State Roles in Implementing Health Insurance Exchanges

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The Affordable Care Act (ACA) requires states to establish competitive insurance marketplaces, called Health Insurance Exchanges, and provides a basic framework and initial funding to states to begin planning. There are two types of exchanges authorized by the ACA: one to serve individual consumers (American Health Benefits Exchange, or AHBE) and one to serve small businesses (Small Business Health Options Program, or SHOP). States are authorized either to design these as separate exchanges or as one consolidated entity. The idea behind the individual exchange is to provide a way for consumers who do not have a health plan provided by their employer to research and purchase affordable health insurance. On the small business side, the SHOP exchange serves a similar purpose for small employers seeking affordable group plans.

Within this framework, states have considerable flexibility to structure an exchange that meets their individual needs. If Georgia chooses not to establish an exchange, a federally operated insurance exchange will be created. States have until November 16, 2012 to notify the federal Centers for Medicare & Medicaid Services (CMS) whether they plan to set up their own exchange.

A key component of the exchange is the ability for consumers to shop for and compare various health plans through a website or online portal operated by the state or by a public-private partnership. Health plans participating in the exchange will have to be preapproved by the state and offer specific coverage and services.

Exchanges are required to allow consumers to apply for and enroll in coverage online, in person, by phone, fax, or mail. To do this, states must provide access to telephone call centers, build a website with information about insurance options and application assistance, and create a Navigator program to improve public awareness and facilitate enrollment. Navigators will adopt a role similar to agents and each state is free to determine how this profession will be regulated, if a license is required, and if licensed brokers and agents can act as Navigators.

Establishing an Exchange

As a state proceeds with establishing its exchange, it will have to determine how the exchange will be structured and governed and how it will contract with qualified health plans (QHPs). A state will have to decide on whether to structure its exchange within an existing or new state agency, as an independent public entity, or as a non-profit. To date, almost every state with an established exchange has created an independent governing Board responsible for planning and operating the exchange. Board members often represent both stakeholders and subject matter experts.

The ACA specifies that an exchange must:

- Implement procedures to certify and decertify QHPs;
- Operate a toll-free hotline;
- Maintain a website through which people can view and compare information on QHPs;

- Provide information on eligibility requirements for Medicaid and other state or local programs and, if the exchange determines a person is eligible for a program, enroll them;
- Provide a calculator to determine a person's actual cost of coverage after taking into account any premium credits and cost-sharing subsidies; and
- Provide employers the names of employees who dropped the employers' coverage and received premium tax credits because the plan was unaffordable.

As previously noted, every state must also establish a SHOP exchange to provide insurance options throughout the year for qualified small employers. However, states have flexibility on a number of elements including deciding whether to limit the size of a qualified small-employer to 50 employees before 2016, whether or not the SHOP exchange should include large employers beginning in 2017, and if the individual and SHOP markets should be merged into a combined pool.

What's Inside: The Qualified Health Plans

QHPs are described in the ACA as a type of health plan that is subject to a specified list of requirements related to marketing, choice of providers, plan networks, essential benefits, and other features.

Defining Essential Health Benefits (EHBs)

The ACA requires health plans that offer insurance coverage in the individual and small group markets to ensure that such coverage includes ten specific Essential Health Benefits (EHBs) for plan years beginning on and after January 1, 2014. According to HHS, non-grandfathered plans in the individual and small group markets (both inside and outside the Health Insurance Exchange) must cover EHBs. Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover EHBs. (A grandfathered plan is health insurance coverage that existed on March 23, 2010 and has not made significant changes since.) The ACA requires EHBs to include the following 10 specific benefit categories:

1. Ambulatory patient services;
2. Emergency services;
3. Hospitalization;
4. Maternity and newborn care;
5. Mental health and substance use disorder services, including behavioral health treatment;
6. Prescription drugs;
7. Rehabilitative and habilitative services and devices;
8. Laboratory services;
9. Preventive and wellness services and chronic disease management; and
10. Pediatric services, including oral and vision care.

Benchmark Plan

Under the ACA, HHS requires states to identify a reference (benchmark) plan based on employer-sponsored coverage currently operating in the state, supplemented as necessary to ensure that the plan covers the ten statutory EHBs. HHS suggests the following four benchmark plan types, from which each state will select one:

- Any one of the three largest small group plans by enrollment being operated in the state;
- Any of the three largest state employee health benefit plans by enrollment;
- Any of the three largest national Federal Employees Health Benefit Program plan options by enrollment; or
- The largest insured commercial non-Medicaid HMO operating in the state.

If a state does not select one of these, the largest plan in the state's small group market will become the default benchmark plan. Depending on the plan selected as a benchmark, current state mandated insurance benefits (e.g., mammograms, autism spectrum disorders, etc.) may be considered part of the EHBs.

Levels of Coverage

Plans inside and outside the exchange in the individual and small group markets must offer distinct levels of coverage categorized by a specific "metal tier" determined by their actuarial value – Bronze, Silver, Gold, and Platinum. Actuarial value is a measure of the percentage of expected health care costs a health plan will cover for a standard population. Plans can provide different benefits and different deductibles or out-of-pocket costs and still have the same actuarial value, allowing consumers a choice among unique plans. However, all plans must provide the minimum EHBs and participating health insurers must offer a Silver and Gold plan in the exchange. The plans will be categorized actuarially as follows:

- Bronze plan benefit coverage is equivalent to 60 percent of the actuarial value of the plan. That means that a health plan at this level would be expected to pay out approximately 60 percent in coverage while the remainder would be covered by the consumer in the form of various out-of-pocket expenses and deductibles;

- Silver plan benefit coverage is equivalent to 70 percent of the actuarial value of the plan;

- Gold plan benefit coverage is equivalent to 80 percent of the actuarial value of the plan.

- Platinum plan benefit coverage is equivalent to 90 percent of the actuarial value of the plan.

Who Will Be Eligible – Subsidies and Tax Credits

Taxpayers with household incomes between 133 percent and 400 percent of the Federal Poverty Level (FPL) will be eligible for premium tax credits for coverage purchased through the exchange for themselves and members of their family who are not eligible for other health care coverage. These premium tax credits are paid on an advance basis to the health insurance provider, which will reduce the monthly premiums owed by families to purchase coverage. The Congressional Budget Office estimates that when the ACA is fully phased in, individuals receiving premium tax credits could receive an average subsidy of over $5,000 per year.

The tax credits will operate on a sliding scale based on income and the percentage that a premium will have on the consumer's income. However, the tax credit is pegged to the Silver benchmark plan. Consumers wishing to purchase a more generous plan could still do so, but they would not receive an additional tax credit to apply toward the more expensive premium. Lower income consumers will also receive assistance with deductibles and co-payments. Consumers with an income above 400 percent of the FPL will not qualify for the tax credits but will still be able to purchase health insurance on the exchange.

State-Federal Partnership Exchange

With the deadline to demonstrate an operational exchange quickly approaching, HHS developed a state-federal partnership model as an option for states, allowing for the combined management of exchange functions and for an easier transition to a fully state-based exchange in the future. States opting for a partnership exchange can choose to operate certain plan management functions, certain consumer assistance functions, or both. In addition, a partnership state can elect to conduct Medicaid and CHIP eligibility determinations or allow the federal government to perform this service. In all partnership states, HHS will perform the remaining exchange functions and ensure the exchange meets ACA standards.

Federally Facilitated Exchange

For a state unable or unwilling to establish a state-based or a state-federal partnership exchange, HHS will assume primary responsibility for operating an exchange in that state. Federally facilitated exchanges will operate somewhat differently in that they certify any health plan that meets all certification standards as a QHP and will establish Navigator programs with a role for agents and brokers to assist consumers in accessing health insurance.

While the federal government will retain primary responsibility for operating these exchanges, it will seek to coordinate with states including plan certification and oversight functions, consumer assistance and outreach, and on streamlining eligibility determinations. Over time, this involvement may allow states in a federal exchange to transition into a partnership model.

Financing and Funding
Federal grants are available for planning and implementation of the exchange, as well as for the first year of an exchange's operation. However, states must be able to fully finance the costs of exchange operations beginning on January 1, 2015. Some states have studied various multiple financing options, such as assessing fees on participating insurers, appropriating state funds to the exchange, and allowing for other public or private funding sources such as grants.

To date, over one billion dollars has been distributed to states through federal exchange planning grants, establishment grants, and early innovator grants, with Georgia receiving a one million dollar planning grant in 2010. All but five states received and accepted some amount of funding to study exchange implementation. Thirty-four states accepted at least one Level One Establishment grant. Two states, Rhode Island and Washington, received a Level Two Establishment grant which funds exchange planning and implementation activities through the first year of operation. At this point, states are using most of the awarded grant funding to build the IT infrastructure necessary to support exchange functions. States have the opportunity to apply for and receive additional grant funding through the end of 2014.

Current National Status
Currently, 15 states plus the District of Columbia have established state-based exchanges. Of those, Rhode Island, New York, and Kentucky have done so through executive order. Three states, Arkansas, Delaware, and Illinois, are planning to pursue a state-federal partnership exchange. A partnership may be the best option for states that have delayed establishing an exchange. States that are not ready to run a fully state-based exchange beginning in 2014 may transition from a partnership exchange to a state-based exchange at a later date. Seven states have declared that they will not create a state-based exchange: Louisiana, Maine, New Hampshire, Texas, Florida, South Carolina, and Alaska.

Another 16 states have not yet committed to a health insurance exchange strategy, but are continuing planning efforts. Some state officials continue to evaluate the policy options related to a state-based exchange in the absence of legislation. Some of these states may consider calling a special legislative session to pass exchange establishment legislation while other states are considering the use of an executive order or other non-legislative strategy.

Nine states, including Georgia, have not shown significant exchange planning activity since 2011, ending their exchange planning efforts in the face of increasing political pressure. Planning initiatives in Georgia, Kansas, Oklahoma, and Wisconsin were halted earlier this year to await the outcomes of the Supreme Court ruling and the November elections. Given the federal timetable for implementation, states with little planning activity face the likelihood of defaulting to a federally-facilitated exchange.

The Situation in Georgia
After the state received a federal Exchange Planning Grant of one million dollars in 2010, Governor Deal issued an executive order in 2011 creating an advisory committee to study the issue of establishing an exchange. The committee's final report did not recommend proceeding with a state-based exchange at that time due to uncertainty pending the Supreme Court decision. Once the Supreme Court upheld most of the ACA, Governor Deal recommended that the state continue to wait until after the November 2012 presidential election.

What the Future May Hold
Opponents of the ACA are hoping that a Romney victory in November coupled with a Republican takeover of the Senate will lead to repeal of the ACA. An outright repeal would still be nearly impossible; Republicans might be able to use the budget reconciliation process, which only requires 51 votes, to repeal parts of the ACA, but a full-scale repeal would require 60 votes to overcome procedural hurdles erected by the Democrats.

Assuming the ACA is not repealed; Romney could slow the law's implementation and give more flexibility to the states. But a Romney Administration could not just ignore the law's requirement for the federal government to establish exchanges in states that do not operate them on their own.

Another likely scenario could be postponing the January 2014 exchange implementation date. This would save the federal government billions of dollars in the short term by delaying federal subsidies to low and moderate income individuals who purchase their insurance through exchanges.

Political maneuvering aside, without exchange legislation or an executive order in place prior to the November 16, 2012 CMS deadline, the state will most likely fail to meet the federal timetable for implementation – resulting in the federal government assuming responsibility for running a health insurance exchange in the state regardless of who wins the Presidential election.