

Health Insurance Marketplace/Exchange: An Overview

A New Marketplace for Individuals and Small Businesses

Marketplaces/Exchanges¹ are essentially organized insurance Marketplaces, which are intended to provide individuals and small business owners with a “one-stop-shop” to compare and purchase health insurance. They will use the power of a large insurance risk pool to generate competition among health plans based on quality and cost. Marketplaces will also have “no wrong door” enrollment in which individuals and families apply for coverage and the Marketplace will determine the program they are eligible for and enroll them, whether it is in Medicaid, CHIP or subsidized Marketplace plans. These new marketplaces will be “open for business” by January 1, 2014 and will serve as the gateway for an estimated 29 million people to access coverage by 2019.

The ACA creates two types of Marketplaces:

1. The American Health Benefit Marketplaces for individuals; and
2. Small Business Health Options Program (SHOP) Marketplaces for small business owners.

While the federal law sets minimum standards and delegates certain responsibilities to the states.

Minimum Standards for Health Insurance Marketplaces

Help consumers compare plans and enroll in coverage: The state Marketplaces must allow consumers and small business owners to compare and purchase insurance plans in person, through the mail, phone, or a web portal. The portal will also have comparative information about participating insurers, including covered benefits, premium rates, cost-sharing, provider networks, and financial information such as the “medical loss ratio,” or the amount plans spend to pay claims relative to overhead costs. Consumers will be able to use an electronic calculator to determine their actual cost of coverage that takes into account any premium subsidy they are eligible to receive. The Marketplaces are also required to maintain a toll-free consumer assistance hotline and make all information available in a culturally and linguistically appropriate manner.

Marketplaces will facilitate enrollment in plans by offering annual open enrollment periods, and provide a standardized form that all exchange participants may use to enroll. The law also provides grants to consumer assistance programs (CAP) and requires Marketplaces to fund “Navigators,” organizations that can help inform consumers about the availability of qualified coverage and financial assistance, and help enroll eligible individuals in the coverage that’s right for their needs.

In addition to Navigators, in-person assisters (IPAs) and certified application counselors (CACs) may be available to assist consumers².

¹The terms Marketplace and Exchanges have the same definition and are often used interchangeably. Originally termed Exchanges, the federal government renamed these “one-stop-shops” Marketplaces.

² Funding, training and availability for the various consumer assistance programs varies and availability is based on the type of Marketplace (state, federal or partnership).

Certify participating plans: The ACA envisions that Marketplaces will be more than just clearinghouses that connect consumers with health plans. Rather, Marketplaces may offer only “qualified” health plans (QHPs) that meet minimum requirements related to marketing and network adequacy, and offer at least a minimum essential health benefits (EHB) package. The comprehensiveness of coverage in each plan will be standardized into four “tiers”: bronze, silver, gold and platinum, with bronze plans being the least generous and platinum being the most. All participating plans must offer at least one silver and one gold option.

They must also “decertify” any health plans that use marketing techniques or benefit designs that discourage sicker individuals from enrolling. The law also encourages Marketplaces to contain premium increases, by allowing them to exclude health plans that have a history of unreasonable premium increases.

Administer subsidies and help individuals and employers meet their coverage requirements: Marketplaces will be responsible for determining who is eligible for premium tax credits (available to those with income up to four times the poverty level),³ and cost sharing subsidies certifying individuals who are exempt from the individual mandate, and sharing that information with the Internal Revenue Service. They will also need to verify whether employees are eligible for premium subsidies through the Marketplace based on whether they have access to “affordable, adequate” employer-sponsored coverage.

Coordinate with state Medicaid and CHIP programs: Many individuals and families may attempt to get coverage through their state Marketplace, but may be eligible for Medicaid or CHIP. In some families, children will be eligible for Medicaid or CHIP, but their parents will be eligible for premium tax credits to purchase private insurance. One of the most challenging and important aspects of the ACA is the requirement that states create a “no wrong door” policy for individuals and families seeking coverage. States must establish procedures for screening applicants no matter where they initially seek coverage (whether through the Marketplace, Medicaid or CHIP, and enrolling them in the appropriate program, without making applicants go through additional, burdensome steps to find out which program they are eligible for.

It is also vital that state Marketplaces coordinate with Medicaid and CHIP programs because, as their income fluctuates, many people will move back and forth between subsidized commercial coverage in the Marketplaces and eligibility for public programs. The ACA makes changes intended to create a seamless eligibility and enrollment system.

- A new income standard, the Modified Adjusted Gross Income (MAGI), will be used when determining eligibility for the exchange subsidies, CHIP, and most populations under Medicaid.
- States must use a single, streamlined application form developed or approved by the Department of Health and Human Services (HHS) to enroll people in exchange subsidies, Medicaid, CHIP. States must also coordinate benefits for families who have some members enrolled in Medicaid and CHIP, and others that receive premium subsidies for commercial insurance.

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- Marketplaces and Medicaid agencies must operate linked web portals through which families can obtain information on their eligibility for the different programs and enroll in coverage. States must establish electronic interfaces that will enable the exchange of information between programs, accept an electronic signature for all programs, and use data matching to federal databases whenever possible to establish, verify, and update eligibility.

Hold health plans accountable: The ACA sets out new requirements for transparency and plan disclosure that will give consumers unprecedented access to information about benefits, cost sharing, and plans' business practices, as well as enhance regulators' ability to identify and crack down on "bad behavior." For example, plans must provide a standardized summary of benefits to consumers that uses uniform definitions of insurance and medical terms, breaks down and describes cost-sharing charges, and details exceptions and limitations on coverage, all in culturally and linguistically appropriate and easily understandable language.

Plans must also provide information to consumers on the availability of in and out-of-network providers. Further, plans must provide a "coverage facts label" that illustrates examples of an enrollee's likely cost-sharing under two common scenarios: delivering a baby or managing diabetes.

For plans to be certified to participate in the Marketplaces, the new law requires them to disclose information on certain business practices, such as claims payment policies and practices, financial disclosures, enrollment and disenrollment, the number of claims denied, rating practices, cost-sharing and payments for out-of-network coverage, enrollee rights and other information as required by HHS.

Improve health plan quality and value: To encourage quality improvement, plans must report to HHS and their enrollees on what programs they are implementing to improve health outcomes, reduce hospital readmissions, implement patient safety and error reduction programs, promote prevention and wellness, and reduce health disparities. HHS will post these reports on www.healthcare.gov.

Marketplaces Vary by State

It is important to understand that while state Marketplaces must meet certain standards and perform key functions, there is considerable flexibility for states in designing and operating their Marketplaces. States can operate their own Marketplaces alone or in partnership with HHS, or can default to complete federal operation of the Marketplace. Depending on who is operating the Marketplace, key policies, procedures and governance issues may differ. To date, states have made a variety of decisions concerning the governance of their Marketplaces. To learn more about your state's Marketplace, visit www.healthcare.gov.