ACA OVERVIEW

Provided by Hickok & Boardman HR Intelligence

Health Insurance Exchanges

The Affordable Care Act (ACA) requires each state to have a competitive marketplace, known as an Affordable Health Insurance Exchange (Exchange), for individuals and small businesses to purchase private health insurance. According to the Department of Health and Human Services (HHS), the Exchanges allow for direct comparisons of private health insurance options on the basis of price, quality and other factors and coordinate eligibility for subsidies and other affordability programs.

The 2017 open enrollment period in the Exchanges began on **Nov. 1, 2016**, and will run through Jan. 31, 2017. After the open enrollment period closes, an individual generally cannot enroll in Exchange coverage for the rest of 2017, unless a special enrollment period applies.

In addition to the ACA's Exchanges, private health insurance exchanges are emerging to provide another way for employers to provide health insurance coverage for employees. Private health insurance exchanges may offer employers more flexibility than the ACA's Exchanges.

LINKS AND RESOURCES

- On Feb. 29, 2016, HHS released its final Notice of Benefit and Payment Parameters for 2017, which establishes the Exchange open enrollment periods for 2017 and beyond.
- HHS' 2015 Notice of Benefit and Payment Parameters Final Rule made a number of changes to the Exchange standards.
- A 2013 final rule delayed implementation of the employee choice model as a requirement for all SHOPs until 2015.

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HIGHLIGHTS

EXCHANGE COMPONENTS

Each Exchange must have:

- An individual market component; and
- A component for small employers, called the Small Business Health Options Program (SHOP).

A state may elect to operate its own individual and/or SHOP Exchange, or let HHS run the Exchange in the state.

OPEN ENROLLMENT PERIODS

- Open enrollment for the 2017 plan year runs from Nov. 1, 2016, through Jan. 31, 2017.
- Open enrollment for the 2018 plan year runs from Nov. 1, 2017, through Jan. 31, 2018.
- Open enrollment for 2019 and beyond runs from Nov. 1 through Dec. 15 of the preceding year.

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EXCHANGE OPTIONS FOR STATES

States have three main options available to them with respect to the establishment of their Exchanges.

1	**Create and operate its own Exchange (state-based Exchange)**
2	**Have HHS operate the federally-facilitated Exchange (FFE) for its residents**
3	**Partner with HHS so that the state is involved with the operation of the FFE**

As a default, HHS will operate an FFE in states that do not establish a state-based or partnership Exchange.

Each Exchange will have an **individual market component** and a component for small employers, which is called the **Small Business Health Options Program (SHOP)**. A state may elect to operate its own SHOP for small employers and let HHS run the individual market Exchange in the state.

To operate a state-based or partnership Exchange, a state must have submitted a blueprint application and declaration letter to HHS for approval. A state may transition between Exchange models each year. The deadline for Exchange blueprint approval for states electing to establish and operate an Exchange after 2014 is **June 15 of the previous year**. For example, a state that decides to operate its own Exchange starting in 2016 must have submitted a blueprint to HHS by June 15, 2015.

The following figure summarizes the different Exchange models available to states under the ACA:

STATE-BASED EXCHANGE	STATE PARTNERSHIP EXCHANGE	FEDERALLY-FACILITATED EXCHANGE (FFE)
State operates all Exchange activities. However, state may use federal government services for the following activities: • Subsidy determination • Exemptions • Risk adjustment program • Reinsurance program	State operates activities for: • Plan management • Consumer assistance State may elect to perform or can use federal government services for the following activities: • Reinsurance program • Medicaid and CHIP eligibility assessment or determination	HHS operates. However, state may elect to perform or can use federal government services for the following activities: • Reinsurance program • Medicaid and CHIP eligibility assessment or determination

The 2017 Notice of Benefit and Payment Parameters added an additional Exchange model—a **state-based Exchange on the federal platform (SBE-FP)**—to enable SBEs to conduct certain processes using the federal eligibility and enrollment technology infrastructure on www.HealthCare.gov. The 2017 rule

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required SBE-FPs to enforce certain plan and issuer requirements that are no less strict than those that HHS applies in the FFEs. The [2018 Notice of Benefit and Payment Parameters] enhances this obligation, requiring SBE-FPs that use the federal platform for certain SHOP functions to establish standards and policies consistent with certain federally facilitated SHOP (FF-SHOP) requirements.

STATE DECISIONS

As of February 2017, 14 states and the District of Columbia are operating state-based Exchanges, five states are operating SBE-FPs, four states are operating a partnership Exchange, and HHS is running the FFE for the remaining 27 states. Utah, Mississippi and New Mexico operate their own state-based SHOP Exchanges, while allowing HHS to operate the FFE in the individual market.

STATE-BASED		PARTNERSHIP	FFE			SBE-FP
Arkansas	Mississippi (SHOP only)	Delaware	Alabama	Mississippi (individual only)	Pennsylvania	Hawaii
California	New Mexico (SHOP only)	Illinois	Alaska	Missouri	South Carolina	Idaho
Colorado	New York	Iowa	Arizona	Montana	South Dakota	Kentucky
Connecticut	Rhode Island	New Hampshire	Florida	Nebraska	Tennessee	Nevada
D.C.	Utah (SHOP only)		Georgia	New Jersey	Texas	Oregon
Maryland	Vermont		Indiana	New Mexico (individual only)	Utah (individual only)	
Massachusetts	Washington		Kansas	North Carolina	Virginia	
Minnesota			Louisiana	North Dakota	West Virginia	
			Maine	Ohio	Wisconsin	
			Michigan	Oklahoma	Wyoming	

EXCHANGE FUNCTIONS AND ROLES

The Exchanges perform a variety of functions, including:

- Certifying health plans as qualified health plans (QHPs) to be offered in the Exchange;
- Operating a website to facilitate comparisons among QHPs for consumers;
- Operating a toll-free hotline for consumer support, providing grant funding to entities called “Navigators” for consumer assistance and conducting consumer outreach and education;

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- Determining individual mandate exemptions and granting approvals related to hardship or other exemptions;
- Determining eligibility of consumers for enrollment in QHPs and for insurance affordability programs (such as subsidies, Medicaid and CHIP state-established basic health plans); and
- Facilitating the enrollment of consumers in QHPs.

States have flexibility in designing their Exchanges. For example, states may decide whether their Exchanges will be operated by a non-profit organization or a public agency. States may also select the number and type of health plans available and may determine some of the standards for QHPs, including the definition of required essential health benefits. States also have flexibility to determine a role for agents and brokers in connection with the Exchanges.

Navigator Program

The Navigator program is an essential component of an Exchange. Navigators help consumers learn about and choose coverage through the Exchanges. For example, a Navigator provides information on various health programs in a manner that is culturally and linguistically appropriate to the needs of the populations being served by the Exchange.

States have flexibility to design their Navigator programs, including selecting the entities that will serve as Navigators. However, the following guidelines apply to the Navigator program:

- Exchanges must have at least two entities serve as Navigators, and one of the entities must be a community and consumer-focused nonprofit group.
- Exchanges must have conflict of interest standards for Navigators. These standards must prohibit a Navigator from receiving any kind of compensation from a health insurance or stop loss insurance issuer for enrolling individuals in health insurance plans. This applies to plans offered both through an Exchange and outside of an Exchange. However, Navigators who sell lines of insurance that are not health or stop loss insurance are not prohibited from receiving consideration from the sale of those other lines of insurance while serving as Navigators, so long as they disclose this to consumers.
- Exchanges must have a set of training standards for Navigators to ensure expertise in the needs of underserved and vulnerable populations, eligibility and enrollment procedures, the range of QHPs and public programs and the Exchange's privacy and security standards.

Agents and Brokers

States may determine what role brokers and agents will serve in their Exchanges. States will also continue to set standards for the broker/agent industry and play their traditional role in licensing and overseeing insurance producers.

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Licensed brokers and agents are eligible to serve as Navigators. However, the responsibilities of a Navigator differ from the traditional activities of a broker or agent. Also, conflict of interest standards preclude brokers and agents who are serving as Navigators from receiving compensation from an issuer for selling health or stop loss insurance.

Where permitted by the state, brokers and agents may assist individuals and small employers with the Exchange's eligibility application and enrollment processes, including plan selection. They may also help eligible individuals apply for the ACA's insurance affordability programs (that is, the advanced premium tax credit and cost-sharing reductions).

If permitted by state law, brokers and agents may:

- **Enroll qualified individuals or small employers in QHPs**
- **Help eligible individuals apply for subsidies**

Agents and brokers working with consumers in the individual market FFE and state partnership Exchanges can assist consumers in two ways:

- An issuer-based pathway, where an agent or broker uses an issuer's website to assist the consumer; or
- An Exchange pathway, where an agent or broker assists the consumer using the Exchange website.

Web-brokers (that is, brokers or agents that use their own websites to help consumers select QHPs) provide another option for assisting consumers in the individual market.

For the federal SHOP (FF-SHOP), brokers work with consumers using the Exchange website to complete the employer and employee applications. If permissible under state law, small employers may enroll in a state-run SHOP or the FF-SHOP through an agent's or broker's own website, if the SHOP has the technical capability to make this possible.

There is no overall prohibition on agents or brokers receiving commissions through an Exchange. How brokers and agents will be compensated for coverage sold through an Exchange will depend on the type of Exchange.

- In state-based Exchanges, states have the flexibility to determine what role brokers and agents will serve, including how compensation will be structured.
- In the FFE and FF-SHOPs, the Exchange will not establish a commission schedule or pay commissions directly to agents or brokers. Instead, agents and brokers will be compensated by insurers or consumers, consistent with state law. However, HHS has established a standard for broker compensation. In order for a plan to be certified as a QHP, issuers must pay the same broker compensation for QHPs in the FFE or FF-SHOP that the issuer pays for similar plans in the outside market.

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To participate in the FFE or FF-SHOP, agents and brokers must adhere to all state requirements for licensure, appointment and market conduct and complete applicable Exchange agreements. Agents and brokers serving in the individual market FFE must also complete online training and security authorization for FFE registration. Training is strongly encouraged, but not required, for agents and brokers working exclusively in FF-SHOPs. State-based Exchanges can either adopt the federal standards or develop their own training and certification requirements.

STANDARDIZED PLAN OPTIONS

The 2017 Notice of Benefit and Payment Parameters established the following six standardized benefit plan options—called "**simple choice plans**"—in the individual market FFE to simplify the plan selection process by allowing consumers to more easily compare plans across issuers in the FFE:

- One bronze standardized option;
- One silver standardized option;
- A separate standardized option for each silver plan variation (73 percent, 87 percent and 94 percent) available to individuals who are eligible for cost-sharing reductions; and
- One gold standardized option.

The 2018 Notice of Benefit and Payment Parameters provides the following **three new sets of six standardized options**:

- The first set of standardized options would be a version of the 2017 standardized plan options that have been updated to reflect modifications for 2016 enrollment weighted QHPs.
- The second set of standardized options is designed to work in states that: (1) require that cost-sharing for physical, occupational or speech therapy be no greater than the cost-sharing for primary care visits; (2) limit the amount that can be charged for each drug tier; or (3) require that all drug tiers carry a copayment rather than coinsurance (Arkansas, Delaware, Iowa, Kentucky, Louisiana, Missouri, Montana and New Hampshire).
- The third set of standardized options is designed for New Jersey, which has maximum deductible requirements and other cost-sharing standards. (Some states also have oral chemotherapy mandates, but CMS believes that these are consistent with standardized plan options.)

Like the 2017 standardized options, the 2018 standardized options each have a single provider tier, fixed deductible, fixed annual cost-sharing limit, four drug tiers, and fixed copayment or coinsurance for a key set of EHB that comprise a large percentage of the total allowed costs for a typical population of enrollees. However, the 2018 final rule includes the following changes to comply with state law requirements on cost-sharing:

- The 2018 options at the **silver**, **silver cost-sharing reduction variations** and **gold** levels of coverage have separate medical and drug deductibles; and

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- The standardized options at the **silver 87 percent cost-sharing reduction plan variation**, **silver 94 percent cost-sharing reduction plan variation** and **gold** levels of coverage have a $0 drug deductible (meaning no deductible applies to the drugs).

Each state would still only have one standardized option at each level of coverage. In addition, the 2018 rule also established a fourth **standardized health savings account (HSA)-eligible bronze high deductible health plan (HDHP) option** that would comply with IRS HSA rules.

SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

According to HHS, SHOPs allow small employers to provide employees with a choice of health plan options and give small businesses the same purchasing power as large businesses. Each Exchange decides how its SHOP is structured.

Eligible Small Employers

The ACA provided that small employers with up to 100 employees would be eligible to participate in the SHOP. However, until 2016, states were permitted to limit participation to businesses with **up to 50 full-time equivalent (FTE) employees**. Beginning in 2017, states could allow businesses with more than 100 FTE employees to participate in the SHOP.

However, on Oct. 7, 2015, President Obama signed into law the **Protecting Affordable Coverage for Employees (PACE) Act**, which **amends the ACA's definition small group market**. As a result, the ACA defines a small employer for purposes of eligibility for SHOP participation as one that has up to 50 employees. Due to this new definition, states now have the option, but are not required, to expand their small group markets to include businesses with up to 100 employees.

Employer Choice Model and Transition Policy

A SHOP must allow employers the option to offer employees all QHPs at a level of coverage chosen by the employer—bronze, silver, gold or platinum. This is called the "employee choice model." Under the employee choice model, the employer chooses a level of coverage and a contribution amount and employees then select any QHP at that level. SHOPs may also allow a qualified employer to choose one QHP for its employees. The FF-SHOP will give employers the option of offering only a single QHP in addition to the employee choice model.

However, **implementation of the employee choice model as a requirement was delayed for all SHOPs until 2015**. According to HHS, this approach provides all SHOPs (both state SHOPs and the FF-SHOP) with additional time to prepare for the employee choice model. Under this approach:

- *State-run Exchanges*: A state-run Exchange's SHOP may have chosen to provide the employee choice model for small employers in 2014, but was not required to provide this model until 2015. Many state-run SHOPs offered the employee choice model to small employers in 2014, including California, Colorado, Massachusetts, Minnesota, New York and Oregon, among others.

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- *FFE*: The FF-SHOP did not provide the employee choice model for small employers in 2014, instead requiring employers to choose a single QHP to offer their qualified employees. Online enrollment in the FF-SHOP became available beginning Nov. 15, 2014.

In addition, HHS allowed state Insurance Commissioners to recommend delaying the employee choice model for their state's SHOP for an additional year, until 2016, if certain market conditions exist in the state. In total, 18 states with an FF-SHOP did not provide the employee choice model in 2015.

Small Business Health Care Tax Credit

Starting in 2014, small employers purchasing coverage through the SHOP may be eligible for a tax credit of up to 50 percent of their premium payments if they have 25 or fewer employees, pay employees an average annual wage of $50,800 or less, offer all full-time employees coverage and pay at least 50 percent of the premium.

PRIVATE EXCHANGES

While the ACA's state-based Exchanges began operating in 2014, some private health insurance exchanges targeted at employers were already operational. As a growing trend, these private exchanges create a marketplace for employees to compare options and shop for coverage. At the same time, they allow private health care companies to market their products at a single location to clients throughout the country.

Some employers may use the private exchanges to offer a defined contribution model of purchasing health coverage. Under this model, employers provide employees with a defined amount of money and direct them to an exchange where they can select a health plan from an array of options.

Private exchanges also have the potential to provide more flexibility than the ACA's Exchanges. They can offer a broader range of insurance products, such as life insurance, and their products can be tailored for different employer segments. In addition, private exchanges have provided employees with a choice of health insurance products, while the SHOP's employee choice model was delayed until 2015. Finally, there is no restriction on larger employers using private exchanges. Thus, all employers can use private exchanges to provide group health insurance benefits to their employees.

Private health insurance exchanges are a relatively new model for providing group health insurance benefits. The availability and success of private exchanges most likely depends on employers' willingness to move from a traditional health plan to a defined contribution health plan.

ADDITIONAL RESOURCES

More information on the Exchanges is available through www.healthcare.gov and http://cciio.cms.gov.

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