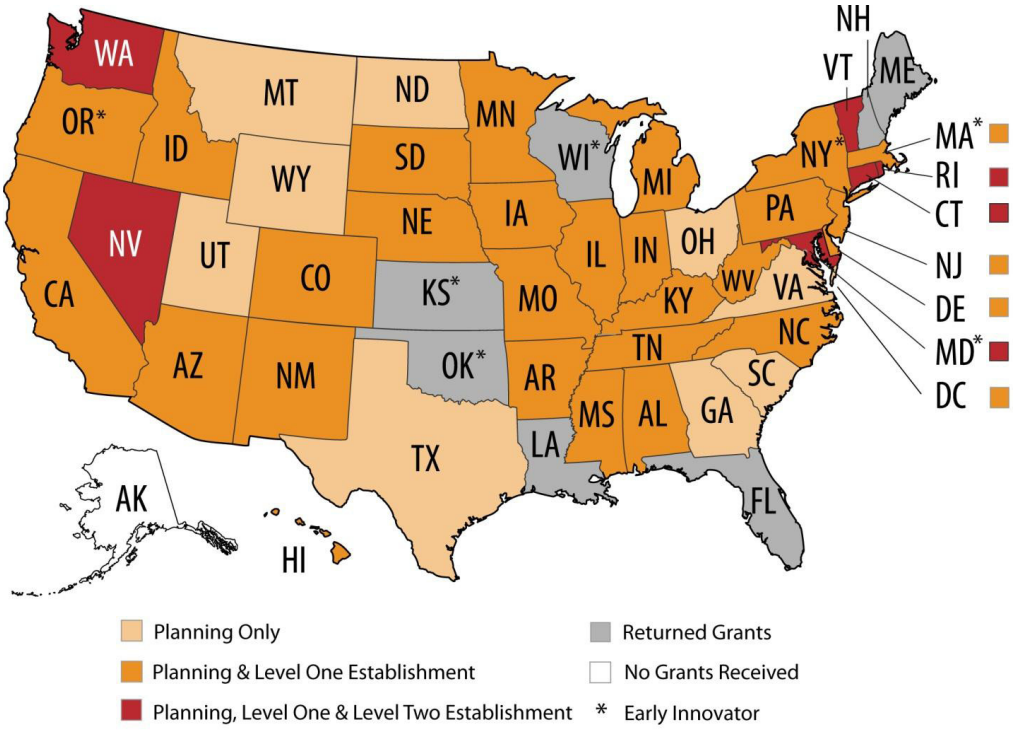
The key differences between the AHBE and the SHOP are whom they serve and the incentives they provide. The AHBE is designed for individuals who do not have access to an affordable health plan through an employer. Those who get coverage through the AHBE may be eligible for premium assistance credits to help offset the cost of health insurance. The credits will apply to individuals or families with modified adjusted gross income (MAGI) between 100 and 400 percent of the federal poverty level (FPL), which translates to between about $19,090 and $76,360 for a family of three in 2012. The premium credit diminishes as income increases. Some assistance with cost sharing (deductibles and coinsurance) may also be available for those with incomes below 250 percent of FPL who purchase coverage through the AHBE.

The SHOP is designed for small businesses up to 100 employees[4]. Tax credits of up to 50 percent of the employer's share of the premium to offset costs for coverage are currently available to businesses with fewer than 25 employees that pay annual average wages less than $50,000. In 2014, these tax credits will only apply to those purchasing coverage through the SHOP[5]. Businesses that do not meet these guidelines but still have fewer than 100 employees may benefit from increased plan selection, administrative simplification, and larger group purchasing power by purchasing coverage through the SHOP. Businesses of all sizes will still have the option after 2014 to purchase health plans outside the SHOP.

Federal Support for Health Insurance Exchange Establishment

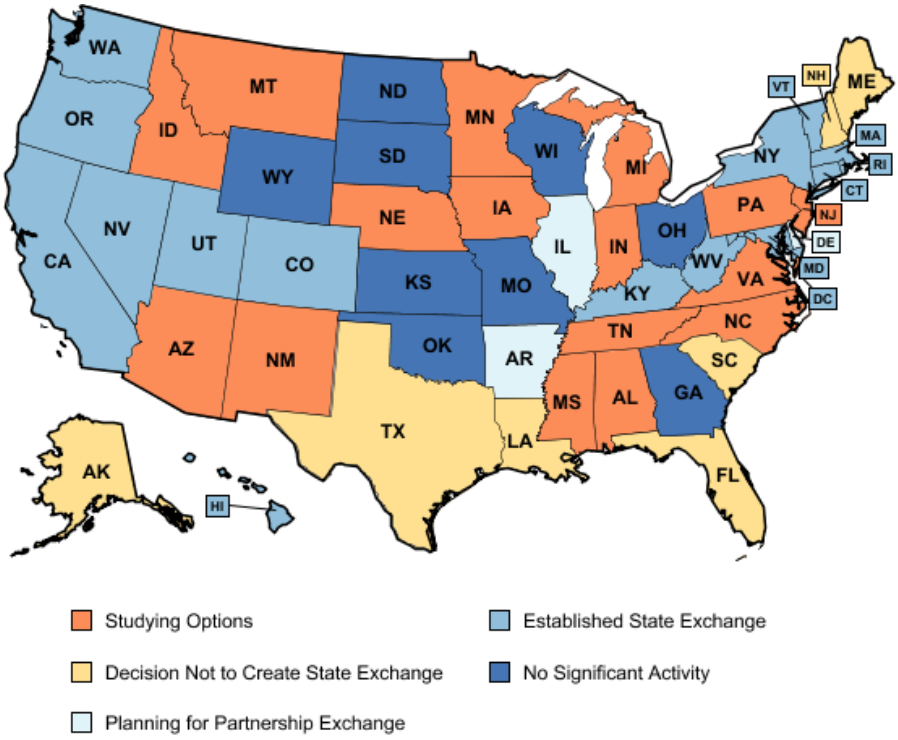
The federal government awarded several kinds of grants to states to establish exchanges. Planning grants of up to $1,000,000 were awarded to forty-nine states, but some states decided to send the money back to the federal government. Early innovator grants were awarded to seven states in early 2011 to develop information technology systems that would be available to other states. Three states – Oklahoma, Kansas, and Wisconsin – returned their grants. Level One and Two establishment grants became available in 2011 to enable states to develop policies and operational elements of their exchanges. As of August 24, 2012, thirty-four states and the District of Columbia had applied for and received Level One establishment grants – including seven with multiple grant awards – while six states had received Level Two funding[6]. The Center on Budget and Policy Priorities produced the map below detailing which states have received which grants.

HHS Exchange Grant Awards to States



Source: Center on Budget and Policy Priorities, Status of State Health Insurance Exchange Implementation, http://www.cbpp.org/files/CBPP-Analysis-on-the-Status-of-State-Exchange-Implementation.pdf, September 2012.

State Action toward Creating Health Insurance Exchanges *(as of August 1, 2012)*



Source: The Henry J. Kaiser Family Foundation, Establishing Health Insurance Exchanges: An Overview of State Efforts, http://www.kff.org/healthreform/upload/8213-2.pdf, August 2012.

State Options for Health Insurance Exchanges

States can choose to implement exchanges alone (the State-Based Exchange, or SBE) or let the federal government implement the exchanges for them (the Federally Facilitated Exchange, or FFE). In a recent development, the federal government is allowing states to partner with the federal government in a State Partnership Exchange where various exchange functions are divided between the state and the federal governments. Guidance was issued by the Health and Human Services (HHS) administration on May 16, 2012 for states that wish to establish a State Partnership Exchange[7]. The Henry J. Kaiser Foundation created the map above that details the progress states have made in their implementation of health insurance exchanges.

According to HHS guidance, "States seeking to operate a State-Based Exchange or electing to participate in a State Partnership Exchange must submit a complete Exchange Blueprint no later than 30 business days prior to the required approval date (November 16, 2012, for plan year 2014)[8]." As of the date of this brief, there is limited time for states to complete the initial work required to establish an exchange or have substantial input into the exchange design within their state. For those states that do meet the November 2012 deadline, they will have made a number of decisions regarding exchange policy and operation. The table below highlights some of the decisions for states.

Table 2: State Decisions[9]
Structure
• Exchange model: SBE, FFE, or partnership;
• Administration: new government agency, quasi-governmental agency, or non-profit;
• Effective date: before or after January 1, 2014;
• Exchange authority: Legislative, executive order, or other; and
• Contracting functions.
Governance
• One governing body for the AHBE and SHOP, or two separate bodies;
• Governing board size and appointment;
• Governing board membership criteria;
• Governing principles;
• Advisory boards; and
• Whether or not to establish a regional exchange.
Financing
• Financing model: Assessments, user fees, etc.; and
• Financing and exchange markets: Uniform or different assessments on issuers.

Note: The information shared in this brief is based on the law as it is known at this time and is our best interpretation of the data. As the law is written into rules and regulations, it will be further interpreted. Details may change during this process.

In addition, there are a number of decisions regarding the regulation of the insurance market outside the exchanges that states must make. For example, states have to decide whether and how states should require health plans operating outside the exchange to participate in the exchange, whether actual rating practices and the range of benefits offered in and outside of the exchange must be comparable, how to implement risk adjustment across plans, and the range of benefits required of plans in the exchange, among others[10]. Related to the question of benefits, HHS, in a December 16, 2011 rule[11], ceded much of the decision making related to essential health benefits to the states. Based on the needs of each state's population, states may benchmark the essential health benefits of plans offered in the exchange to:

- One of the three largest small group plans in the state by enrollment;
- One of the three largest state employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment; or,
- The largest HMO plan offered in the state's commercial market by enrollment[12].

Again, based on the Henry J. Kaiser Foundation's analysis of state actions, only about 18 states are in a position to be able to make these decisions on their own or in partnership with the federal government by the November 16, 2012 deadline.

How did the 2012 Supreme Court Decision Affect Health Insurance Exchanges?

The June 28, 2012 Supreme Court decision left the majority of the ACA intact, with changes to the Medicaid expansion provision allowing states the option of increasing Medicaid eligibility beyond what they currently provide. With the individual mandate upheld, AHBEs and SHOP exchanges will play critical roles in linking previously uninsured individuals to affordable coverage.

The Supreme Court's decision regarding Medicaid creates consequence for the implementation of the ACA. States can choose to not expand Medicaid, but federal subsidies within the SHBE are available only to those between 100 and 400 percent of FPL. Potentially, millions of individuals with incomes below 100 percent FPL could remain uninsured after 2014. Before the Supreme Court ruling, states were expected to expand their Medicaid programs to all adults with incomes at or below 133 percent of FPL or potentially lose all existing federal Medicaid funding. This would have provided a smooth transition between coverage through Medicaid and subsidized coverage through the SHBE. The decisions within each state on Medicaid expansion and determination of Medicaid eligibility levels will have significant effect on the potential demand for coverage within the exchange.

Conclusion

As it stands today, a minority of states are positioned to implement state exchanges and have control over the multitude of decisions that must be made regarding structure, governance, and financing. The remainder will have either federally facilitated exchanges, or state partnership exchanges where various exchange functions are divided between the state and the federal governments. HHS guidelines allow states to gradually assume control of either type of exchange after one year of operation.

References

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