



## FEDERAL HEALTH CARE REFORM: STATE HEALTH INSURANCE EXCHANGES

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In March 2010, federal health care reform, also known as the Patient Protection and Affordable Care Act (PPACA), was adopted by the U.S. Congress and signed by the President. PPACA expands health care coverage by increasing access to private health insurance and expanding eligibility for Medicaid. The law also increases regulations on health insurance providers and makes changes to how the health insurance market operates. PPACA also places requirements on individuals to have health care coverage and on employers to offer health insurance to employees.

This issue brief, part of a series on federal health care reform, examines state-based health insurance exchanges. Other topics in this series include the expansion of Medicaid and changes to health insurance laws.

### Introduction

A key component of health care reform is the creation of state-based health insurance exchanges. Health insurance exchanges are regulated marketplaces in which individuals and small businesses can shop for health insurance. Several goals of health insurance exchanges are to:

- foster a competitive marketplace that gives consumers and businesses access to health insurance;

- provide information about the coverage, costs, and quality of health plans to consumers;
- ensure that health plans meet minimum standards for costs and quality; and
- assist consumers who may qualify for federal subsidies to purchase insurance, or are eligible for public health plans.

### Structure and Operations

State health insurance exchanges must be operational by January 1, 2014. If a state has not taken action to establish an exchange by January 1, 2013, the federal government is to create the exchange within that state. Although states have some discretion in establishing exchanges, federal law includes requirements that all state exchanges must meet. For example, exchanges must either be a governmental agency or a nonprofit entity that is established by the state. Also, among the various duties specified in federal law, the exchanges must:

- only offer qualified health plans;
- develop procedures for the certification of plans as qualified health plans; and
- offer health plans for both the individual and the small group markets.

States may elect to create a single exchange for both the individual and small group markets, or to operate two separate exchanges. States also have the option to make large group coverage available through exchanges beginning in 2017.

## Eligibility to Participate in Health Exchanges

Only U.S. citizens and legal immigrants who are not incarcerated are allowed to purchase health insurance through a state exchange. To be eligible for federal subsidies to purchase insurance on an exchange, a person must meet one of the following criteria:

- not be offered health insurance by his or her employer;
- only be offered health insurance by his or her employer that does not provide essential benefits; has a high level of cost sharing (such as deductibles and co-payments); or requires the employee to pay more than 9.5 percent of family income for the employee share of the premium; or
- not be eligible for Medicaid, Medicare, or other public health program.

For small businesses, federal law states that only a qualified small business may purchase insurance for its employees through the exchange. States have the option of defining small businesses as having up to 100 employees. Additional rules specifying which businesses are qualified to purchase in the exchanges have not yet been established by the federal Department of Health and Human Services.

## Determination of Federal Subsidies

Persons who purchase health insurance through a state-based exchange may qualify for federal premium subsidies if they have income between 133 percent and 400 percent of the federal poverty level. The health insurance exchanges are responsible for informing people about their eligibility for federal premium subsidies. Premium subsidies are made available through a refundable and advanceable tax credit, which means that the premium subsidy would be provided even if the person has no other tax liability. It is made available when insurance is

purchased, rather than at end of the year when a tax return is filed. The federal Department of the Treasury is required to make rules about how the premium tax credit will be provided and will set forth the duties of state-based exchanges in the process.

## Qualified Health Plans

Federal health reform specifies that only qualified health plans may be sold through state insurance exchanges. It is the responsibility of the exchange to certify each health plan offered by insurers in the exchange. To be certified as a qualified health plan, insurance providers must, among other requirements:

- include essential health benefits in all health plans, as defined in law and rule (see Table 1);
- be properly licensed and in good standing in the state;
- offer at health plans at specified coverage levels on the exchange; and
- set premiums for plans offered through the exchange at the same level as identical plans offered outside the exchange.

**Table 1**  
**Essential Health Benefits for Qualified Health Plans on State Exchanges**

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services
- Chronic disease management
- Pediatric services, including oral and vision care
- Other services as defined by the Secretary of Health and Human Services

Source: Patient Protection and Affordable Care Act.

Federal law allows qualified health plans on state exchanges to be offered at several coverage levels. The coverage levels are based on the actuarial value of the plans. A health insurance plan's actuarial value refers to the average share of medical spending that is paid for by the plan as opposed to by the covered person. Actuarial value depends on the plan's cost-sharing requirements, as well as the specific services that the plan covers. The coverage levels created by PPACA are intended to give consumers a simple way to judge how generous the benefits of health plans are when shopping for coverage. The coverage levels of health plans, in order of actuarial value, are bronze, silver, gold, and platinum. Plans at each of the coverage levels can be expected to pay at least the following percent of the costs typically incurred under the plan:

- Bronze - 60 percent;
- Silver - 70 percent;
- Gold - 80 percent;
- Platinum - 90 percent.

Insurance providers must offer at least one plan at the silver and gold coverage levels in order to have plans certified on the exchange. In addition, insurance providers may sell catastrophic health plans to persons under the age of 30. Insurance providers that sell health insurance on state exchanges are also required to submit justifications to the state exchange for any increase in premiums prior to the implementation of the increase.

### **Information for Consumers**

State health insurance exchanges are required to make certain information about health care plans and services available to consumers. For example, each health exchange must:

- have a website and operate a toll-free consumer assistance telephone hotline;

- assign a rating to each plan offered on the exchange that takes into account the plan's costs and coverage level;
- present coverage options for health plans in a standardized format;
- establish a navigator program to help consumers evaluate insurance options, conduct public education activities, and refer persons with complaints or questions to assistance; and
- provide information to individuals about public programs, such as Medicaid, for which they may be eligible.

### **Key Implementation Questions**

If the General Assembly wishes to take action to implement a health insurance exchange in Colorado, it would likely need to do so in the 2011 legislative session in order to meet the January 1, 2014, deadline for health exchanges to be operational. Key questions that the state must determine with regard to health insurance exchanges are whether to:

- operate an exchange or allow the federal government to set up the exchange within the state;
- operate separate exchanges for individuals and small businesses, or to combine these exchanges;
- operate a regional exchange with other states, or to operate multiple exchanges within geographically distinct regions of the state;
- permit large employers to purchase coverage through the exchanges in 2017; and
- establish a funding mechanism for the exchanges to replace federal funding that will end on January 1, 2015.