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American Health Benefit Exchanges Fact Sheet

A Provision of the Patient Protection and Affordable Care Act (PPACA)

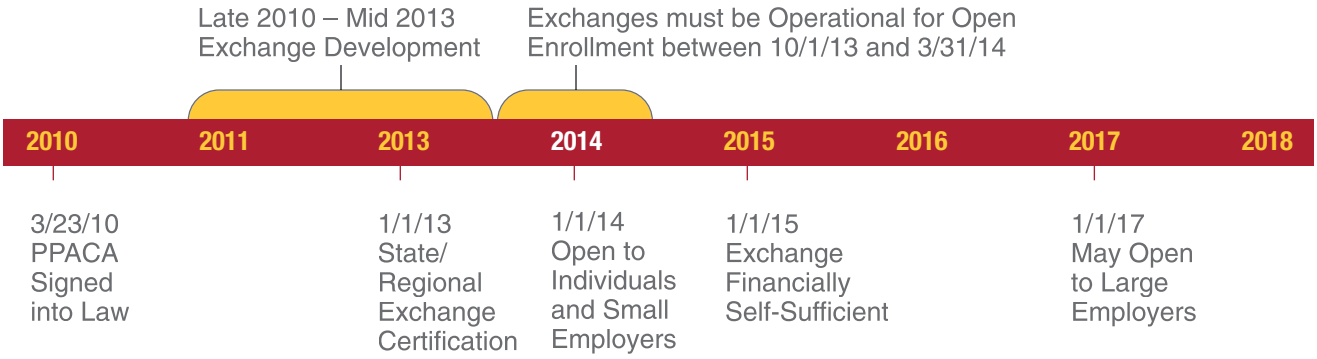
This Fact Sheet reflects the Final Ruling published by the Department of Health and Human Services (HHS) on March 12, 2012.

By 2014, states are required to operate health care exchanges that will be a new option for individuals and small employers to purchase health insurance, or states can defer to the federal government to establish an exchange for its citizens. Exchanges will offer standardized health plans, and individuals purchasing coverage through an exchange may be eligible for federal premium assistance under certain circumstances.

There are still many critical details yet to be clarified through regulations and as the states define their operating models. But the main objective of the exchanges is to make health insurance coverage more affordable, accessible and easier to purchase for small businesses and individuals.

In 2017, states may allow employers with more than 100 employees to purchase coverage on the exchange.

Exchanges Timeline



The Exchange Marketplace

There are several key things to know about the exchanges, including:

1. **Governance and Models** – Exchanges will vary from state to state but they all must conform to established requirements, which are to be determined by the Department of Health and Human Services (HHS) and states.
2. **Plan Requirements** – Any plan offered by an insurer or HMO through an exchange must be a Qualified Health Plan (QHP).
3. **Individuals** – Who might use the exchanges? Who is eligible for a subsidy?
4. **Employers** – Which small employers will consider sending their employees to the exchange? What are cost implications for employers whose employees opt-out and receive a subsidy?

1. Governance and Models

States have a number of things to consider as they develop their exchange. While more details are yet to come, here is some important information:

- ★ Each state must establish an individual and a small business exchange. States may choose to establish a single exchange that performs both functions.
- ★ Small Business Health Options Program (SHOP) exchanges are established to assist "small employers." Until 2016, states have the option of defining a "small employer" as 1-50 employees. In 2016, employers with 1-100 employees can participate in a SHOP. And after 2017, states may choose to offer large group coverage through the SHOP.
- ★ States may operate multiple exchanges within a state.
- ★ States may jointly form regional exchanges. States do not need to share a common border to be part of a regional exchange.
- ★ States may choose to establish and operate an exchange under a state-federal partnership model.
- ★ A federal exchange will be established for those states that choose not to build one, or that are not certified as ready in January 2013.

Exchanges must be operational for open enrollment by October 2013. It's expected that HHS will certify state or regional exchanges by January 1, 2013, confirming which ones are approved and prepared for open enrollment between October 1, 2013 and March 31, 2014. HHS may issue "conditional approval" to states that are making progress toward establishing an exchange even if the state cannot demonstrate full operational readiness by January 1, 2013. States that aren't ready for certification (or those that opt out) will instead participate in the federal exchange.

Governance

Exchange governance models options include:

- ★ ***Public Agency Model:*** Governed and administered by a state agency
- ★ ***Public Non-Profit Model:*** Independent nonprofit or authority separate from state government
- ★ ***Quasi-Governmental Model:*** Administered by a state agency and governed by an independent board

Exchanges that are run by independent agencies or non-profits must have governance principles, include consumer representation, and ensure freedom from conflicts of interest and promote ethical and financial disclosure standards.

Models

There are three types of exchange models.

- ★ ***Clearinghouses*** are places where employers and individuals can go to find a range of coverage offerings and compare price, quality and service levels. Participating plans compete for exchange enrollees based on cost and quality.
- ★ ***Market Organizers*** do not directly negotiate prices or selectively contract but may define standard benefit packages, provide some degree of endorsement, and otherwise encourage health plans to offer high-value coverage.
- ★ ***Active Purchasers*** negotiate and contract with select insurers to provide coverage.

Funding

To date, Health and Human Services has awarded states $314 million in grants. All state exchanges must be financially self-sustaining by 2015.

Navigator Program

Each exchange will have Navigators who will conduct public education activities, distribute information about exchange health plans and facilitate enrollment. Agents may serve as Navigators.

States are directed to choose at least two Navigator organizations (one of which must be a community or consumer-focused non-profit organization).

Agents and Brokers

States may allow agents and brokers to enroll qualified individuals, employers and employees in exchange coverage. In addition, a state may provide agent and broker information on its website.

2. Plan Requirements and Offerings

Exchanges will vary from state to state with regard to plan options and requirements. However, PPACA requires that a plan offered on the exchange must be a Qualified Health Plan (QHP). The legislation defines a QHP as an insurance plan that is certified by the exchange through which it is offered, provides essential health benefits, agrees to offer one silver plan, one gold plan and a child-only plan, agrees to charge the same premium for a particular plan whether sold on or off the exchange, and meets other requirements.

The benefit plans sold or offered on the exchange must include the following:

- ★ Essential health benefits (see box)
- ★ Fully insured plans only
- ★ Accreditation on clinical quality measures
- ★ No pre-existing conditions for all ages
- ★ No annual limits on essential health benefits
- ★ No lifetime dollar limits on essential health benefits
- ★ Minimum of five levels of coverage (see box)

Essential Health Benefits

Essential health benefits are yet to be defined, but the following items are likely to be included:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Laboratory services
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services, and devices
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Coverage Levels	
Plan	**% of Costs***
Catastrophic (Individual Only)	**Up to age 30/ exempt from mandate**
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

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

- QHPs must offer at least one silver plan, one gold and a child-only plan to participate on the exchange.
- Subsidies will be based on the second lowest cost silver plan available. (See individual section.).

Additionally:

- QHPs will need to offer a child-only plan.
- Standalone dental plans may be offered with a QHP.
- QHP networks must offer sufficient choice and include "essential community providers."
- Issuers may provide coverage through direct primary care medical homes that meet HHS criteria.

3. Individuals

Beginning in 2014, the Congressional Budget Office estimates about 25 million people will shop for coverage on the individual exchanges. This group might include people who are currently in the individual marketplace, unemployed, self-employed, or work for businesses that don't offer insurance or whose plan is unaffordable.

Financial Aid

- ★ About 19 million people who secure coverage through an exchange are likely to be eligible for a subsidy called a Federal Premium Assistance Tax Credit to help pay for their coverage.
- ★ The credit is available to individuals and families with incomes between 100% and 400% of the federal poverty level (as of today, approximately $45,000 for an individual or $92,000 for a family of four).
- ★ The credit amount is determined by the Secretary of Health and Human Services, based on the amount by which premiums exceed a threshold amount — that is, the maximum percentage of income that individuals will be required to pay toward the second-lowest cost "silver" exchange plan in the area. For those not eligible for Medicaid, the threshold rises from 2% of income for those at 133% of the federal poverty level to 9.5% of income for those at 400% of the federal poverty level.
- ★ For those not eligible for Medicaid and with a household income between 133% - 400% of FPL, the threshold rises incrementally from 2% to 9.5% of income. The size of the tax credits are determined on a sliding scale based on income, with the lowest incomes receiving the largest tax credit.

Enrollment

According to the Final Rule:

- ★ The initial open enrollment will run from October 1, 2013 through March 31, 2014.
- ★ Future open enrollments will be each year from October 15 through December 7.
- ★ Special enrollment must be granted to individuals with qualifying events between the 1st and 15th of any month, with coverage effective the first day of the following month.

Individual Responsibility

Beginning in 2014, all individuals must maintain "minimum essential coverage" through an employer-sponsored plan, or individual plan such as one purchased on an exchange. Failure to do so will result in a penalty or tax. The penalty is on a sliding scale for three years and is 1/12th of the greater of:

- **2014:** $95 per uninsured adult in the household or 1% of the household income over the filing threshold
- **2015:** $325 per uninsured adult in the household or 2% of the household income over the filing threshold
- **2016:** $695 per uninsured adult in the household or 2.5% of the household income over the filing threshold

The penalty will be half of the amounts listed above for those under age 18. The total household penalty may not exceed 300% of the adult penalty or the national average annual premium for bronze level health coverage.

Exceptions for individual responsibility include:

- Individuals not lawfully present in the U.S.
- Those who cannot afford coverage (contributions toward coverage exceed 8% of household income)
- Taxpayers with income under 100% of the poverty level (They qualify for Medicaid)
- Those who were not covered for a period of less than three months during the year

4. Employers

In 2014, many small employers sponsoring an insured group health plan will begin using SHOP exchanges.

SHOP exchanges will serve "small employers." Prior to plan years beginning on or after 1/1/16, states have the option of defining "small employer" as 1-50. For plan years beginning on or after 1/1/16, it's uniformly 1-100.

Assistance for Those With Fewer Than 25 Employees

Beginning in 2010, tax credits became available for small employers providing health insurance to their workers. Eligibility for this assistance is:

- ★ Limited to firms with fewer than 25 employees and where the average annual employee compensation does not exceed $50,000
- ★ Available to a "for-profit" business at 35% of the employer's cost of health insurance if the employer provides more than 50% of the employees' premium expenses
- ★ Available to small "not-for-profit" business at 25% of the employer's cost of insurance and offsets any payroll taxes that employees incur

These subsidies will increase in 2014 to 50% and 35% for the "for-profit" and "not-for-profit" businesses, respectively.

Employer Responsibility

Beginning in 2014, employers with 50 or more employees may be penalized whether or not they provide health coverage. Employers with fewer than 50 employees are exempt from penalties.

Employers that provide employee coverage are subject to penalties (see below) if the coverage is considered "unaffordable" or does not provide "minimum value." As defined by HHS:

- A plan provides minimum value if it pays at least 60% of the cost of services.
- A plan is affordable if a full-time employee does not have to pay more than 9.5% of ***household*** income for premium. As of September 2011, there is a proposed "safe harbor" so coverage would be considered affordable if the premium contribution for single coverage does not exceed 9.5% of an ***employee's*** W-2 wages.

	Employers who DO NOT provide coverage	Employers who DO provide coverage*
Trigger	At least one employee obtains subsidized coverage from the exchange	At least one employee receives subsidized coverage from the exchange
Fee	Must pay a fee equal to $2,000 per year for each full-time (30+ hours) employee minus the first 30 employees	Must pay a fee equal to the lesser of $3,000 for each employee receiving subsidized coverage or $2,000 for each full-time (30+ hours) employee minus the first 30 employees

** But the coverage is "unaffordable" or does not provide "minimum value."*

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Cigna's Guiding Principles for Exchanges

At Cigna, we support the development of an exchange marketplace that focuses on access, cost and quality. Our guiding principles for exchanges support a level playing field that includes:

- ★ ***Meaningful Choice*** – Plans should have the flexibility in product offering, cost-sharing, and network design to participate fully and provide choice to the consumers.
- ★ ***Transparency*** – A transparent governance model includes representation by a wide range of stakeholders; an open policy for state records, meetings and policies; and a not-for-profit or trust structure that's financed by a broad funding source.
- ★ ***Competition*** – Exchanges need to ensure competition on fundamentals and value, including the ability to offer qualified plans both on and off exchange.
- ★ ***Incentives for Healthy Outcomes*** – Exchanges should promote quality and improved health outcomes.

Next Steps and More Information

Here are a few suggestions of things you can do to learn more or become involved with exchanges.

- ★ **Make your views heard.** Contact your senator and/or representative so that they understand what is important to you. If your state exchange development involves committees or hearings, participate wherever possible.
- ★ **Ensure your employees are engaged** – in both their benefits and their health.
- ★ **Make changes as needed** to achieve short- and long-term objectives.
- ★ **Bookmark *InformedonReform.com*** – check back often for the latest updates and news alerts.

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