AFFORDABLE CARE ACT: HEALTH INSURANCE EXCHANGE

AN ISSUE BRIEF FROM LEGISLATIVE BUDGET BOARD STAFF

ID: 397 APRIL 2013

OBJECTIVE

The Affordable Care Act's Health Insurance Exchange requirement was included as a means to increase access to health insurance.

KEY FACTS

- The Affordable Care Act requires every state to have a fully operational health insurance exchange by January 1, 2014.
- A health insurance exchange is a structured virtual marketplace where individuals and small businesses will be able to purchase health insurance.
- Individuals with household incomes between 100 percent and 400 percent of the federal poverty level who do not have access to affordable employer-sponsored insurance or public insurance coverage will be eligible for federal subsidies to help pay for health insurance purchased through the new health insurance exchange.

STATUTORY REFERENCES

Affordable Care Act, P.L. 111-148, as amended

A health insurance exchange (HIX) is a structured virtual marketplace where individuals and small businesses will be able to compare, select and purchase health insurance from multiple coverage options. The Affordable Care Act (ACA) requires every state to have a fully operational HIX by January 1, 2014. The HIX requirement was included in the ACA as a means to increase access to health insurance. HIXs must also screen individuals for eligibility for certain public health insurance programs, such as Medicaid and the Children's Health Insurance Program (CHIP), and connect the individuals with the appropriate agencies. In addition, HIXs will determine eligibility for federal subsidies for insurance purchased through the HIX.

IMPLEMENTATION OPTIONS FOR A HIX

States have the option to: 1) build a fully state-based HIX, 2) enter into a state-federal partnership HIX, or 3) default into a federally facilitated HIX. States planning to operate a state-facilitated HIX were required to declare their state's intention to establish a HIX by submitting a letter to the federal Department of Health and Human Services (HHS) by November 16, 2012. These states were required to submit HIX planning documents to HHS by December 14, 2012. HHS has indicated that states may opt out of running their own HIX at any time.

For states that default into a federally facilitated HIX, the HHS Secretary has the authority to establish and operate a HIX in that state. HHS can choose to operate a HIX in a state through an agreement with a non-profit entity. In December 2012, Texas was one of 25 states that opted to default into a federally facilitated HIX. HHS will coordinate with these states on health insurance plan certification, oversight functions, consumer assistance and outreach, and streamlining eligibility determinations.

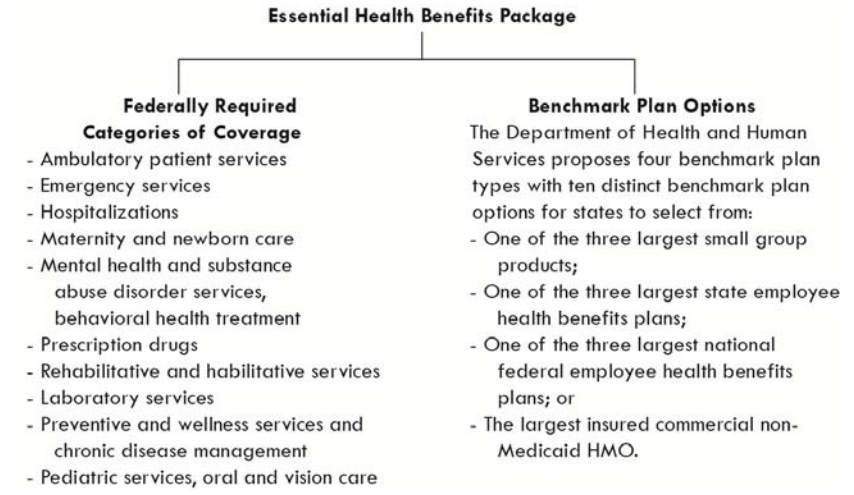
KEY REQUIREMENTS FOR PLANS OFFERED THROUGH THE HIX

Health insurance plans offered through the HIX must be certified as "Qualified Health Plans" or QHPs. One of the requirements to be certified as a QHP is coverage of the federally defined Essential Health Benefits (EHB). The ACA requires that all individual and small group health insurance plans offered in and out of the HIX provide coverage of the EHBs beginning in January 2014. Fig. 1 shows the EHBs listed under the "Federally Required Categories of Coverage." An essential health benefits package will be defined by a benchmark plan specific to each state. States had the option to choose from 1 of 10 plans identified by federal law, as listed in Fig. 1.

States were required to submit their selected benchmark plan to HHS by September 30, 2012. If a state did not select a benchmark, the small group plan with the largest enrollment in the state became the default benchmark. Texas did not select a benchmark plan, so the default plan became the Blue Cross/Blue Shield Best Choice Preferred Provider Organization (PPO) plan. A benchmark plan that does not provide all of the federally required categories must

ensure that the categories are covered in accordance with the ACA. According to a December 2012 report by the of Texas Department of Insurance, in November 2012 HHS proposed rules explaining that state mandated benefits enacted prior to 2012 will not be considered in addition to the EHB, and thus the state will not be required to defray any costs associated with those mandates. Texas will only have a responsibility to defray the cost of mandates if the Texas Legislature enacts new mandates in the future, or if HHS issues future rulemaking that changes the proposed interpretation of additional benefits.

FIG. 1
ESSENTIAL HEALTH BENEFITS PACKAGE, NOVEMBER 2012



SOURCE: Texas Department of Insurance.

COORDINATION WITH PUBLIC INSURANCE PROGRAMS

The Texas Health and Human Services Commission (HHSC) will be required to coordinate Medicaid and CHIP eligibility processes with the HIX. HHSC will have to refer people not eligible for Medicaid or CHIP to the HIX. The HIX will have to refer people eligible for Medicaid or CHIP to HHSC. HHSC was awarded a federal grant in April 2012 to update the Texas Integrated Eligibility Redesign System to enable this coordination.

INDIVIDUAL ELIGIBILITY

An individual must meet the following criteria to be eligible for enrollment in a health insurance plan through the HIX: 1) Be a citizen, national, or noncitizen who is lawfully present in the United States; 2) Not be incarcerated, other than pending the disposition of charge; and 3) Meet applicable state residency standards. Individuals with household incomes between 100 percent and 400 percent of the federal poverty level (FPL) with no access to other insurance coverage will be eligible for federal subsidies to help pay for health insurance purchased through the HIX. The subsidies come in the form of tax credits for premium assistance and reduced cost-sharing. Fig. 2 shows criteria that individuals must meet to be eligible for premium and cost-sharing assistance through the HIX.

FIG. 2
KEY ELIGIBILITY CRITERIA FOR PREMIUM ASSISTANCE CREDITS AND REDUCED COST-SHARING THROUGH THE HIX, JANUARY 2014

ADVANCED PAYMENT OF PREMIUM TAX CREDITS	COST SHARING SUBSIDIES
• Meets the criteria for eligibility for enrollment in a QHP through the HIX. • Is part of a tax-filing unit. • Is enrolled in a QHP offered through a HIX. • Has a household income that either is: between 100 and 400 percent FPL; or an income that is not greater than 100 percent FPL and is a lawfully present alien (but not eligible for Medicaid because of duration of U.S. residency).	• Meets the criteria for eligibility for enrollment in a QHP through a HIX. • Meets the criteria for eligibility for advance payment of premium tax credits. • Is enrolled in a silver (mid- level) plan through the HIX. • Has a household income between 100 and 400 percent FPL.

SOURCE: Congressional Research Service.

USEFUL REFERENCES

Congressional Research Center, Health Insurance Exchanges Under the ACA: http://www.fas.org/sgp/crs/misc/R42663.pdf

Legislative Budget Board, Federal Healthcare Reform Legislative Primer: http://www.lbb.state.tx.us/Federal_Funds/Other_Publications/Federal%20Healthcare%20Reform%20Legislative%20Primer%20212011.pdf

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