Health insurance exchanges

What to expect in 2014

Anthem BlueCross

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The basics of exchanges

As part of the Affordable Care Act (ACA or health care reform law), starting in 2014 ALL Americans must have a minimum amount of health insurance or be taxed by the government. The law also requires each state to have a health insurance exchange where people can buy health insurance coverage. People who don't get health insurance at work, or can't afford it, may be able to get it through an exchange. The exchanges do not replace buying health insurance privately. They are simply a new place to shop and buy.

Exchange = a new place to shop for and buy health insurance

Three exchange model options

On the exchanges, individuals and small businesses can buy qualified health plans (QHPs). Exchanges can be set up in one of three ways. Each state determines how its exchange will be set up:

State-run facilitator model

- Any carrier meeting minimum federal and state requirements set for the health insurance exchanges can be in this exchange.
- Carriers compete in an open market.

State-run active purchaser model

- The state solicits bids from health insurance companies and determines which plans it will offer.
- The state directly negotiates the price and benefits offered.

Federally run model

- The U.S. Department of Health and Human Services (HHS) runs the exchange in states that choose not to create one.

Four levels of coverage on the exchanges

Exchange plans will be offered in a tiered format. The tiers are named after metals: bronze, silver, gold and platinum. Each tier will have several plans to choose from and will include essential health benefits. Bronze plans will have the lowest monthly premium, but cost shares will be more when health care services are provided. Platinum plans will have the highest monthly premium, but cost shares will be less.

All plans must include "essential health benefits" as defined by the health care reform law. Specifically, the plans must include items and services from at least these 10 categories of care:*

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
10. Pediatric services, including oral and vision care

*Healthcare.gov: *Essential health benefits* (accessed October 2012).

Exchange plans are tiered:

Platinum – 90% coverage
Gold – 80% coverage
Silver – 70% coverage
Bronze – 60% coverage

Qualified Health Plan (QHP) requirements

All health plans must follow new coverage and benefit rules starting in 2014 (see the chart below and read on for details about exchange coverage and essential health benefits). These requirements are based on:

- If the plan is offered on or off the exchange.
- If the plan is fully insured or self-insured.
- Group size.

Premiums for these individual and small group plans will not be based on health status. Instead, they will be based on family tier, age, geography and tobacco use. (State-specific rules may vary when a federally run model is not in place.) These plans also must use "3 to 1" age bands. This means the highest premium cannot be more than three times the lowest premium for the same plan. All of these requirements may have an impact on rates, although the specific effects are difficult to define at this time as qualified health plans continue to be developed.

	Inside exchange	Outside exchange – fully insured small group and individual	Outside exchange – fully insured large group and self-insured
Include essential health benefits	✔	✔	
Provide 60% actuarial value minimum	✔	✔	*
Adhere to deductible and out-of-pocket maximum limits	✔	✔	
Comply with "metal levels" – benefit tiers with specified actuarial values (60% 70% 80% 90%)	✔	✔	
Be certified by the exchange through which the plan is offered (certification requirement to be determined)	✔		

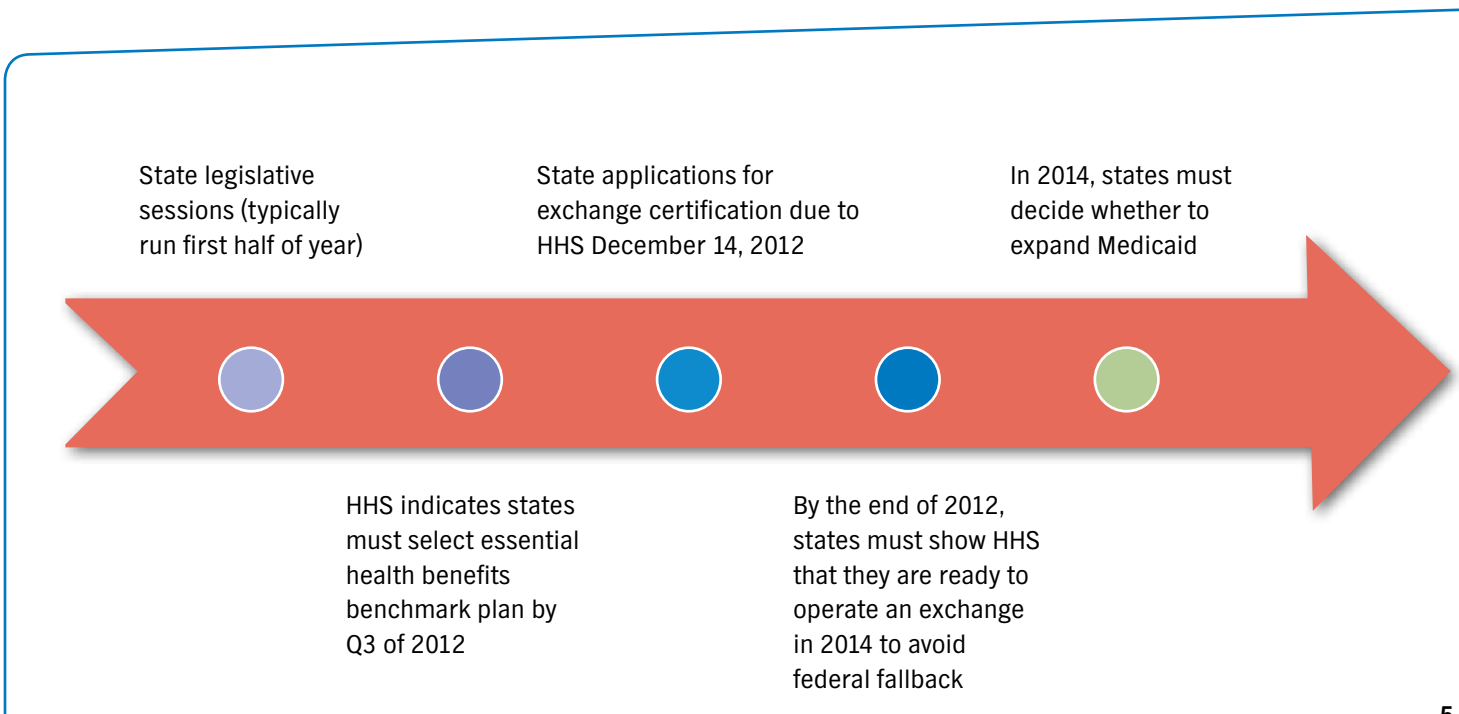
*The health care reform law does not require carriers to offer plans with at least a 60% actuarial value, nor does it require employers to provide health coverage. However, it imposes penalties on 50+ employers that do not provide minimum coverage.

Five functions the exchanges offer:

1. *Consumer assistance* – Staff will manage the exchange website and call centers. "Navigators" will help consumers use the exchanges.
2. *Plan management* – Consumers will be able to choose QHPs sold on exchanges and see important data for each QHP.
3. *Eligibility* – Applicant information is collected and verified to determine eligibility for enrollment, tax credits or subsidies.
4. *Enrollment* – Staff help consumers enroll and send information to health plans as well as transmit information related to premium tax credits and cost-sharing reductions as required by HHS.
5. *Financial management* – Exchanges will perform several financial functions including handling user fees, risk adjustment, reinsurance and risk corridor programs (this program runs from 2014-2016 and gives HHS governance over refunds and charges for QHPs that go over or under projected costs).

Exchange timeline

If all goes as planned, exchanges will open for enrollment on October 1, 2013. Coverage effective dates will begin January 1, 2014. And in 2017, states have the option to offer plans on the exchanges to large group employers with 100 or more employees.



Individuals

Three options for health insurance in 2014

The law requires health insurance to be "guaranteed issue." That means a person (or family) can't be denied coverage or charged more because of a health condition he or she already has. Individuals not covered by a government health plan have three choices:

1. Get coverage through their employer, if available.
2. Buy a plan through either:
   - The individual market exchange.
   - The traditional market.
3. Go uninsured and pay a penalty, unless exempt.

Subsidies and credits for individuals

Those who don't have access to affordable, minimum essential health coverage can buy a health plan from the exchange and get a credit or subsidy if they meet income requirements. Credits and subsidies help with the cost of premiums and out-of-pocket health care expenses.

Income requirements

133% to 400% of federal poverty level

- For an **individual** that equals $14,856 to $44,680 per year (in 2012).
- For a **family of four** that equals $30,656 to $92,200 per year (in 2012).

Those that meet the income level, can get a tax **credit** that may be applied to any level exchange plan (bronze, silver, gold or platinum).

The **cost-sharing subsidy** is available to those who earn up to 250% of federal poverty level and enroll in a silver exchange plan only.

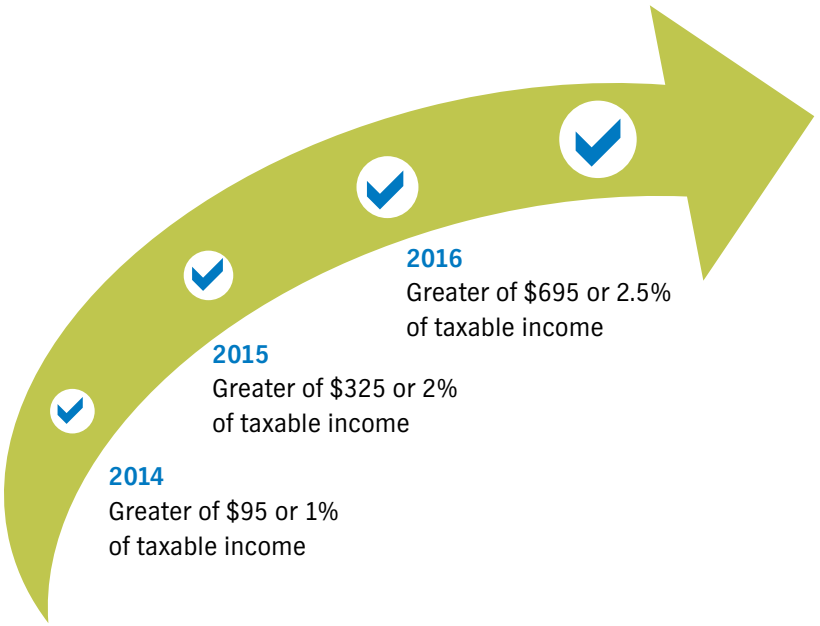
An affordable health plan = individual's share of premium is no more than 9.5% of income

Penalties for individuals

In 2014, legal U.S. citizens who do not have a minimum amount of health coverage will receive a penalty of $95 or 1% of their taxable income, whichever is greater.

Penalty timeline

Penalties will increase each year through 2016. In future years, the penalties will adjust annually.



Small group employers
(less than 49 employees)

Small businesses also can use an exchange to find insurance for their employees. These are called Small Business Health Options Programs, or SHOPs, for short. The individual and SHOP exchanges may be separate or combined.

Three options for health insurance in 2014

1

Offer a fully insured plan through either:

- A SHOP exchange.
- The traditional market.

2

Offer an ASO plan, if allowed by state law, where essential health benefits and metal level requirements don't exist.

3

Stop offering coverage and let employees buy an individual plan on or off the exchange.

Subsidies for small employers

Tax credits will increase for employers with 25 or fewer employees (with an average wage of less than $50,000 a year) who offer coverage through an exchange.

- The credit will cover up to 50% of the employer's cost (35% for small nonprofit organizations).
- Employers will be eligible for credits in the first two years they offer coverage through an exchange.
- Credits decrease on a sliding scale as group size and employee wages increase.

Other options may exist such as defined contributions or adjusting contributions by employee. This means employers give each employee a certain amount to spend on health insurance they find themselves.

Large group employers
(50+ employees)

Three options for health insurance in 2014

1. Offer health insurance (either fully insured or ASO) that meets the minimum coverage definition* and is affordable.

2. Offer some level of coverage that does not meet minimum requirements and pay the employer penalty.

3. Stop offering coverage, let employees buy through the Individual market exchange, and pay the employer penalty.

*Minimum coverage is any medical insurance coverage that does not limit coverage to specific benefits such as dental or vision only. This includes major medical (or catastrophic) plans. Minimum coverage does not have an actuarial value minimum (such as 60%) and does not need to be considered "affordable."

Penalties for large group employers

- If minimum coverage is not offered to full-time employees, and at least one employee gets subsidized coverage through an exchange, then a $2,000 penalty is assessed for each employee (after the first 30).
- If minimum coverage is offered to full-time employees but it is not affordable for an employee, and that employee gets subsidized coverage through an exchange, then a $3,000 penalty is assessed for each employee getting subsidized coverage.

Health care reform does NOT require employers to:

- Contribute to the premium. (Although if they do not, their plan may not be affordable, putting the employer at risk for penalties.)
- Offer dependent coverage.

Other taxes and fees

Individuals and employers may be responsible for other taxes and fees related to the health care reform law. The chart below highlights some of them.

Tax/Fee	Effective Date	Responsible Party	Annual Tax/Fee Amount
Pharmaceutical industry fee – an annual fee on branded prescription drug manufacturers and importers	Applies to any branded prescription drug sales after December 31, 2008	Manufacturers or importers with gross receipts from branded prescription drug sales	Amount is determined by the branded prescription drug sales during the calendar year and percentage of gross receipts taken into account.
Medical device manufacturer fee – an annual fee on medical device manufacturers and importers	Applies to any medical device sales after December 21, 2008	Manufacturers or importers with gross receipts from medical device sales	Amount is determined by the medical device sales during the calendar year and percentage of gross receipts taken into account.
Indoor tanning services tax – a tax on any service that uses an electronic product with 1 or more ultraviolet lamps for skin tanning	Applies to services performed on or after July 1, 2010	Individuals that use the services	Tax equal to 10% of the amount paid for a service.
Comparative effectiveness research fee – this fee funds research on the effectiveness, risks and benefits of medical treatments through the Patient-Centered Outcomes Research Institute	Plan/policy years that end after September 30, 2012 and beginning before October 1, 2019	Issuers of fully insured plans Self-insured plan customers	For plan years that end during October 1, 2012, through September 30, 2013, this fee is $1 per participant per year. For plan years that end during October 1, 2013, through September 30, 2014, the fee increases to $2 per participant per year. After that, the rate increases each year by the medical inflation rate.
Tax on high earners and unearned income – an annual tax on wages or unearned income of more than $200,000 for singles and $250,000 for married couples	Tax years beginning January 1, 2013 and later	Individual taxpayers	0.9% Medicare surtax on wages in excess of $200,000 single/$250,000 married couples. 3.8% tax on unearned income for taxpayers with modified adjusted gross income in excess of $200,000 single/ $250,000 married couples.

Tax/Fee	Effective Date	Responsible Party	Annual Tax/Fee Amount
ACA insurer fee – an annual excise tax on health insurance to fund premium subsidies and Medicaid expansion	Tax years beginning January 1, 2014 and later	Issuers of fully insured plans	Based on the insurer's market share of net premiums written based on the previous year. For example, the 2014 fee will be based on 2013 premiums. Total fee amount to be collected across all insurers starts at $8 billion in 2014 and increases to $14.3 billion in 2018. After 2018 the fee increases annually based on premium growth. Starting in 2014 the fee is 2.46% of premium.
ACA reinsurance fee – this will support the transitional reinsurance program that aims to stabilize premiums for coverage in the individual market and lower the effects of adverse selection	Plan/policy years beginning in the 3-year period starting January 1, 2014	Issuers of fully insured plans Sponsors/ administrators will collect and send the contributions on behalf of self-insured plans	Funds will be used to make reinsurance payments to health insurance issuers that cover high-cost individuals in nongrandfathered individual market plans. This fee is $6.35 per participant per month.
High-cost insurance tax – an annual excise tax on high-cost health plans	Tax years beginning January 1, 2018 and later	Issuers of fully insured plans Sponsors/ administrators of self-insured plans	Tax of 40% on health plan costs that exceed "Cadillac" plan thresholds of $10,200 for single coverage or $27,500 for family coverage.

Producers*

The exchanges don't replace private health insurance. They are simply a new place for qualified individuals and small group employers to shop for and buy it.

HHS expects producers will work with individuals and small group employers looking for coverage on the exchanges, but each exchange will decide how producers will be involved. They may allow producers to help people enroll in QHPs or help them with their applications for credits and subsidies. As more guidance is given about the producer role, more information will be provided, including how the states will continue to oversee licensing of producers.

*Healthcare.gov: *Affordable Insurance Exchanges: More Choices, Competition and Clout* (accessed October 2012).

Our company

We are proactively preparing for the exchange marketplace across our organization and in all of the states we serve. We are working to develop qualified health plans that comply with the new 2014 benefit requirements set forth by the health care reform law. And, we're staying focused on improving the lives of the people we serve and the health of our communities. Here's what teams in our company are doing:

Product development team

- Providing plan information to healthcare.gov
- Updating plan designs to comply with qualified health plan requirements
- Developing and maintaining plan designs that meet post-2014 benefit requirements

Public policy team

- *Federal level* – evaluating the guidance and providing comments
- *State level* – advocating for exchange rules that maintain choice and don't disrupt the existing marketplace

Exchange strategy team

- Working with local leaders to define opportunities and priorities in each state

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