

HEALTH INSURANCE EXCHANGE FAQs

TABLE OF CONTENTS

INTRODUCTION 1

BACKGROUND 1

HEALTH INSURANCE EXCHANGE FAQs..... 1

INTRODUCTION

IN EARLY 2010, CONGRESS PASSED THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) AND WITH IT A NUMBER OF SWEEPING CHANGES THAT AFFECT ACCESS TO, DELIVERY OF, AND FINANCING OF ALL TYPES OF HEALTH CARE. A CENTRAL FEATURE OF THE NEW FEDERAL HEALTH CARE REFORM LAW IS THE CREATION OF STATE HEALTH INSURANCE EXCHANGES—MARKETPLACES IN WHICH CONSUMERS WILL SHOP FOR, COMPARE, AND ENROLL IN HEALTH INSURANCE PLANS. AS THE LAW IS IMPLEMENTED AND STATE INSURANCE EXCHANGES ARE ESTABLISHED, A NUMBER OF POLICY DECISIONS MUST TAKE PLACE BOTH AT THE FEDERAL AND STATE LEVELS. MANY OF THESE POLICY DECISIONS WILL DEPEND ON CRITICAL INPUT FROM STAKEHOLDERS, INCLUDING THE ORAL HEALTH PROVIDER COMMUNITY. IT IS CRITICAL, THEREFORE, THAT ADVOCACY EFFORTS BE APPROPRIATELY AND SUFFICIENTLY INFORMED.

IN KEEPING WITH THE GOALS OF THE STATE OF MISSISSIPPI AND THE MISSION OF THE MISSISSIPPI INSURANCE DEPARTMENT (MID), THE DEPARTMENT ENGAGED LEAVITT PARTNERS TO ASSIST IN PREPARING THIS DOCUMENT. THE PURPOSE OF THIS DOCUMENT IS TO PROVIDE EXCHANGE ADVISORY BOARD (EAB) MEMBERS A QUICK REFERENCE FOR SOME OF THE MOST FREQUENTLY ASKED QUESTIONS REGARDING STATE HEALTH INSURANCE EXCHANGES.

MISSION OF THE MISSISSIPPI INSURANCE DEPARTMENT

THE MISSISSIPPI INSURANCE DEPARTMENT MISSION IS TO IMPARTIALLY AND FAIRLY ENFORCE THE LAWS AND REGULATIONS ENUMERATED IN MISS. CODE ANN., § 83-1-1 ET. SEQ., THEREBY CREATING A COMPETITIVE MARKETPLACE FOR THE SALE OF INSURANCE PRODUCTS AND SERVICES WHILE PROVIDING THE STATE'S CITIZENS WITH THE MAXIMUM AMOUNT OF CONSUMER PROTECTION. OUR GOAL IS TO CREATE THE HIGHEST DEGREE OF ECONOMIC SECURITY, QUALITY OF LIFE, PUBLIC SAFETY AND FIRE PROTECTION FOR THE STATE'S CITIZENS AT THE LOWEST POSSIBLE COST. WE ARE COMMITTED TO PROVIDING ASSISTANCE TO MISSISSIPPIANS IN A TIMELY, CARING AND ETHICAL MANNER.

ABOUT LEAVITT PARTNERS

LEAVITT PARTNERS WAS FOUNDED IN 2009 BY FORMER UTAH GOVERNOR AND HHS SECRETARY MICHAEL O. LEAVITT. LEAVITT PARTNERS ADVISES CLIENTS IN THE PRACTICE AREAS OF HEALTH CARE WITH SPECIFIC GUIDANCE ON HEALTH REFORM AND GOVERNMENT ACTION. OUR TEAM INCLUDES INDIVIDUALS WITH DEEP EXPERIENCE IN HEALTH CARE REFORM AND A COMPREHENSIVE UNDERSTANDING OF THE HEALTH INSURANCE EXCHANGE ENVIRONMENT. WE APPLY THIS EXPERIENCE, OUR KNOWLEDGE AND A NETWORK OF GLOBAL RELATIONSHIPS TO SUPPLEMENT THE THINKING OF SENIOR EXECUTIVE TEAMS, FACILITATE CONNECTIONS, SOLVE PROBLEMS, CREATE VALUE AND DELIVER RESULTS.

BACKGROUND

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA)

THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) WAS SIGNED INTO LAW IN MARCH OF 2010, SETTING INTO MOTION A NUMBER OF GROUNDBREAKING PROVISIONS INTENDED TO TRANSFORM AND IMPROVE THE CURRENT HEALTH CARE SYSTEM. INCLUDED IN THE ACT ARE MEASURES THAT AIM TO EXPAND INSURANCE COVERAGE, STRENGTHEN QUALITY MEASUREMENT, PROMOTE PREVENTION, INCREASE THE PRIMARY CARE AND PUBLIC HEALTH WORKFORCE, AND DEVELOP MODELS FOR PAYMENT AND DELIVERY SYSTEM REFORM. TO ACCOMPLISH THESE PROVISIONS, THE LAW OUTLINES A SERIES OF PROCESSES, REQUIREMENTS AND MILESTONES TO BE MET. ONE OF THOSE PROVISIONS REQUIRES STATE TO ESTABLISH A HEALTH BENEFITS EXCHANGE.

STATES ARE DIRECTED TO ESTABLISH EITHER TWO SEPARATE HEALTH INSURANCE EXCHANGES—ONE AMERICAN HEALTH BENEFIT EXCHANGE (AHBE) FOR INDIVIDUALS TO PURCHASE COVERAGE AND ONE SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) WHERE SMALL EMPLOYERS MAY PURCHASE COVERAGE FOR THEIR FULL-TIME EMPLOYEES—OR A SINGLE EXCHANGE FOR USE BY BOTH INDIVIDUALS AND SMALL EMPLOYERS.

THERE ARE CURRENTLY TWO STATE-ESTABLISHED EXCHANGES IN OPERATION—MASSACHUSETTS' COMMONWEALTH CONNECTOR AND THE UTAH HEALTH EXCHANGE. PRIOR TO THE ADVENT OF FEDERAL REFORM, BOTH STATES INITIATED STATE-BASED INSURANCE MARKET REFORMS THAT INCLUDED ESTABLISHING EXCHANGES. THE MASSACHUSETTS AND UTAH MODELS SHARE A NUMBER OF COMMON COMPONENTS (THOUGH MOST WERE IMPLEMENTED IN A DIFFERENT ORDER OF PRIORITY) BUT ALSO INCLUDE A NUMBER OF DISTINCT AND IMPORTANT DIFFERENCES. MASSACHUSETTS BEGAN THEIR EFFORTS IN THE INDIVIDUAL MARKET AND STRUCTURED THEIR EXCHANGE AS A "SELECTIVE CONTRACTING AGENT", WHEREAS UTAH'S EFFORTS BEGAN IN THE SMALL GROUP MARKET AND THE EXCHANGE WAS STRUCTURED AS A "MARKET FACILITATOR" OR "FARMERS MARKET" MODEL.

WHILE PPACA ALLOWS THE U.S. SECRETARY OF HEALTH AND HUMAN SERVICES (HHS) CONSIDERABLE AUTHORITY OVER THE OPERATION OF THESE EXCHANGES, THE STATES WILL BE RESPONSIBLE FOR A NUMBER OF ORGANIZATION AND IMPLEMENTATION DECISIONS. THE DEADLINE FOR ESTABLISHING STATE-BASED EXCHANGES IS JANUARY 1, 2014. STATES CHOOSING TO ESTABLISH AND OPERATE THEIR OWN EXCHANGES WILL NEED TO ENGAGE IN SIGNIFICANT UP-FRONT PLANNING AND PREPARATION IN ORDER TO MEET THE 2014 DEADLINE. THOSE STATES ELECTING TO NOT ESTABLISH EXCHANGES WILL, IN EFFECT, ELECT TO PARTICIPATE IN A FEDERALLY ESTABLISHED EXCHANGE. THOSE STATES DEEMED BY HHS TO HAVE NOT MADE SUFFICIENT PROGRESS TOWARD ESTABLISHING AN OPERATIONAL EXCHANGE BY JANUARY 1, 2013 WILL AUTOMATICALLY DEFAULT INTO THE FEDERALLY ESTABLISHED EXCHANGE.

HEALTH INSURANCE EXCHANGE FAQs

ON MARCH 23, 2010, THE PATIENT PROTECTION AND AFFORDABLE CARE ACT (PPACA) WAS SIGNED INTO LAW. PPACA IS ALSO COMMONLY REFERRED TO AS THE AFFORDABLE CARE ACT, THE ACA, FEDERAL HEALTH CARE REFORM, AND OBAMACARE (GENERALLY USED PEJORATIVELY). THE LAW PUTS IN PLACE COMPREHENSIVE HEALTH INSURANCE REFORMS AND A MAJOR EXPANSION OF STATE MEDICAID PROGRAMS.¹

Q. WHAT ARE THE MAJOR HEALTH COVERAGE-RELATED PROVISIONS OF THE PPACA AND WHEN DO THEY TAKE EFFECT?

PROVISIONS OF THE LAW ARE SCHEDULED TO ROLL OUT OVER FOUR YEARS AND BEYOND, WITH MOST CHANGES TAKING PLACE BY 2014. SEVERAL KEY HEALTH COVERAGE PROVISIONS TOOK EFFECT IN 2010; MOST OF THE REMAINING COVERAGE PROVISIONS ARE SCHEDULED TO TAKE EFFECT IN JANUARY 1, 2014. SOME OF THESE MAJOR PROVISIONS INCLUDE:

2010

- PROHIBITION OF DENYING COVERAGE OF CHILDREN BASED ON PRE-EXISTING CONDITIONS
- REGULATION OF ANNUAL LIMITS ON INSURANCE COVERAGE
- DISALLOWANCE OF CHARGING A DEDUCTIBLE, CO-PAYS, OR CO-INSURANCE FOR CERTAIN PREVENTIVE SERVICES
- EXTENSION OF COVERAGE FOR YOUNG ADULTS BY ALLOWING THEM TO STAY ON THEIR PARENT'S PLAN UNTIL THEY TURN 26 YEARS OLD.²
- INSURANCE COMPANIES PROHIBITED FROM RESCINDING COVERAGE EXCEPT IN CERTAIN CASES
- ELIMINATION LIFETIME LIMITS ON INSURANCE COVERAGE
- CREATION OF RATE REVIEW PROGRAMS IN STATES INTENDED TO GUARD AGAINST HEALTH INSURANCE RATE INCREASES DEEMED "UNREASONABLE".³
- AVAILABILITY OF SMALL BUSINESS TAX CREDITS FOR PURCHASE OF EMPLOYEE HEALTH INSURANCE COVERAGE.⁴

2011

- IMPLEMENTATION OF THE MINIMUM MEDICAL LOSS RATIO (MLR) PROVISION IN EVERY STATE.⁵

2014

- GUARANTEED ISSUE AND COMMUNITY RATING ⁶
- ENFORCEMENT OF THE LAW'S INDIVIDUAL MANDATE
- ENFORCEMENT OF THE LAW'S EMPLOYER PENALTY FOR NO INSURANCE
- ELIMINATING ANNUAL LIMITS ON INSURANCE COVERAGE
- ESTABLISHMENT OF STATE HEALTH INSURANCE EXCHANGES
- AVAILABILITY OF FEDERAL PREMIUM TAX CREDITS FOR PAYMENT OF HEALTH INSURANCE COVERAGE ⁷
- AVAILABILITY OF ENHANCED SMALL BUSINESS TAX CREDITS
- EXPANSION OF STATE MEDICAID PROGRAMS UP TO 138% ⁸ OF THE FEDERAL POVERTY LEVEL ⁹

Q. WHAT IS A HEALTH INSURANCE EXCHANGE?

A HEALTH INSURANCE EXCHANGE IS A VIRTUAL MARKETPLACE—AN ONLINE TOOL THAT ENABLES INDIVIDUALS TO SHOP, COMPARE, AND ENROLL IN A HEALTH INSURANCE PLAN. AN EXCHANGE PROVIDES CONSUMERS WITH AGGREGATED HEALTH PLAN INFORMATION FROM MULTIPLE CARRIERS IN A WAY THAT PERMITS EASY COMPARISON OF AVAILABLE HEALTH PLANS BASED ON PRICE, BENEFITS, SERVICES AND QUALITY. HEALTH INSURANCE EXCHANGES ARE INTENDED TO CREATE MORE EFFICIENT AND COMPETITIVE MARKETS FOR INDIVIDUALS AND SMALL EMPLOYERS BY REDUCING TRANSACTION COSTS AND INCREASING TRANSPARENCY.

Q. WHO MUST ESTABLISH A HEALTH INSURANCE EXCHANGE?

UNDER PPACA, ALL STATES AND THE DISTRICT OF COLUMBIA MUST ESTABLISH TWO TYPES OF HEALTH INSURANCE EXCHANGES-- THE AMERICAN HEALTH BENEFIT EXCHANGE (AHBE) AND THE SMALL BUSINESS HEALTH OPTIONS PROGRAM EXCHANGE (SHOP).

Q. WHAT IS THE DIFFERENCE BETWEEN THE AMERICAN HEALTH BENEFIT EXCHANGE (AHBE) AND THE SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP) EXCHANGES?

IN 2014, **INDIVIDUALS AND FAMILIES** MAY PURCHASE QUALIFIED COVERAGE THROUGH THE AHBE AND **SMALL BUSINESSES** ¹⁰ WITH UP TO 100 EMPLOYEES MAY PURCHASE QUALIFIED COVERAGE THROUGH THE SHOP. BEGINNING IN 2017, STATES MAY ALLOW INSURERS TO OFFER LARGE GROUP PLANS (TO EMPLOYERS WITH MORE THAN 100 EMPLOYEES) THROUGH THE EXCHANGE.

Q. WHAT IS THE TIMING ASSOCIATED WITH IMPLEMENTATION OF THE PPACA, INCLUDING

EXCHANGE ESTABLISHMENT?

BY LAW, STATE HEALTH INSURANCE EXCHANGES MUST BE OPERATIONAL BY JANUARY 1, 2014. BY JANUARY 1, 2013, HHS MUST MAKE STATE-BY-STATE DETERMINATIONS AS TO WHETHER STATES HAVE MADE SUFFICIENT PROGRESS TO MEET THE 2014 DEADLINE. THOSE STATES DEEMED BY HHS TO HAVE NOT MADE SUFFICIENT PROGRESS TOWARD ESTABLISHING AN OPERATIONAL EXCHANGE BY JANUARY 1, 2013 WILL AUTOMATICALLY DEFAULT INTO A FEDERALLY ESTABLISHED EXCHANGE.

Q. ARE THERE CURRENTLY ANY STATE HEALTH INSURANCE EXCHANGES THAT ARE FUNCTIONAL?

YES, IN MASSACHUSETTS AND IN UTAH; HOWEVER, BOTH OF THESE EXCHANGES WERE ESTABLISHED PRIOR TO THE ADVENT OF THE PPACA AND BOTH WILL NEED TO BE MODIFIED IN ORDER TO BE FULLY PPACA-COMPLIANT.¹¹

Q. WHAT KIND OF EXCHANGE OVERSIGHT MUST STATES ESTABLISH?

EXCHANGE OVERSIGHT IS A BROAD TERM THAT GENERALLY REFERS TO 1) REGULATORY AUTHORITY, 2) NON-REGULATORY POLICY-MAKING AUTHORITY AND 3) OPERATION/ADMINISTRATIVE FUNCTIONS. HOW THESE DUTIES SHOULD BE SCOPED, ASSIGNED, COMBINED, LAYERED, OR LIMITED IS ALMOST ENTIRELY UP TO THE STATE. THEREFORE, EXCHANGE OVERSIGHT AUTHORITY WILL VARY FROM STATE TO STATE, DEPENDING ON THE STATE'S OVERSIGHT NEEDS, POLICY GOALS, PUBLIC AND PRIVATE RESOURCES, AND EXISTING CONSTITUTIONAL LAWS.

Q. WHERE WILL STATE EXCHANGES BE LOCATED INSTITUTIONALLY?

PPACA ALLOWS STATES TO ESTABLISH THE EXCHANGE IN TWO BASIC WAYS: INSIDE OR OUTSIDE OF GOVERNMENT. SOME STATES WILL CHOOSE TO ESTABLISH A NEW GOVERNMENTAL AGENCY FOR PURPOSES OF EXCHANGE OPERATION WHILE OTHER STATES WILL HOUSE THEIR EXCHANGE WITHIN AN EXISTING STATE AGENCY. ALTERNATIVELY, THE LAW ALSO ALLOWS STATES TO ESTABLISH A NONPROFIT ENTITY SUCH AS A PUBLIC CORPORATION OR AN INDEPENDENT PUBLIC AUTHORITY TO OVERSEE EXCHANGE OPERATIONS.¹²

Q. WHAT WILL BE THE ROLE OF THE STATE EXCHANGE?

THIS DECISION IS ALMOST ENTIRELY LEFT UP TO THE STATES AND PRIMARILY DEPENDS ON WHAT STATE POLICY MAKERS DETERMINE IS NECESSARY, SUFFICIENT, AND APPROPRIATE IN ORDER TO ACHIEVE CERTAIN POLICY OBJECTIVES (SUCH AS EXPANDING ACCESS, FOSTERING COMPETITION, ETC.)

THE ROLE OF ANY SINGLE STATE EXCHANGE GENERALLY FALLS ALONG A SPECTRUM, WITH “ACTIVE PURCHASER” AT ONE END AND “OPEN MARKETPLACE” AT THE OTHER, AND A “SELECTIVE CONTRACTOR” SOMEWHERE IN BETWEEN. THE ROLE OF AN “OPEN MARKETPLACE” EXCHANGE IS SIMILAR TO THAT OF A STOCK EXCHANGE—PROVIDE AN OPEN FORUM AND GENERAL STRUCTURE CAPABLE OF FACILITATING MARKET COMPETITION, ESTABLISH CERTAIN BASIC RULES TO WHICH ALL PARTICIPATING BUYERS AND SELLERS MUST ABIDE, AND SERVE AS A SOURCE OF RELIABLE, IMPARTIAL INFORMATION ABOUT THE PLANS AVAILABLE IN THE MARKET. AN “ACTIVE PURCHASER” EXCHANGE TAKES A MORE HANDS-ON APPROACH BY LIMITING THE NUMBER OF SELLERS IN THE MARKET THROUGH SELECTIVE CONTRACTING, ESTABLISHING AND STANDARDIZING PLAN DESIGN PARAMETERS, AND DIRECTLY NEGOTIATING RATES WITH CONTRACTED PLANS. A “SELECTIVE CONTRACTOR” EXCHANGE IS QUITE SIMILAR TO AN “ACTIVE PURCHASER”; HOWEVER, UNDER THIS MODEL THE EXCHANGE GENERALLY DOES NOT NEGOTIATE PREMIUM PRICES DIRECTLY WITH INSURANCE CARRIERS; HOWEVER, THE EXCHANGE DOES LIMIT THE NUMBER OF PARTICIPATING CARRIERS AND ONLY OFFERS INSURANCE PLANS THAT HAVE BEEN SPECIFICALLY ENDORSED BY THE EXCHANGE AS HAVING MET CERTAIN CRITERIA.

HHS HAS INDICATED THAT AN “OPEN MARKETPLACE” EXCHANGE, A “SELECTIVE CONTRACTOR”, AN “ACTIVE PURCHASER” EXCHANGE, OR MOST ANYTHING IN BETWEEN IS ACCEPTABLE.¹³

Q. HOW DO STATES FUND THE DEVELOPMENT AND OPERATION OF AN EXCHANGE?

CURRENTLY, EXCHANGE DEVELOPMENT IS BEING FUNDED THROUGH A SERIES OF FEDERAL GRANTS AVAILABLE THROUGH THE END OF 2014. EXCHANGES MUST BE SELF-SUSTAINING BEGINNING IN 2015, AND MAY GENERATE REVENUE THROUGH ASSESSMENTS, USER FEES OR OTHER MEANS.

Q. CAN STATES COME TOGETHER TO FORM MULTI-STATE EXCHANGES?

YES, AN EXCHANGE MAY OPERATE IN MORE THAN ONE STATE IF EACH STATE IN WHICH THE

EXCHANGE OPERATES PERMITS SUCH AN OPERATION AND HHS APPROVES SUCH A REGIONAL OR INTERSTATE EXCHANGE.

Q. WHAT HAPPENS IF A STATE IS UNABLE OR CHOOSES NOT TO ESTABLISH AN EXCHANGE?

IF HHS DETERMINES BY JANUARY 1, 2013 THAT A STATE WILL NOT BE OPERATING AN EXCHANGE, HHS WILL OPERATE THAT STATE'S EXCHANGE, EITHER DIRECTLY OR THROUGH AGREEMENT WITH A NON-PROFIT ENTITY. BROADLY SPEAKING, THERE ARE THREE SCENARIOS UNDER WHICH HHS WOULD OPERATE A STATE'S EXCHANGE:

- 1) FOR PRACTICAL OR POLITICAL REASONS, THE STATE ELECTED TO NOT BUILD AN EXCHANGE
- 2) FOR PRACTICAL OR POLITICAL REASONS, THE STATE WAS UNABLE TO MAKE SUFFICIENT PROGRESS TOWARD ENSURING THE EXCHANGE WOULD OPERATIONAL BY JANUARY 1, 2014, OR
- 3) FOR PRACTICAL OR POLITICAL REASONS, THE STATE DID NOT TAKE NECESSARY ACTIONS TO IMPLEMENT OTHER MARKET REFORMS REQUIRED UNDER PPACA

Q. WHAT TYPES OF PREMIUM ASSISTANCE IS AVAILABLE THROUGH THE EXCHANGE AND WHO IS ELIGIBLE?

STARTING IN 2014, INDIVIDUALS AND FAMILIES WITH INCOMES BETWEEN 100% AND 400% OF THE FEDERAL POVERTY LINE (FPL)¹⁴ WHO ARE NOT ELIGIBLE FOR OTHER AFFORDABLE¹⁵ COVERAGE WILL BE ELIGIBLE FOR A FEDERAL PREMIUM TAX CREDIT FOR PURCHASE OF INSURANCE COVERAGE THROUGH A HEALTH INSURANCE EXCHANGE.

ALSO IN 2014, SMALL BUSINESSES PURCHASING COVERAGE THROUGH THE SHOP MAY BE ELIGIBLE FOR FEDERAL PREMIUM TAX CREDITS, PROVIDED THEY MEET CERTAIN REQUIREMENTS.¹⁶

Q. WHAT KIND OF HEALTH CARE COVERAGE WILL BE OFFERED THROUGH THE EXCHANGE?

ALL PLANS AVAILABLE IN THE EXCHANGE MUST MEET CERTAIN REQUIREMENTS IN ORDER TO BE CERTIFIED AS A "QUALIFIED HEALTH PLAN" (QHP). QUALIFIED HEALTH PLANS MUST PROVIDE TREATMENT AND SERVICES MEETING THE CRITERIA OF "ESSENTIAL HEALTH BENEFITS", AS DEFINED BY STATUTE (GENERALLY) AND BY HHS (MORE SPECIFICALLY) AND ARE SUBJECT TO CERTAIN LIMITS ON COST-SHARING.¹⁷ IN ADDITION, INSURERS MUST BE LICENSED AND IN GOOD STANDING IN EACH STATE IN WHICH IT OFFERS POLICIES, MUST OFFER PLANS OF CERTAIN ACTUARIAL VALUES¹⁸, AND MUST PRICE PLANS THE SAME, WHETHER THEY ARE SOLD INSIDE OR OUTSIDE OF THE EXCHANGE. EXCHANGES MAY NOT SELL PLANS THAT ARE NOT "QUALIFIED HEALTH PLANS", EXCEPT

FOR STAND-ALONE DENTAL PLANS, SO LONG AS THOSE PLANS OFFER PEDIATRIC DENTAL BENEFITS MEETING THE REQUIREMENTS OF THE LAW.

Q. CAN INSURANCE COVERAGE STILL BE PURCHASED OUTSIDE OF HEALTH INSURANCE EXCHANGES?

HEALTH INSURANCE EXCHANGES ARE INTENDED TO OPERATE PARALLEL TO THE EXISTING INDIVIDUAL AND SMALL GROUP MARKETS. NOTHING IN THE PPACA PROHIBITS AN INSURER FROM OFFERING INSURANCE OUTSIDE OF THE STATE EXCHANGE OR ELIGIBLE INDIVIDUALS AND EMPLOYERS FROM PURCHASING COVERAGE OUTSIDE THE EXCHANGE. NO INDIVIDUAL OR EMPLOYER CAN DIRECTLY BE COMPELLED TO PURCHASE COVERAGE THROUGH THE EXCHANGE.

Q. WHAT TREATMENTS AND SERVICES MUST BE COVERED UNDER THE “ESSENTIAL HEALTH BENEFITS” (EHB) PACKAGE?

THE SCOPE OF BENEFITS IS TO BE DETERMINED BY THE SECRETARY OF HHS AND EQUAL TO THE SCOPE OF BENEFITS UNDER A TYPICAL EMPLOYER-BASED PLAN. HHS HAS YET TO FINALIZE THE SCOPE; HOWEVER THE LAW PROVIDES THAT THE FOLLOWING GENERAL CATEGORIES OF SERVICES MUST BE COVERED:

- AMBULATORY PATIENT SERVICES
- EMERGENCY SERVICES
- HOSPITALIZATION
- MATERNITY AND NEWBORN CARE
- MENTAL HEALTH AND SUBSTANCE ABUSE DISORDER SERVICES, INCLUDING BEHAVIORAL HEALTH TREATMENT
- 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

IN THE ESSENTIAL HEALTH BENEFITS BULLETIN ISSUED ON DECEMBER 16, 2011, HHS INDICATED IT WOULD GIVE STATES MORE FLEXIBILITY IN IMPLEMENTING ASPECTS OF HEALTH REFORM. UNDER THE DEPARTMENT’S INTENDED APPROACH, STATES WOULD HAVE THE FLEXIBILITY TO SELECT AN EXISTING STATE HEALTH PLAN AS THE “BENCHMARK” FOR THE ITEMS AND SERVICES INCLUDED IN THE ESSENTIAL HEALTH BENEFITS PACKAGE. FOR EXAMPLE, STATES

COULD CHOOSE ONE OF THE FOLLOWING HEALTH INSURANCE PLANS AS THEIR BENCHMARK:

1. ONE OF THE THREE LARGEST SMALL GROUP PLANS IN THE STATE
2. ONE OF THE THREE LARGEST STATE EMPLOYEE HEALTH PLANS
3. ONE OF THE THREE LARGEST FEDERAL EMPLOYEE HEALTH PLAN OPTIONS
4. THE LARGEST HMO PLAN OFFERED IN THE STATE'S COMMERCIAL MARKET

Q. WHO IS REQUIRED TO PURCHASE COVERAGE UNDER THE LAW'S INDIVIDUAL MANDATE?

STARTING IN 2014, MOST AMERICANS MUST BE ENROLLED IN A HEALTH INSURANCE PLAN THAT MEETS BASIC MINIMUM STANDARDS AS DEFINED BY HHS. THOSE WHO AREN'T ARE SUBJECT TO PAYMENT OF A PENALTY. WAIVERS MAY BE GRANTED FOR PERSONS FOR WHOM COVERAGE IS DETERMINED TO BE "UNAFFORDABLE"¹⁹ OR FOR OTHER REASONS SUCH AS RELIGIOUS BELIEFS.

Q. ARE EMPLOYERS REQUIRED TO OFFER INSURANCE COVERAGE UNDER THE LAW?

UNDER PPACA, NO EMPLOYER IS REQUIRED TO OFFER EMPLOYER-SPONSORED INSURANCE; HOWEVER, A PENALTY OF \$2,000 PER EMPLOYEE WOULD APPLY TO COMPANIES WITH 50 OR MORE EMPLOYEES²⁰ THAT DON'T OFFER HEALTH BENEFITS. EMPLOYERS WITH 50 OR MORE WORKERS THAT DO PROVIDE HEALTH INSURANCE BENEFITS COULD BE SUBJECT TO THE PENALTY IF JUST ONE EMPLOYEE APPLIES FOR A FEDERAL SUBSIDY TO HELP PAY FOR THEIR HEALTH CARE INSURANCE. COMPANIES WITH FEWER THAN 50 WORKERS ARE EXEMPT FROM THE PER-EMPLOYEE PENALTY.²¹

ENDNOTES

1. The law actually references the combined provisions of two acts: The Patient Protection and Affordable Care Act (P.L. 11-148), enacted March 23, 2010 and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152, enacted March 30, 2010).
2. Children can join or remain on their parent's plan up to age 26 even if they are married, not living with the parent, attending school, not financially dependent on the parent, or eligible to enroll in their own employer's insurance plan.
3. Starting on September 1, 2011, health insurers must justify any rate increase of 10% or more before the increase takes effect.
4. For tax years 2010 through 2013, the maximum credit is 35 percent for small business employers and 25 percent for small tax-exempt employers such as charities. To be eligible, employers must also have fewer than 25 full-time equivalent employees (FTEs) and those employees must have average wages of less than \$50,000 a year. In addition, employers must cover at least 50 percent of the cost of single (not family) health care coverage for each of employee in order to be eligible.
5. The law generally requires that at least 85% of all premium dollars collected by insurance companies for large employer plans to be spent on health care services and health care quality improvement and allows a maximum of 15% to go toward administrative costs or profits. For plans sold to individuals and small employers, at least 80% of the premium must be spent on benefits and quality improvement. If insurance companies do not meet these goals, the law requires them to provide rebates to consumers.
6. Will require insurers to offer the same premium to all applicants of the same age and geographical location without regard to most pre-existing conditions (excluding tobacco use)
7. In general, on Jan. 1, 2014, the maximum credit will increase from 35 percent for small business employers and 25 percent for small tax-exempt employers such as charities, to 50 percent and 35 percent, respectively.
8. The law calls for Medicaid to be expanded to those earning up to 133% FPL; however, due to the allowable 5% income disregard, the effective eligibility threshold is 138%.
9. 138% FPL would be about \$15,000 annually for an individual and about \$30,843 for a family of four according to the 2011 Poverty Guidelines for the 48 Contiguous States and the District of Columbia
10. Small group market is defined to include employers with 1-100 employees. Until January 1, 2016, states may elect to define it as employers with 1-50 employees.
11. The Massachusetts Commonwealth Connector – <https://www.mahealthconnector.org/> and the Utah Health Exchange - <http://exchange.utah.gov/>
12. Definitions of terms such as “public corporation” and “public authority” differ from state to state. Additionally, some states may have constitutional constraints that prevent them from turning over certain duties (regulatory functions, tax assessment, etc.) that, under PPACA, are considered “functions of an exchange” to non-governmental non-profit entities.
13. In its Initial Guidance to States on Exchanges issued November 18, 2010, HHS indicated, “States have a range of options for how the Exchange operates from an “active purchaser” model, in which the Exchange

operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers, to an “open marketplace” model, in which the Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings.”

14. 100% FPL would be about \$10,890 annually for an individual and about \$22,350 for a family of four according to the 2011 Poverty Guidelines for the 48 Contiguous States and the District of Columbia. 400% FPL would be about \$10,890 annually for an individual and about \$89,400 for a family of four, according to the same source.
15. If an individual is offered employer-sponsored coverage but is not enrolled in the coverage and if the individual’s required contribution toward the plan premium would exceed 9.5% of their household income, or if the plan pays for less than 60%, on average, of covered health expenses, then the individual is determined to not have access to minimum affordable coverage.
16. An employer is generally eligible if the employer 1) has fewer than 25 full-time equivalent employees (“FTEs”) for the tax year 2) the average annual wages of employees for the year is less than \$50,000 per FTE, and 3) the employer pays at least 50% of the cost of single coverage under a “qualifying arrangement” as defined by the IRS.
17. Cost-sharing under a health plan in the exchange may not exceed the cost-sharing for high-deductible health plans in 2014 (currently \$5,950 individual/\$11,900 family). In following years, the limitation on cost-sharing is indexed to the rate or average premium growth. Deductibles for plans in the small group market are limited to \$2,000 individual/\$4,000 family, indexed to average premium growth. This amount may be increased by the maximum amount of reimbursement available to an employee under a flexible spending arrangement.
18. The law calls for plans to be categorized according to four tiers: Bronze plans must provide coverage that provides benefits that are actuarially equivalent to 60% of the full actuarial value of benefits under the plan. Silver, Gold, and Platinum plans must provide benefits that are actuarially equivalent to 70%, 80%, and 90% (respectively) of the full actuarial value of benefits under the plan.
19. If the cost of minimum coverage (as defined by HHS) exceeds 9.5% of the monthly income of an individual or family, it is determined to be unaffordable.
20. In general, to be subject to these penalties must have “at least 50 full-time employees during the preceding calendar year.” “Full-time employees” are defined as those working 30 or more hours per week. The number of full-time employees excludes those full-time seasonal employees who work fewer than 120 days during the year.
21. In 2014, the monthly penalty assessed to the employer for each full-time employee who receives a premium credit will be 1/12 of \$3,000 for any applicable month. However, the total penalty for an employer would be limited to the total number of the firm’s full-time employees minus 30, multiplied by 1/12 of \$2,000 for any applicable month. After 2014, the penalty amounts would be indexed by a premium adjustment percentage for the calendar year.