Health Insurance

Health Insurance Exchanges in the States

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INNOVATIONS IN HEALTH CARE | A TOOLKIT FOR STATE LEGISLATORS

Overview

Prior to the Affordable Care Act (ACA) becoming law in 2010, Americans who were not eligible for employer-subsidized or public health insurance programs often found coverage through a category known as individual or commercial health insurance. In many locations, however, consumers faced limited or costly options in the commercial health insurance market. For enrollees with preexisting conditions, such as asthma, diabetes, arthritis or cancer, health insurance coverage could be costlier than coverage for healthier enrollees—or denied altogether. Private insurance coverage also often excluded benefits such as maternity care or prescription drugs.[1] Moreover, insurers could use other types of premium ratings, like gender or age, which allowed them to sell policies at higher monthly premiums than for other enrollees.

After the ACA, insurance carriers were banned from using such practices. Furthermore, the ACA established a new option for health coverage, known as health insurance exchanges or marketplaces. The exchanges use an online eligibility and enrollment platform that provides a place for individuals and families to compare prices and benefits and purchase coverage. The ACA also established the Small Business Health Options Program (SHOP) as an exchange for small employers to purchase coverage for themselves and their employees.

Plans sold both in and out of the exchanges must follow the same set of rules: They must be guaranteed issue, meaning they must offer all applicants a plan regardless of health status or other factors; they must follow the ACA's cost-sharing guidelines; and they must cover 10 "essential health benefits," or EHBs, with no lifetime or annual maximums. To help mitigate the risk of taking on enrollees with greater health risks and potential costs, the ACA imposed an individual health insurance mandate, which required that all Americans purchase some form of health coverage. Even though the individual mandate penalty was reduced to $0 under the Tax Cuts and Jobs Act of 2017, the mandate itself remains in place pending further congressional or legal action.

■ **Federal subsidies.** A major component of the ACA related to exchanges is the availability of federal subsidies. There are two types of subsidies: advance premium tax credits (APTCs) and cost-sharing reductions (CSRs). Enrollees with annual household incomes between 100 percent and 400 percent of the federal poverty level (FPL) can access APTCs to reduce their monthly insurance premiums. Enrollees can use APTCs to purchase a plan from any tier on the ACA health insurance marketplaces. Those with annual household incomes below 250 percent FPL can also receive extra savings with CSRs to reduce the amount they pay toward deductibles, copays and other cost-sharing mechanisms for plans purchased through the marketplaces. To qualify for CSRs, enrollees much purchase a plan in the "silver" metal tier.[2]

Health plans in the ACA are sold in four levels of coverage: bronze, silver, gold and platinum. Bronze plans have the most affordable premiums but offer the least amount of coverage and the highest out-of-pocket expenses. In contrast, platinum level plan premiums are the most expensive but provide greater coverage with less out-of-pocket costs.

For the past five years, at least 80 percent of exchange consumers have been eligible for APTCs. Of that group, 50 percent or more received CSRs.[3] In 2017, advance tax credits reduced the actual monthly premium paid by an individual from an average of $460 per month to $167 per month.[4] It should be noted that, although many who shop for insurance through the exchanges receive subsidies, individuals or families with incomes above 400 percent FPL may also

use the marketplaces to buy nonsubsidized health coverage.

The ACA requires insurers to provide CSRs to people with lower earnings and, until recently, the federal government reimbursed carriers for those subsidies. The law was challenged and reversed in 2016 and the federal government stopped making CSR payments to insurers the following year. As Health Affairs reports, all but two states—Vermont and North Dakota—and the District of Columbia allowed insurers to amend their rate filings for plan year 2018. To buffer against the loss of CSR reimbursements, insurance regulators in 43 states allowed plans to "silver load."[5] This method permits the insurer to pass the full effect of the reduction in funds onto silver tier marketplace plans.

This had a positive consequence for many consumers. Since premium tax credits are tied to the second lowest-cost silver plan, consumers received higher premium tax credits from the government. And because consumers can use their tax credits to purchase a plan in any of the four metal tiers, about 4.5 million people could obtain a bronze-level plan at no cost in 2018.[6]

Guidance released from the Centers for Medicare & Medicaid Services (CMS) states that silver-loading is allowed for the 2019 plan year, but the discussion of CSR payments continues to evolve. Despite the Trump administration's previous action to discontinue the reimbursements, there are projections of significant costs to insurers and taxpayers,[7] as well as estimates of increases in insurance exchange premiums.[8]

Policy Options

All states were given the opportunity to receive federal planning and implementation grants to develop their health insurance exchange platforms. An exchange has operated within each state since 2014. Exchanges are intended and designed as a state-federal collaboration. Each state is given the choice of whether or not to run its own exchange, create its own website, take on plan management tasks, or defer to the federal government for some or all of these responsibilities. States have taken on varying degrees of responsibility for operating exchanges, giving some states more autonomy over certain policy decisions.

As of 2018, 11 states and the District of Columbia have a fully state-run exchange, or state-based marketplaces (SBMs), which allow for more locally focused decisions and administration. The state legislature and executive agencies can set deadlines and hours of operation, enforce consumer regulations and personalize marketing activities such as using storefronts and social media. Five states have a hybrid structure with a state-run exchange but federal web platform.[9] In 17 other states, the federal government is legally responsible for all marketplace functions but defers to the state to manage the plans. Another 17 states have adopted or defaulted entirely to the federally facilitated marketplace.[10]

Despite differing choices, all 50 states and the District of Columbia have the authority to regulate in-state sales of health insurance policies. This state regulation is focused on the individual and small

group market, most commonly defined as between one and 50 enrollees or full-time employees. Over the past 30 years, all states also have established coverage requirements for a wide range of specific treatments and benefits. They have also required reimbursement by specific categories of providers not traditionally covered, such as chiropractors, psychologists, podiatrists or social workers.

The EHBs created within the ACA were aligned with, but not identical to, widely used existing state laws. The newly defined federal mandates for coverage were tied to state "benchmark plans," defined as an exchange's silver plan within a certain region. In plan years 2017, 2018 and 2019, each state's EHB benchmark plan had to be one that was sold in its marketplace in 2014. A 2018 HHS notice makes significant changes to the way in which states can select an EHB benchmark plan by offering three new options for plan year 2020 and annually thereafter:[11]

- **Option 1:** Selecting the EHB-benchmark plan that another state used for the 2017 plan year.

- **Option 2:** Replacing one or more categories of EHBs under its EHB-benchmark plan used for the 2017 plan year with the same category or categories from the EHB-benchmark plan that another state used for the 2017 plan year.

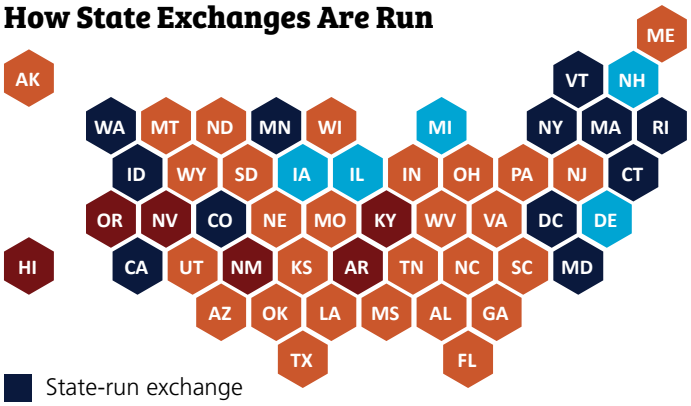
- **Option 3:** Otherwise selecting a set of benefits that would become the state's EHB-benchmark plan.

The notice also grants insurers greater flexibility to substitute benefits across the 10 EHB benefit categories, if permitted by the state.[12] States that opt not to exercise one of these options will continue to use the same benchmark plan from plan years 2017 to 2019.

State Examples

- **State-Run Exchange—Colorado.** The Colorado General Assembly enacted bipartisan legislation creating a state-run

How State Exchanges Are Run



Source: NCSL, 2019

exchange in 2011, choosing to create a nonprofit entity governed by an independent 12-member board. The Colorado exchange, Connect for Health Colorado, allows all qualified health plans to participate in the exchange rather than selecting specific carriers. State general funds cannot be used to establish or operate the exchange, and the law established a financial assessment on insurers to support the exchange starting in 2014. It also created the Legislative Health Benefit Exchange Implementation Review Committee. The board has emphasized creative public marketing using paid and public service ads, a colorful and interactive website for eligibility determinations and enrollment, and state-managed Twitter and Facebook accounts. Connect for Health has also operated storefronts during open enrollment periods. State and local navigators and assistors play a highly visible role in person and on the phone to help consumers shop for and purchase appropriate plans. In 2014, approximately 129,000 Coloradans signed up for private health insurance through Connect for Health Colorado during the first open enrollment period. For 2019, enrollment increased to more than 169,000 covered people.

■ **Federally facilitated marketplace—Florida.** Florida was one of 18 states in which the legislature, by 2011 state statute, sought to prohibit any person from being compelled to purchase health insurance. The governor also refused to accept the $1 million in planning funds to design a health exchange, as part of a challenge to the ACA.[13] Even so, Florida residents were able to access the federal platform, HealthCare.gov, during the enrollment period beginning Oct. 1, 2013. Florida has experienced the highest sign-up rate of any state. In 2014, its first year, 983,775 people purchased insurance on the marketplace, with 91 percent receiving financial assistance; in 2018, enrollment grew to 1,715,000.[14]

■ **Federal-state partnership—Iowa.** In 2012, Iowa's governor announced that the state would run the plan management portion of the exchange. It would allow the federal default approach to define EHBs based on the state's largest operating small group health plan. Iowa accepted $59 million in total federal grants. For 2018, silver metal tier plans in Iowa faced the highest annual premium increase in the nation, at 69 percent.[15] Despite projections that enrollment might decrease, after federally mandated subsidies were deducted from premiums, the state's enrollment in 2018 was 3 percent higher than in 2017.[16]

State Legislators Assisting Local Residents

More than 11 million applicants are enrolling in private health coverage each year nationwide, which translates to an average of more than 1,500 in each of the 7,383 legislative districts. Legislators often receive a steady stream of questions from constituents and their friends or neighbors. These quick tips may be helpful:

- Federal open enrollment runs only from Nov. 1 to Dec. 15. As of December 2018, seven state-run exchanges extended their deadlines by several weeks.[17]
- Some individuals are eligible for the Special Enrollment Period. Special enrollment during the year is possible for those who have a "qualifying event" such as moving to or from another state, losing or leaving a job, having a child, or getting married or divorced.
- Federally funded subsidies are available to many individuals or families with incomes between 100 percent and 400 percent of federal poverty guidelines ($48,560 for an individual; up to $100,400 for family of four).
- Anyone can browse through plans www.HealthCare.gov/see-plans. Just enter a ZIP code to start.
- Anyone can call and ask to speak with a trained navigator at no charge or obligation.
- Visit HealthCare.gov to enroll online in an individual plan. Or call 1-800-318-2596 (TTY: 1-855-889-4325).
- For small business owners or employees, visit online to enroll in a SHOP plan. Small employers with no more than 25 employees may qualify for the Small Business Health Care Tax Credit that could be worth up to 50 percent of the costs paid for employees' premiums (35 percent for nonprofit employers).[18]

■ **2018-2019 federal rules.** Under the Trump administration, several new issues and approaches are affecting state-based coverage for 2018 and beyond.

- **Individual mandate penalty.** While most of the 2010 federal law remains in effect, in 2017, Congress eliminated the individual mandate penalty for those who do not obtain minimum essential coverage, effective Jan. 1, 2019. In response, some states have established a state-based requirement to obtain coverage to replace the federal requirement.

- **Innovation waivers for reinsurance.** Some states are mitigating the rising cost of premiums by implementing a reinsurance program, using a Section 1332 Innovation Waiver. Built into the ACA, 1332 waivers allow states to explore ways to modify key parts of the health law while still fulfilling the original aims of the ACA. Seven states—Alaska, Maine, Maryland, Minnesota, New Jersey, Oregon and Wisconsin—have begun operating or received approval for state reinsurance programs, allowing federal and state funds to provide a buffer against high-cost enrollees and thereby lowering monthly premiums.[19]

- **Association health plans (AHPs).** As of July 2018, new federal regulations allow for the expanded sale of health policies outside of the health insurance exchanges that do not need to comply with certain ACA consumer protections. These policies are designed to be less expensive. Such plans, for example, can exclude coverage of the EHBs and charge higher rates based on various demographic factors such as gender or, in some cases, preexisting conditions. Several states with state-based exchanges have moved to restrict these non-ACA-compliant policies. The full effect of selling such policies will be a matter of discussion and evaluation in 2019.[20]

- **Short-term plans:** Previously limited to three-month duration, the final rule allows these plans to be renewed or extended for up to 36 months. Much like AHPs, this expanded category of lower-cost health insurance can be non-compliant with the requirements of policies on health exchanges.[21]

- **The Small Business Health Options Program (SHOP**). This option was designed and launched in 2014 for small employers who want to provide health and/or dental insurance to their employees "affordably, flexibly, and conveniently." SHOP was available through the federal platform at HealthCare.gov, but is now only available through SHOP-registered agents and brokers, directly through carriers, or in some cases through state-based SHOP platforms. The federal platform continues to provide eligibility determinations for participating in SHOP and qualifying for the small business tax credit.[22] See 2019 SHOP Plans and Prices.[23]

- **Enrollment Results.** After five years of operation there is an informative track record of results, with comparative examples in the following table:

Health Insurance Exchanges: Structure and Enrollment

- **State:** State-run exchange
- **Fed-State:** State-run exchange using federally-supported website
- **State-FP:** State-federal partnership
- **Federal:** Federally facilitated marketplace/exchange

State	Run by	Number of people enrolled, 2018	Number of people enrolled, 2017	% Change in Enrollment 2017 to 2018
Alaska	Federal	18,313	19,145	-4.35%
Alabama	Federal	170,211	178,414	-4.60%
Arizona	Federal	165,758	196,291	-15.55%
Arkansas	State-FP	68,100	70,404	-3.27%
California	State	1,521,524	1,556,676	-2.26%
Colorado	State	165,777	161,568	2.61%
Connecticut	State	114,134	111,542	2.32%
Delaware	Fed-state	24,500	27,584	-11.18%
District of Columbia	State	22,469	21,248	5.75%
Florida	Federal	1,715,227	1,760,025	-2.55%
Georgia	Federal	480,912	493,880	-2.63%
Hawaii	State-FP	19,799	18,938	4.55%
Idaho	State	94,507	100,082	-5.57%
Iowa	Fed-state	53,217	51,573	3.19%
Illinois	Fed-state	334,979	356,403	-6.01%
Indiana	Federal	166,711	174,611	-4.52%
Kansas	Federal	98,238	98,780	-0.55%
Kentucky [1]	State-FP	81,155	89,569	10.37%
Idaho	State	94,507	100,082	-5.57%
Louisiana	Federal	109,855	143,577	-23.49%
Maine	Federal	75,809	79,407	-4.53%
Maryland	State	153,584	157,832	-2.69%
Massachusetts	State	270,688	266,664	1.51%
Michigan	Fed-state	293,940	321,451	-8.56%
Minnesota	State	116,358	109,974	5.81%
Mississippi	Federal	83,649	88,483	-5.46%
Missouri	Federal	243,382	244,382	-0.41%
Montana	Federal	47,699	52,473	-9.10%
Nebraska	Federal	88,213	84,371	4.55%
Nevada	State-FP	91,003	89,061	2.18%
New Hampshire	Fed-state	49,573	53,024	-6.51%
New Jersey	Federal	274,782	295,067	-6.87%
New Mexico	State-FP	49,792	54,653	-8.89%
New York	State	253,102	242,880	4.21%

State	Run by	Number of people enrolled, 2018	Number of people enrolled, 2017	% Change in Enrollment 2017 to 2018
North Carolina	Federal	519,803	549,158	-5.35%
North Dakota	Federal	22,486	21,982	2.29%
Ohio	Federal	230,127	238,843	-3.65%
Oklahoma	Federal	140184	146,286	-4.17%
Oregon	State-FP	156,105	155,430	0.43%
Pennsylvania	Federal	389,081	426,059	-8.68%
Rhode Island	State	33,021	29,456	12.10%
South Carolina	Federal	215,983	230211	-6.18%
South Dakota	Federal	29,652	29,622	0.10%
Tennessee	Federal	228,646	234,125	-2.34%
Texas	Federal	1,126,838	1,227,290	-8.18%
Utah [2]	Federal/state	194,118	197,187	-1.56%
Vermont	State	28,762	30,682	-6.26%
Virginia	Federal	400,015	410,726	-2.61%
Washington	State	242,850	225,594	7.65%
Wisconsin	Federal	225,435	242,863	-7.18%
West Virginia	Federal	27,409	34,045	-19.49%
Wyoming	Federal	24,529	24,826	-1.20%
		2018 Exchange Enrollment	**2017 Exchange Enrollment**	**% Change in Enrollment 2017 to 2018**
National Total		11,760,418	12,216,003	-3.73%
Federal Only Totals		8,289,073	8,751,102	-5.28%
State and State-FP Only		3,471,345	3,464,901	0.19%

Calculated by CMS/CCIIO and AP

Source: Commonwealth Fund, "The Affordable Care Act's Health Insurance Marketplace by Type"

Notes

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