July 2013

The Affordable Care Act:
Health Insurance Exchanges

BlueCross BlueShield of Illinois

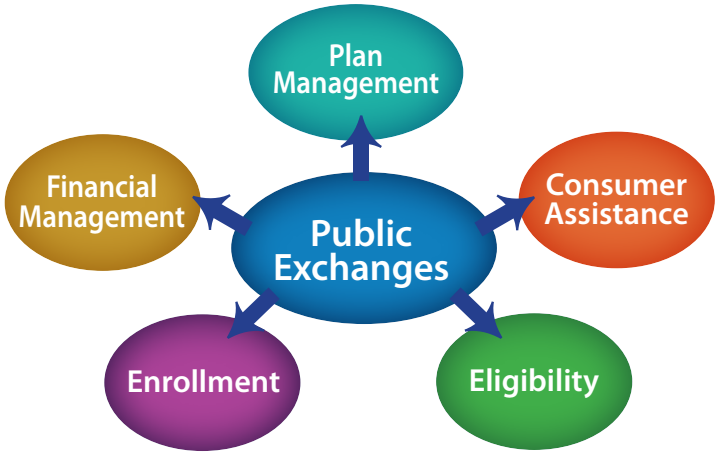
Frequently Asked Questions

When Do the Health Insurance Exchanges Open?

Open enrollment period for 2014 on the individual exchanges begins Oct. 1, 2013, and continues through March 31, 2014. Open enrollment on the Small Business Health Options Program (SHOP) exchanges begins Oct. 1, 2013. As with today's small business health insurance market, enrollment in small group coverage will occur on a rolling basis throughout the year.

What Will Health Insurance Exchanges Do?

Exchanges will provide five minimum functions:



- **Plan management:** Consumers and small businesses will be able to review information and choose among many qualified health plans (QHPs), which have been certified by the exchanges to meet essential health benefit and actuarial value criteria outlined in the Affordable Care Act (ACA).
- **Consumer assistance:** Navigators, call centers, online assistance tools, certified application counselors and in-person assisters, in addition to other assistance aids, will help consumers and small businesses apply for coverage on the exchanges.
- **Eligibility:** Applicant information is collected and verified to determine eligibility for enrollment, premium tax credits, cost-sharing reductions, as well as Medicaid and CHIP programs.
- **Enrollment:** Consumers and small employers can choose and enroll in a QHP, taking into consideration their eligibility for financial assistance. Consumers will also be able to enroll in exchange coverage directly with QHP issuers, by visiting the health insurer's website.
- **Financial management:** Exchanges will conduct oversight of QHP issuers, will be required to keep accurate accounting of all financial activities, and must submit a report annually to the secretary of the U.S. Department of Health and Human Services about such accounting.

Summary

Beginning in 2014, the Affordable Care Act (ACA) requires most U.S. citizens and legal residents to obtain a minimum amount of health insurance or potentially face financial penalties. ACA requires health insurance exchanges (also known as the health insurance marketplaces) to be available in every state by October 2013. These exchanges will allow consumers and small businesses to shop, compare and enroll in health insurance coverage.

Much like travel search engines, an individual or small employer can go to the online health insurance exchanges to purchase and enroll in health coverage. They will also be able to enroll over the phone or by submitting a paper application.

Exchanges will display options for qualified health plans (QHPs) offered in their area, provide details on the plan design and premium, give information to help decide which plan best suits their needs, and help individuals and small employers learn more about potential financial assistance.

Small Business Health Options Program (SHOP) exchanges will provide information to small business employers and their employees to help them compare benefits across health plans.

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Who Will Use Health Insurance Exchanges?

Individuals and small businesses will be the initial users of the exchanges. In 2017, the health insurance exchanges will be expanded to include large employers.

What Types of Plans Can Be Sold on the Exchanges?

Only plans certified as QHPs may be sold on the exchanges. There are additional market reform requirements around coverage and other levels of benefits (commonly referred to as the metallic levels) that must be met by non-grandfathered individual plans and non-grandfathered, fully insured small group plans, whether on or off the exchanges.

What Will Health Insurance Exchange Plans Look Like?

In addition to meeting all 2014 health market reform requirements mandated by ACA, including guaranteed issue and modified community rating, all QHPs will cover essential health benefits (EHBs), a package of benefits based on those covered by a typical employer health plan. Benefits will be offered in four metal levels (discussed below) based on the amount of coverage that the plan provides.

What Are the Four Levels of Coverage for QHPs?

Each level of coverage corresponds to one of four tiers based on the share of health care costs that will be covered by the plan (actuarial value): **Bronze, Silver, Gold and Platinum (i.e., "the metallics")**. Within each tier, there may be several plans to choose from and all will include essential health benefits. For example, in a bronze plan, the lowest metal level, an individual's share of the cost will be higher when health care services are provided. In a platinum plan, the highest metal level, an individual's share of the cost will be lower. However, platinum plans are likely to come with a higher monthly premium.

Bronze	• Lower monthly payments • Higher out-of-pocket costs when you receive medical care
Silver	• Higher monthly payment than a Bronze plan • Lower out-of-pocket costs than a Bronze plan when you receive medical care • Silver plans eligible for cost-sharing assistance based on income
Gold	• Higher monthly payment than a Silver plan • Lower out-of-pocket costs than a Silver plan when you receive medical care
Platinum	• Highest monthly payments • Lowest out-of-pocket costs when you receive medical care

Note: A catastrophic plan will be offered only to individuals who purchase coverage on the exchanges and who are less than 30 years of age, or for individuals who received certification for lack of affordable coverage or financial hardship. The federal premium tax credit cannot be used to purchase catastrophic coverage.

What Are Multi-State Plans?

The Multi-State Plan Program (MSPP), which will be operated by the Office of Personnel Management (OPM), is designed to increase consumer options on the exchanges. Issuers participating in the MSPP will contract with OPM, and plan approval by OPM automatically qualifies the plan to be sold on the exchanges. MSPP eligibility requirements will be similar to that of QHP — issuers must offer plans that meet a recognized level of coverage or "metallic."

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Overview of ACA's Impact on Small Businesses

Beginning in 2014, small businesses (less than 50 full-time employees and full-time equivalents combined) will have new opportunities to offer coverage. Small groups can continue to offer coverage as they do today (through a traditional group contract) or pursue an alternative means to offer coverage to their employees. A new option available to small businesses will be to purchase health care coverage through the Small Business Health Options Program (SHOP), which is a type of health insurance exchange for small businesses.

Can Small Groups with Grandfathered Plans Keep Their Existing Coverage?

Yes. Grandfathered small businesses with plans in place prior to March 23, 2010, that wish to keep the insurance plan they currently have, may still do so unless they choose to make certain changes that reduce benefits or increase costs to consumers. This would cause a loss in their grandfathered status.

What Causes a Plan to Lose Grandfathered Health Plan Status?

Among other things, a group health plan will lose its grandfathered status if any of the following changes are made after March 23, 2010:

- **Elimination of Benefits**. The elimination of all or substantially all benefits to diagnose or treat a particular condition or any necessary element to diagnose or treat a condition.
- **Coinsurance Changes**. Any increase in a percentage cost-sharing requirement.
- **Copayment Changes**. An increase in a fixed amount copayment if the total increase in the copayment exceeds the greater of $5 (increased by medical inflation) or a percentage equal to medical inflation plus 15 percentage points.
- **Deductible Increases**. An increase in a fixed amount, cost-sharing requirement other than a copayment (e.g., deductibles or out-of-pocket limits) if the total percentage increases in the cost-sharing requirement exceeds medical inflation plus 15 percentage points.
- **Decrease in Employer Contributions**. A decrease in the rate of employer contributions by more than 5 percentage points for any coverage tier.
- **Annual Dollar Limits Added or Tightened**. A plan that: (1) does not have an overall annual or lifetime dollar limit on all benefits adopts an overall annual dollar limit on benefits; (2) has an overall lifetime dollar limit on all benefits (but no overall annual dollar limit) adopts an overall annual dollar limit that is lower than the lifetime dollar limit; or (3) has an annual dollar limit on all benefits decreases the value of the annual dollar limit.
- **Zero Enrollment**. ACA regulations also address plans that have had enrollment fall to zero members at any time since March 23, 2010. A plan or coverage has to have continuously covered someone since March 23, 2010. If a plan falls to zero members after March 23, 2010, the plan will lose grandfathered status.

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What Are the Major Impacts for Fully Insured, Non-Grandfathered Small Group Plans in 2014?

- Exclusions for pre-existing conditions for enrollees of all ages are prohibited.
- Waiting periods for employees eligible for group coverage cannot be longer than 90 days for plan years starting on or after Jan. 1, 2014.
- Health insurance issuers will only be allowed to vary rates based on geographic area, family size, age and tobacco use. State rating rules will still apply.
- Beginning in 2014, non-grandfathered health plans in the individual and small group markets will be measured using actuarial value (metallic levels). Actuarial value will allow consumers to compare plans with similar levels of coverage, which along with consideration of premiums, provider participation, and other factors, would help the consumer make an informed decision.
- Essential health benefits (EHBs) are mandated.
- For plan years beginning on or after Jan. 1, 2014, all non-grandfathered plans that cover EHBs, must limit annual out-of-pocket member expenses for in-network EHBs. Expenses for EHBs including coinsurance, deductibles, copays and similar charges cannot exceed 2014 out-of-pocket limits under the Internal Revenue Code for Health Savings Accounts (HSAs), which are $6,350 for self-only coverage and $12,700 for family coverage. In some circumstances, where multiple service providers are used, a one-year safe harbor may be applicable with regard to limits for the non-major medical portion of the coverage.
- For plan years beginning on or after Jan. 1, 2014, non-grandfathered, fully insured small group plans and individual plans must limit deductibles to $2,000 for individuals and $4,000 for families. This applies only to in-network EHBs. A health plan may exceed the deductible limit if it cannot reasonably reach a given level of coverage (metallic level) without doing so.

What Is Guaranteed Availability and Renewability?

ACA prohibits insurance companies from declining to sell coverage to small employers (1 to 100 employees, or 1 to 50 if the state elects, until 2016) based on health or medical claims. Insurers can't cancel a group or individual policy if a member gets sick. Insurers also have to renew a policy at a group's or individual's request. Premiums can vary only based on age, tobacco use, family size and geography. This is called **"guaranteed availability"** and **"guaranteed renewability."**

All carriers in the individual and group markets will be required to offer all products approved for sale in a particular market on and off the exchanges and accept any individual or group that applies for any of those products. Plans and policies are guaranteed renewable. If a plan sponsor in the small group market can't meet employer contribution or group participation rules, a carrier may limit the availability to an annual enrollment period of November 15 through December 15 of each year.

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Are Employers Required to Use the Exchanges to Purchase Insurance?

No. The federal law specifically states that businesses are not required to purchase insurance through the SHOP exchanges and can continue to buy health insurance through an insurance agent or broker, as they do today.

Are There Reasons a Small Group Employer Might Use the SHOP Exchanges?

Yes. Small group employers with 25 or fewer employees (with an average wage of less than $50,000 a year) may be eligible for tax credits. The tax credit will cover up to 50 percent of the employer's cost (up to 35 percent for small nonprofit organizations) and is available for the first two years an employer offers coverage through a state exchange.

What Options Will Employers Have on the Exchanges?

Recently, the federal government finalized rules delaying part of the SHOP exchange until 2015. For 2014 only, employers will be able to select one plan for their employees for states with federally facilitated exchanges; employee choice is optional for state-based exchanges in 2014.

Beginning in 2015, states can provide the following three options to employers for providing health insurance to their employees via SHOP:

Small Business Health Options Program (SHOP) Exchanges

SHOP exchanges are marketplaces where small employers (1-100 employees, or 1-50 if the states elects, until 2016) can obtain health coverage for their employees and possibly take advantage of the tax credits.

States will have the flexibility to determine who selects the coverage.

Employer Choice	Hybrid Choice	Employee Choice
Employer may be permitted to select one or more specific plans on behalf of employees or self	Employer can select metallic level and then employee can select any plan (from any carrier) within that level	Employee can select any plan offered on the exchange, as long as it meets SHOP benefit plan design requirements

What Will the Role of the Broker Be with Respect to Exchanges?

It depends. While CMS has stated that agents and brokers, including web brokers, will be able to sell exchange products on the federally facilitated exchanges, each state has the flexibility to determine the role of agents and brokers in their exchanges. There may be various means a state may choose to integrate agents, brokers and web-brokers in the enrollment process. An agent or broker serving as a **Navigator** (an individual who will conduct public education activities, distribute information about exchange health plans and facilitate enrollment) would not be permitted to receive commission from a health insurance issuer for enrolling individuals in particular health plans. Exchanges also have flexibility to establish training, registration and licensing requirements, as well as determine compensation levels for agents and brokers who wish to participate in the exchanges.

How Are SHOP Plan Premiums Set?

Beginning Jan. 1, 2014, insurance companies must meet the ACA's minimum premium rating rules for health plans for small businesses. Under ACA, health plans will be allowed to adjust premiums based only on age, tobacco use, family size and geography (of the employer group). State rating rules will still apply.

NOTE: This information is a high-level summary and for general informational purposes only. The information is not comprehensive and does not constitute legal, tax, compliance or other advice or guidance. Decisions on certain portions of the Affordable Care Act and its implementation are forthcoming. Many of the answers above represent current understanding of rules that are still in a "proposed" status. Therefore, the above is universally subject to change.