Module 5

HEALTH INSURANCE MARKETPLACES

Health Insurance Marketplaces (sometimes called exchanges) facilitate the purchase of health insurance by individuals and small businesses and play a central role in the implementation of the Affordable Care Act (ACA). Marketplaces in each state offer consumers a way to compare and shop for private health insurance plans. Subsidies are available to individuals with family income between 100 percent and 400 percent of the Federal Poverty Level (FPL). Marketplaces also screen individuals for eligibility for Medicaid and Children's Health Insurance Program (CHIP) coverage, ensuring that individuals experience "no wrong door" to health coverage.

Marketplace Structure and Operations

Marketplaces opened for enrollment in every state on October 1, 2013. As of December 2014, 14 states ran their own state-based Marketplace; 3 states ran a federally-supported Marketplace; 7 states ran a state-partnership Marketplace; and 27 states ran a federally-facilitated Marketplace. State-based Marketplaces are responsible for all Marketplace functions, including selecting the private plans that are sold on the Marketplace, determining individual eligibility, and providing consumer assistance. Consumers in these states apply for and enroll in coverage through the state's own website. Similarly, federally-supported states maintain their own enrollment website and are responsible for performing all Marketplace functions, however on the back-end, these states rely on the federal Marketplace IT platform. State-partnership states use the federal Marketplace website, healthcare.gov, to enroll consumers, but the state administers certain Marketplace functions such as consumer assistance. Finally, in federally-facilitated states, consumers enroll through healthcare.gov and the Department of Heath and Human Services performs all Marketplace functions.[i]

Qualified Health Plans

Plans certified to be sold through Marketplaces are known as Qualified Health Plans (QHPs). All QHPs must cover, at a minimum, the same basic categories of health care services, known as essential health benefits (see Module 6 for a more detailed discussion). All plans charge a monthly premium, which varies depending on the deductible, percent of costs covered by the plan, and other factors. Marketplaces allow consumers to compare QHPs by dividing them into four categories: platinum; gold; silver; and bronze. Bronze plans charge the lowest premiums and platinum plans charge the highest premiums. However, when individuals and families access health care, those with bronze plans will have to pay more out of pocket before the plan contributes, while those with platinum plans will be required to pay less before the plan contributes. Thus, families who use many health services may find a "higher metal" plan more affordable overall. On average, platinum plans cover 90 percent of health care costs, while bronze plans cover 60 percent of health care costs. It is important to remember that each category of health plans only tells you the *average* amount of health care costs that the plan will pay.[ii]

Eligibility

Adults and children without other options for affordable health coverage (for instance through employment), can purchase insurance on Marketplaces and may receive federal subsidies to reduce the costs. Individuals who have access to affordable coverage through employer sponsored coverage, or individuals who are eligible for Medicaid or CHIP, will not receive tax credit subsidies toward the purchase of a Marketplace QHP.

[i] http://kff.org/health-reform/state-indicator/state-health-insurance-marketplace-types/

[ii] https://www.healthcare.gov/choose-a-plan/plans-categories/

Affordability

Two kinds of federal subsidies are available on a sliding scale to help individuals and families with incomes between 100 and 400 percent FPL afford Marketplace QHPs. Advance Premium Tax Credits (APTC) help reduce the price of premiums. Individuals with income between 100 and 400 percent FPL can choose to have tax credit subsidies paid in advance directly to the insurance company, thereby lowering monthly premiums, or can claim the entire credit when filing taxes for the year. The tax credit amount is calculated based on household income, family composition, and the price of a silver-level plan. In addition to offering APTC, the federal government also provides cost-sharing reductions (CSR) for individuals with income between 100 and 250 percent of the FPL who purchase a silver plan. CSRs help reduce out-of-pocket costs—such as copayments, co-insurance, and deductibles—associated with health insurance. The ACA places a limit on total out-of-pocket costs associated with any non-grandfathered plan; for 2015, the maximum out-of-pocket amount anyone must pay is $6,600 for an individual plan and $13,200 for a family plan. Premiums do not count towards the maximum out-of-pocket amount.[iii]

Applying for Marketplace Coverage

Each Marketplace maintains a website where individuals and families can shop for and purchase QHPs. The federal Marketplace, healthcare.gov, serves this function in the 34 federally-facilitated and state-partnership states. Healthcare.gov also provides links to state Marketplace websites. Individuals and families can apply for Marketplace coverage online, by telephone or in person. Individuals can enroll in Marketplace coverage only during an annual open enrollment period or during specified special enrollment periods. There are qualifying life circumstances such as getting married, having a baby, losing employer coverage, or aging out of a parent's plan, when individuals can qualify for a special enrollment period. By completing a Marketplace application, individuals and families can learn whether they are eligible for:

- **Financial aid to buy private insurance plans** – Marketplaces tell individuals if they are eligible for subsidies to buy qualified health plans and whether they qualify for lower out-of-pocket costs based on income and household size; or
- **Medicaid or CHIP** – These programs provide coverage to millions of children and families with limited income. If it looks like an individual qualifies for one of these programs, the individual's information is transferred to the appropriate state agency for an eligibility determination and further processing.

Consumer Assistance

To help connect individuals to coverage, all Marketplaces are required to set up consumer assistance programs. Consumer assistance programs provide individualized counseling to help consumers understand their coverage options, apply, and choose a QHP. Consumer assisters are known by various names: navigators; in-person assisters (IPAs); and certified application counselors (CACs). Consumer assisters provide impartial information about QHP options, help consumers compare and select a QHP, and help consumers complete and file applications. They can also help consumers report changes during the coverage year, assist consumers with renewing coverage, and connect consumers who have grievances, questions, or complaints to the appropriate agency for resolution. Consumer assisters receive federal training that includes: methods to address the needs of underserved and vulnerable populations, basic information on qualified health plans, eligibility and enrollment rules and procedures, and privacy and security requirements. States can provide additional training as well. Insurance agents, brokers, and certain federally qualified health centers also can help people choose and enroll in QHPs.

Issues for MCH Populations

There are three issues related to Marketplace coverage that are important to note, as they may have significant impact on coverage for women, children, and families:

1. **The "family glitch"** – According to Internal Revenue Service (IRS) regulations, if an individual has access to employer-sponsored insurance, the cost to the employee for such coverage must not exceed 9.5 percent of the employee's income, based on the cost of an individual-only policy. This rule does not take into consideration the often significantly higher cost of a family plan. This is know as the family glitch.

[iii] https://www.healthcare.gov/glossary/out-of-pocket-maximum-limit/

Average annual premiums for employer-sponsored insurance in 2013 were $5,884 for individual coverage and $16,351 for family coverage.[iv] As a result, families with low- to moderate-income may not be able to afford either the employer sponsored insurance or Marketplace coverage without the subsidy.

2. **"Premium stacking"** – The calculation for premium tax credits does not take into account premiums that families might already pay for children enrolled in CHIP or Medicaid. In 2013, 29 states charged premiums for some children in Medicaid or CHIP.[v] The need to pay Medicaid or CHIP premiums in addition to premiums for parents' QHP coverage imposes an additional financial burden on families where coverage is split across multiple programs. Premium stacking may be particularly burdensome for families purchasing stand-alone dental coverage through the Marketplace (see module 6 on Benefits for more information).

3. **Continuity for Pregnant Women** – The introduction of QHPs creates new complexity for coverage of some pregnant women. As noted in module 4, prior to the ACA, pregnant women were a mandatory Medicaid population. When states filed their State Plan Amendments (SPA) for MAGI for pregnant women, most noted they would be providing full Medicaid benefits to pregnant women, which is minimum essential coverage (MEC); individuals who are eligible for MEC are not eligible for subsidized Marketplace coverage. Depending on the state and household income, a woman who is eligible for and enrolled in a subsidized QHP who becomes pregnant may be eligible for full Medicaid benefits. In order to ensure continuity of care, under these circumstances, she may choose to forego Medicaid to retain her subsidized QHP coverage. Or she can unenroll in the QHP and enroll in Medicaid, but she cannot have full Medicaid benefits and subsidized Marketplace coverage simultaneously.[vi]

[iv] http://kff.org/private-insurance/report/2013-employer-health-benefits/

[v] http://kaiserfamilyfoundation.files.wordpress.com/2013/05/8401.pdf

[vi] http://www.medicaid.gov/federal-policy-guidance/downloads/sho-14-002.pdf

Test your knowledge

1. Marketplaces in every state offer:

   a. A website where consumers can compare and enroll in QHPs
   b. Call centers to assist individuals with eligibility and enrollment questions
   c. In person assistance with QHP selection and enrollment
   d. All of the above

2. **True or False:** If the premiums for employee-only coverage offered by an employer are less than 9.5 percent of the employee's household income, the coverage is deemed affordable. Even if family coverage exceeds 9.5%, the family will not be eligible for subsidized Marketplace coverage.

3. Which of the following is NOT correct?

   a. Plans sold on all Marketplaces must offer a basic set of benefits called essential health benefits.
   b. Marketplaces may be run by an individual state, a state-federal partnership, or by the federal government.
   c. Individuals need to submit separate applications to be considered for Medicaid/CHIP coverage or Marketplace coverage.
   d. Subsidies are available to individuals between 100 and 400 percent FPL to purchase QHPs through the Marketplace.

Find Out in Your State

1. What kind of Marketplace does your state operate (state-based Marketplace, federally supported Marketplace, state-partnership Marketplace, or federally facilitated Marketplace)? If your state has a state-based Marketplace, what is the agency or entity that runs the Marketplace?

2. What are the consumer assistance entities in your state?

3. What type of training is provided in your state for consumer assistance? Who provides the training? Does it include information specifically related to challenges MCH and CYSHCN populations may face?

Test Your Knowledge Answers: 1. d
2. True. Under the ACA, "affordable" is defined as individual coverage lower than 9.5 percent of household income.
3. c

This document is part of *The Affordable Care Act: A Working Guide for MCH Professionals*, available in its entirety on the Web at http://www.amchp.org/Transformation-Station/Pages/ACA-101.aspx

The National MCH Workforce Development Center is supported by the Health Resources and Services Administration (HRSA) of the U.S. Department of Health and Human Services (HHS) under grant number UE7MC26282 for $1,837,391 with no financial support from nongovernmental sources. This information and conclusions are those of the authors and should not be construed as the official position or policy of, nor should any endorsements be inferred by HRSA, HHS or the U.S. Government.