Exchanges

A Review of What They Are & How They Work

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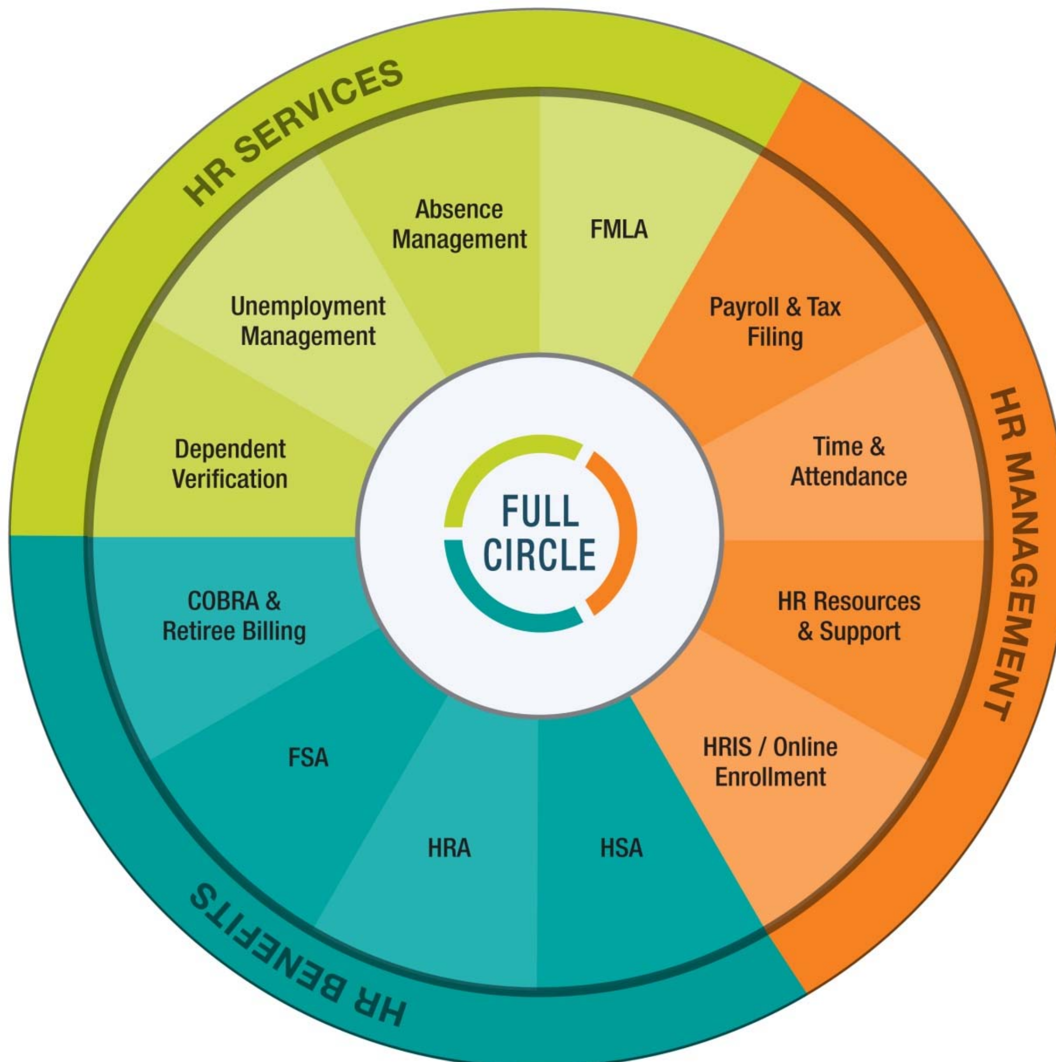

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Structure of the Exchanges

Establishment of Exchanges

- Health care reform requires each state to establish an American Health Benefit Exchange (Exchange), also known as a Marketplace, by January 1, 2014.
- If a state does not establish its own Exchange, then it can participate in a federally facilitated Exchange (also known as an FFE) established by the federal government.
- A state can also adopt a hybrid model, known as a state partnership Exchange or partnership FFE, which permits a state to assume primary responsibility for some of the functions of a federally facilitated Exchange.

Exchange Functions

- HHS regulations outline the functions that health care reform requires be provided by an Exchange, and that HHS will require for approval, including the following:
  - certifying, recertifying, and decertifying QHPs;
  - assigning relative quality and price ratings to each QHP offered through the Exchange;
  - providing standardized consumer information on QHPs;
  - creating an electronic calculator that allows consumers to assess the cost of coverage after application of any advance premium tax credits and cost-sharing reductions;
  - operating a website and toll-free call center providing comparative information on QHPs and allowing eligible individuals to apply for and purchase coverage;
  - determining eligibility for the Exchange, tax credits and cost-sharing reductions, public health coverage programs (such as Medicaid and CHIP), and facilitating enrollment of eligible individuals in such programs;
  - determining exemptions from the individual mandate and granting approvals relating to hardship or other exemptions; and
  - establishing a Navigator program.
- In addition to these basic functions, HHS requires Exchanges to implement outreach and education programs and comply with oversight and program integrity requirements

Functions of Federally Facilitated Exchanges (FFEs) and Partnership FFEs

- In states without a state-based Exchange, HHS will establish a federally facilitated Exchange (FFE) and perform all Exchange functions including:
  - plan management functions (such as certifying, recertifying, and decertifying QHPs) and
  - consumer-assistance functions (such as providing consumer assistance in determining individual eligibility for enrollment and insurance affordability programs, including advance payment of the premium tax credit and determination of cost-sharing reductions)

Functions of Federally Facilitated Exchanges (FFEs) and Partnership FFEs

- A state may, however, choose to establish a partnership FFE which permits the state to administer plan management functions and/or consumer-assistance functions.

- HHS has issued guidance on state partnership Exchanges, including a "roadmap" and recommended timeline for so-called "state plan management partnership Exchanges" and "state consumer partnership Exchanges.

Functions of Federally Facilitated Exchanges (FFEs) and Partnership FFEs

- In either case, states will continue performing their traditional regulatory role for insurers and health plans—an insurer that offers QHPs through an FFE must meet both applicable state requirements and QHP certification standards.

- HHS has made available applications for use in determining eligibility to enroll in a QHP and to receive advance payment of the premium tax credit and cost-sharing reductions.

Functions of Federally Facilitated Exchanges (FFEs) and Partnership FFEs

- To fund FFEs, participating insurers will pay a monthly user fee to support the operation of the FFE and partnership FFE.
- For the 2014 benefit year, this monthly user fee rate will be 3.5%
- This rate may be adjusted to take into account state-based Exchange rates.

EXHIBIT 1

Key Milestones In Health Insurance Exchange Development

Date	Milestone
March 23, 2010	Affordable Care Act enacted
September 1, 2010	Opportunity to apply for exchange planning grants announced
January 20, 2011	Opportunity to apply for exchange establishment grants announced
March 27, 2012	Final rule on exchange establishment published
May 16, 2012	General guidance on federally facilitated exchanges released
November 16, 2012	Initial application and Blueprint submission deadline for state-based and state partnership exchanges
December 14, 2012	Revised application and Blueprint submission deadline for state-based exchanges
January 1, 2013	Approval deadline for state-based exchanges
January 3, 2013	Guidance on state partnership exchanges released
February 15, 2013	Revised application and Blueprint submission deadline for state partnership exchanges
February 20, 2013	Marketplace plan management option announced
March 1, 2013	Approval deadline for state partnership exchanges
May 10, 2013	Bifurcated exchange model announced
June 19, 2013	Proposed rule codifying bifurcated exchange model published
October 1, 2013	Initial exchange open-enrollment period begins
January 1, 2014	Exchange coverage effective
October 15, 2014	Last opportunity for states to apply for exchange establishment grants

SOURCE Authors' analysis.

EXHIBIT 2

Overview of Exchange Models, June 2013

Exchange model	Exchange activity	Number of states	States
State-based exchange	State operates all core exchange functions; may use federal services for certain exchange functions	14 states and Washington, DC	CA, CO, CT, DC, HI, KY, MD, MA, MN, NV, NY, OR, RI, VT, WA
Supported state-based exchange	State operates most core exchange functions; uses federal information technology infrastructure	2 states	ID, NM
Federally facilitated exchange	Federal government operates all core exchange functions	19 states	AL, AK, AZ, FL, GA, IN, LA, MS, MO, NJ, NC, ND, OK, PA, SC, TN, TX, WI, WY
Variant 1: state partnership exchange	State conducts plan management and/or consumer assistance, outreach, and education functions on behalf of federal government; federal government operates remaining core exchange functions	7 states	AR, DE, IL, IA, MI, NH, WV
Variant 2: marketplace plan management	State conducts plan management on behalf of federal government; federal government operates remaining core exchange functions	7 states	KS, ME, MT, NE, OH, SD, VA
Bifurcated exchange	State operates all core exchange functions for small-business exchanges and conducts plan management on behalf of federal government for individual exchange; federal government operates remaining core exchange functions for individual exchange	1 state	UT

SOURCE Authors' analysis.

Enrollment Periods

Initial, Annual, and Special Enrollment Periods Required for Exchanges

- Exchanges are required by health care reform to have an initial open enrollment period, an annual open enrollment period, and certain special enrollment periods.

Initial, Annual, and Special Enrollment Periods Required for Exchanges

Initial Enrollment Period for Exchanges:

- HHS has provided that the initial open enrollment period will run from October 1, 2013 through March 31, 2014.
- Coverage must be offered effective January 1, 2014 for qualified individuals whose QHP selections are received by the Exchange on or before December 15, 2013.
- For selections received between the first and 15th day of January, February, or March 2014, coverage must be provided effective the first day of the following month.
- For those received between the 16th day of the month and the last day of the month of December, January, February, or March, the Exchange must ensure coverage effective the first day of the second following month.

Initial, Annual, and Special Enrollment Periods Required for Exchanges

Annual Enrollment Period for Exchanges:

- The annual enrollment period for 2015 and subsequent years will begin October 15 and extend through December 7 of the preceding calendar year.
- Starting in 2014, the Exchange must provide advance written notice to each enrollee about annual open enrollment no earlier than September 1, and no later than September 30.

Initial, Annual, and Special Enrollment Periods Required for Exchanges

Special Enrollment Periods for Exchanges:

- Health care reform requires Exchanges to offer special enrollment periods.
- Under final Exchange regulations, the Exchanges must allow qualified individuals and enrollees to enroll in a QHP or change from one to another as a result of the following triggering events:
  - A qualified individual or dependent loses minimum essential coverage;
  - A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;
  - An individual, who was not previously a citizen, national, or lawfully present individual gains such status;
  - A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of the Exchange or HHS;

Initial, Annual, and Special Enrollment Periods Required for Exchanges

- An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. (The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan);
- A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
- An Indian may enroll in a QHP or change from one to another one time per month; and
- A qualified individual or enrollee demonstrates to the Exchange that the individual meets other exceptional circumstances (as defined by the Exchange).

Consumer Assistance Tools

Consumer Assistance Tools

Web Portal Available:

- HHS has launched a website, http://www.healthcare.gov/, referred to as a "web portal" or an "Options Finder," through which individuals and small businesses can access information about health coverage options, including coverage options in an Exchange.
- The website has a locator feature that asks users to select a state and to answer a few questions about themselves, such as age, health, and family status.
- The locator then provides information about public and private coverage options that may be available, including information about high risk pools and free or low-cost community services.

Consumer Assistance Tools

Exchanges Must Provide Consumer Assistance Tools:

Each Exchange must provide a variety of consumer-assistance tool, including the following:

- toll-free call center to address the needs of those seeking assistance;
- Internet website providing a variety of features, including comparative information on available QHPs, certain financial information, and information about the Navigator and call center;
- an Exchange calculator to facilitate comparisons of QHPs that takes into consideration the premium tax credit and any cost-sharing reductions;
- a consumer-assistance function, including the Navigator program discussed below; and
- outreach and education activities.

The Navigator Program

The Navigator Program

- Health care reform requires an Exchange—whether state-based or a federally facilitated—to establish a Navigator program, under which it awards grants to public or private entities to carry out certain Navigator functions.
- To be eligible, an entity must demonstrate that it has existing relationships or could readily establish relationships with employers, employees, consumers, or self-employed individuals likely to be eligible for enrollment in a QHP; must meet licensing, certification, or other standards imposed by the state or Exchange; and must not have a conflict of interest.
- Exchanges are required to include entities from at least two of a variety of categories, including community and consumer-focused nonprofit groups; unions; trade, industry, and professional associations; and licensed agents and brokers.
- But a Navigator must not be a health insurer or receive any direct or indirect consideration from a health insurer.

The Navigator Program

The minimum duties of a Navigator include the following:

- maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness of the Exchanges;
- provide information and services in a fair, accurate, and impartial manner;
- facilitate enrollment in QHPs;
- provide referrals to any applicable consumer-assistance program or ombudsman in the case of grievances, complaints, or questions about health plans or coverage; and
- provide information in a culturally and linguistically appropriate manner for the needs of the population being served by the Exchange.

Who is Eligible for the Exchange?

Individuals and Employers Eligible for the Exchange

- Beginning in 2014, individuals may enroll in a plan through the Exchange of the state where they reside.
- Only lawful residents may obtain coverage in an Exchange.
- Unauthorized aliens will be prohibited from obtaining coverage through an Exchange.

Individuals and Employers Eligible for the Exchange

- Beginning in 2014, small employers can offer coverage to their employees through an Exchange.
- A “small employer” is an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year.
- Before 2016, a state will have the option to define “small employer” by substituting 50 for 100 in the standard definition.

Individuals and Employers Eligible for the Exchange

- Coverage offered through an Exchange generally will not constitute a qualified benefit under Code 125 and therefore cannot be offered under a cafeteria plan. However, there is an exception for Exchange-eligible employers that offer their employees the opportunity to enroll through an Exchange in a qualified health plan in a group market.

- Under these circumstances, employees may pay for such coverage with pre-tax dollars under the employer's cafeteria plan.

Individuals Eligible for the Exchange

- Exchanges are required to perform eligibility determinations.
- HHS regulations require Exchanges to establish a system of coordinated eligibility and enrollment so that an individual can simultaneously apply for enrollment in a QHP and advance payment of the premium tax credit and cost-sharing reductions, as well as other insurance affordability programs.
- HHS is building a tool called the "Data Services Hub" to help verify applicant information used to determine eligibility for enrollment in QHPs, advance payment of the premium tax credit, cost-sharing reductions, and other insurance affordability programs.

Individuals Eligible for the Exchange

- An individual is eligible for enrollment in a QHP through the Exchange if he or she meets basic standards that establish that he or she—
  - is a citizen, national, or non-citizen lawfully present, and is reasonably expected to remain so for the entire period for which enrollment is sought;
  - is not incarcerated; and
  - resides in the state that established the Exchange.

Eligibility Determinations for Premium Tax Credit and Cost-Sharing Reductions

- The Exchange will coordinate determinations of eligibility for a QHP with determinations for insurance affordability programs, including premium tax credits and cost-sharing reductions.
- The IRS has issued regulations relating to eligibility standards to assist the Exchange to make advance payments of the premium tax credit. And HHS regulations contain standards for eligibility for advance payments of the premium tax credit to determine that—
  - taxpayer is expected to have a household income of at least 100% but not more than 400% of the federal poverty level (FPL) for the benefit year for which coverage is requested, and
  - the applicants for whom the taxpayer expects to claim a personal exemption deduction on his or her tax return for the benefit year meet the standards for eligibility for enrollment in a QHP through the Exchange and are not eligible for minimum essential coverage (with the exception of coverage in the individual market), in accordance with Code 36B(c)(2)(B) and (C).

Verification of Employer-Sponsored Coverage

- An applicant—or a representative authorized by the applicant—must submit specified information (attestations) to the Exchange when applying to receive advance payment of the premium tax credit.
- The Exchange is required to verify the attestations and determine whether the applicant is eligible.

Exchanges will obtain verification data from:

- publicly available sources (although the preamble acknowledges that such sources are limited at this time) and
- records of the Small Business Health Options Program (SHOP) operating in the same state as the Exchange.

Verification of Employer-Sponsored Coverage

- The Exchange notifies an employer if an employee is determined eligible for advance payment of the premium tax credit, with notice of the employer's right to appeal the determination.

Roles of Agents/Brokers

- States may permit agents and brokers to assist employers and employees enrolling in QHPs.
- Although agents and brokers may help qualified individuals enroll in a QHP through the Exchange, they cannot perform eligibility determinations.
- Eligibility determinations must be made through the Exchange, and information collected must be firewalled from insurers, agents, and brokers.
- Agents and brokers are permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions.

Roles of Agents/Brokers

- HHS has indicated that agents and brokers will continue to be appointed by insurers that will check licensure status and verify the agent's or broker's registration with Exchanges.
- In addition, in states with an FFE or state partnership FFE, all agents and brokers must register with HHS and complete an online training course to assist with individual coverage.
- HHS expects online registration to begin this summer.
- Agents and brokers working exclusively with employers in a federally facilitated SHOP (FF-SHOP) are encouraged, but not required, to register and complete the training.

Roles of Agents/Brokers

- Agents and brokers in FFEs and state partnership FFEs will be permitted to assist individuals and employers through two "pathways":
  - an insurer-based pathway (initiated through an insurer's website) that redirects to an Exchange website; or
  - an Exchange-based pathway that directly accesses an Exchange website.

- Both pathways will allow agents and brokers to assist individuals and employers to receive eligibility determinations, compare plans, and enroll in coverage, and will transmit agent- and broker-identifying information to the appropriate insurer to facilitate payment

Roles of Agents/Brokers

- State-based Exchanges may establish their own rules for compensation of agents or brokers, including parameters for direct compensation from an Exchange or through insurer-paid commissions.

- HHS also notes that, if insurers will be paying commissions to agents or broker, it has encouraged state-based Exchanges to consider providing information to insurers (e.g., agent or broker identifying information) to facilitate these transactions.

Roles of Agents/Brokers

- FFEs and state partnership FFEs will not establish a commission schedule or pay commissions directly to agents or brokers, and HHS expects that the amount and terms of commissions will be negotiated by the insurer and the agent or broker.
- HHS notes that the QHP certification standards require QHP insurers to pay the same agent and broker compensation for enrollment in similar health plans offered inside and outside of FFEs and state-partnership FFEs.
- HHS has reiterated that agents and brokers acting as Navigators may not receive compensation from insurers.

Qualified Health Plans on the Exchange

Qualified Health Plans (QHPs)

- An Exchange will be required to make qualified health plans (QHPs) available to qualified individuals and qualified employers.
- An Exchange cannot make available any health plan that is not a QHP.
- Health care reform does not prevent health insurers from offering a health plan outside of the Exchange to a qualifying individual or employer.
- An individual is not prevented from enrolling in a health plan offered outside of an Exchange, and an employer is not prevented from selecting a health plan outside of an Exchange.

Qualified Health Plans (QHPs)

QHP Certification:

- Health care reform requires HHS to establish the certification requirements for a QHP.
- Among the minimum requirements, plans will be required to:
  - meet certain marketing requirements;
  - ensure a sufficient provider choice and include, where available, providers that serve low-income and medically underserved individuals;
  - be accredited (see discussion below) for clinical quality, patient experience, consumer access, and quality assurance and implement a quality improvement strategy;
  - use a uniform enrollment form and a standard format for presenting plan options; and
  - provide information on quality standards used to measure plan performance.

Qualified Health Plans (QHPs)

What Is a Qualified Health Plan?

- A qualified health plan (QHP) is an Exchange-certified "health plan" that offers an "essential health benefits package."
- A QHP must be offered by an insurer that—
  - is licensed and in good standing to offer health insurance coverage in each state in which it offers health coverage;
  - agrees to offer at least one QHP in the silver level, and at least one QHP in the gold level, in each Exchange;
  - agrees to charge the same premium rate for each QHP, whether offered through an Exchange or offered directly from the insurer or through an agent; and
  - complies with regulations to be issued by HHS and any requirements established by an applicable Exchange.

- A QHP may vary premiums by rating area.

What is an Essential Health Benefits Package?

An essential health benefits package must—

- provide essential health benefits, as described in PPACA 1302(b);
- limit cost-sharing, as described in PPACA 1302(c); and
- provide either bronze, silver, gold, or platinum level coverage (that is, benefits that are actuarially equivalent to 60%, 70%, 80%, or 90% (respectively) of the full actuarial benefits provided under the plan), as described in PPACA 1302(d), or a catastrophic plan (also known as "young invincibles" coverage), as described in PPACA 1302(e).

- In addition, an insurer that offers bronze, silver, gold, or platinum level coverage, as described in PPACA 1302(d), is required to offer the same level of coverage in a "child-only plan" specifically designed for individuals under age 21.

What are Essential Health Benefits?

Essential health benefits must include items and services covered within the following ten categories:

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

What Types of Plans Must Cover Essential Health Benefits?

- Non-grandfathered plans in the small group market (both inside and outside of the Exchanges) must offer essential health benefits beginning in 2014.
- Grandfathered plans, self-insured group health plans, and health insurance coverage offered in the large group market are not required to offer essential health benefits.
- Self-insured plans cannot qualify as QHPs.
- It is important to note that, beginning in 2017, states may allow large employers to obtain coverage through an Exchange and, thus, this requirement may become applicable to a broader range of plans.

Scope of Essential Health Benefits

- The scope of essential health benefits is intended to equal the scope of benefits provided under a "typical employer plan" and establish an appropriate balance among the ten benefit categories.
- HHS defines essential health benefits based on state-specific benchmark plans.
- The plan selected by a state is known as the base-benchmark plan. After the application of any adjustments, the plan is known as the "EHB-benchmark plan."
- The EHB-benchmark plan serves as a reference plan, reflecting both the scope of services and limits offered by a typical employer plan in that state.
- According to HHS, this approach and benchmark selection, which applies for at least the 2014 and 2015 benefit years, allows states to build on coverage that is already widely available, minimize market disruption, and provide consumers with familiar products

Scope of Essential Health Benefits

- A state may select its base-benchmark plan from among four types of health plans:
- any of the three largest small group plans in the state by enrollment;
- any of the three largest state employee health plans by enrollment;
- any of the three largest federal employee health plan options by enrollment; or
- the largest insured commercial HMO operating in the state by enrollment.

Cost Sharing on Essential Health Benefits

- There is also an annual limitation on cost-sharing.
- All QHPs must comply with these limits, as must insurers offering non-grandfathered coverage.
- For 2014, the maximum out-of-pocket expense limit (that is, the sum of the plan's annual deductible and other annual out-of-pocket expenses (other than premiums) that the insured is required to pay, such as co-payments and co-insurance for an HDHP) cannot exceed $6,350 for self-only coverage and $12,700 for family coverage.
- The deductible cannot exceed $2,000 for a plan covering a single individual, or $4,000 for any other plan.
- HHS regulations provide standards for the cost-sharing features (such as deductibles, co-payments, and co-insurance) of the essential health benefits package along with rules to determine the actuarial value of the plan, which is expressed as a "metal value" (e.g., bronze, silver, gold, and platinum).

Metal Levels for Essential Health Benefits Package

- An essential health benefits package must either provide a level of coverage that meets the definition of bronze, silver, gold, or platinum “metal” level of coverage under PPACA 1302(d), or, for individual insurers, may instead offer a catastrophic plan (sometimes referred to as “young invincibles” coverage).
- The four prescribed coverage “metal” levels vary based on the percentage of full actuarial value of benefits the plan is designed to provide, as follows:
  – Bronze: designed to provide benefits actuarially equivalent to 60% of full value;
  – Silver: designed to provide benefits actuarially equivalent to 70% of full value;
  – Gold: designed to provide benefits actuarially equivalent to 80% of full value; and
  – Platinum: designed to provide benefits actuarially equivalent to 90% of full value.

Metal Levels for Essential Health Benefits Package

- The level of coverage of a plan will be determined on the basis that the essential health benefits will be provided to a standard population (and without regard to the population to which the plan actually provides benefits).
- HHS regulations provide standards for de minimis variation in the actuarial value used to determine levels of coverage.
- A de minimis variation of +/- 2 percentage points is permitted for all non-grandfathered plans.
- For example, a silver plan could have an actuarial value between 68% and 72%.

Individual Insurers May Offer Catastrophic Plan Option

- Another plan option available to individual insurers in 2014 is a catastrophic plan.
- A catastrophic plan is one that provides coverage for essential health benefits and provides no benefit for any plan year until the individual has incurred cost-sharing expenses equal to the overall cost-sharing limit (described above) for the plan year.
- The deductible cannot apply to at least three primary care visits.
- A catastrophic plan is permitted only in the individual market and only for :
  - young adults who are under age 30 before the plan year begins (a group sometimes referred to as the "young invincibles" because they are more likely than older populations to forego insurance), and
  - those persons exempt from the individual mandate because affordable coverage is not available or they have a hardship exemption.

Small Business Health Options Program ("SHOP")

Small Business Health Options Program (SHOP)

- SHOPs are intended to allow small employers to offer their employees a choice of QHPs, the way large employers can—giving the small employer and its employees more bargaining power, a bigger risk pool, and more choices.
- Each state Exchange is required to create a Small Business Health Options Program (“SHOP”).
- HHS has also provided for a federally facilitated SHOP (FF-SHOP) in states that do not establish a state-based Exchange.

SHOP Functions

- A SHOP is required to carry out all of the functions of an Exchange, but is not required to carry out certain requirements related to individual coverage.
- A state may choose to merge its individual and small group market risk pools and operate the Exchange and SHOP through the same structure, and may allow individuals and employees of small businesses to have the same plan options.
- And starting in 2017, an Exchange could choose to allow insurers in the large group market to offer QHPs inside the SHOP.)
- If a state does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

SHOP Functions

- Different structures have been established for state-operated SHOPs and FF-SHOPs. Health care reform requires a SHOP to allow a qualified employer to choose a “metal” level of coverage (i.e., bronze, silver, gold, platinum band make all QHPs within that level available to its qualified employees.
- This is referred to as the “employee choice model.”
- State-operated SHOPs are not required to offer the employee choice model for plan years beginning before January 1, 2015, and FF-SHOPs will not start offering the employee choice model until plan years beginning on or after January 1, 2015.

SHOP Functions

- State-operated SHOPs have flexibility to allow a qualified employer to make QHPs available to employees by other methods in addition to the employee choice model.
- For example, according to HHS, some health insurers expressed openness to allowing an employee to “buy up” to certain plans at the next higher metal level above the one specified by the employer.
- This would give employees access to a broader range of health plans.
- While this may be a feature of some state-operated SHOPs, it will not be offered through the FF-SHOPs, at least in the first year of SHOP operation.

SHOP Functions

- A SHOP must provide a premium calculator to help employees determine their cost of coverage after any employer contribution.
- The calculator must compare available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and any cost-sharing reductions.
- Bills provided by a SHOP must contain, in addition to the total amount due by the employer, the portion of each employee's premium for which the employer is responsible and the portion for which the employee is responsible.
- A SHOP may also include an average premium on the billing statement to assist employers in smoothing premium costs between employees

SHOP Functions

- A state-operated SHOP may have minimum participation requirements so long as they are based on the rate of employee participation in the SHOP, not on the rate of employee participation in any QHP of a particular issuer.
- Under final insurance market reform regulations, insurers cannot deny coverage for failure to meet minimum participation requirements.
- The default minimum participation rate for the FF-SHOP is 70%, also calculated at the level of the participation of the employees of the employer in the FF-SHOP and not enrollment in a single QHP.

SHOP Functions

- Federally facilitated SHOPs (FF-SHOPs) are expected to provide a number of tools and resources to help employers, employees, agents, and brokers evaluate coverage options.
- They will allow employers to model scenarios, for instance by changing the employer contribution percentage, before selecting coverage.
- FF-SHOPs will collect a single, aggregated payment from each employer and distribute the payment to QHP insurers based on participating employee plan selections.

SHOP Functions

- FF-SHOPs are expected to offer additional administrative support, including employer billing, receipt of payments, disbursements to plans, and payment reconciliation.

- Multi-state employers participating in the FF-SHOP will offer coverage to all eligible employees either through the FF-SHOP serving the employer's primary place of business or through the state-based or the FF-SHOP serving each employee's primary worksite.

SHOP Functions

- State-operated SHOPs have flexibility to allow a qualified employer to make QHPs available to employees by other methods in addition to the employee choice model.
- For example, according to HHS, some health insurers expressed openness to allowing an employee to “buy up” to certain plans at the next higher metal level above the one specified by the employer.
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- While this may be a feature of some state-operated SHOPs, it will not be offered through the FF-SHOPs, at least in the first year of SHOP operation.

Employers and Employees Eligible for a SHOP

- A SHOP must permit qualified employers to purchase coverage for qualified employees through the SHOP. A qualified employer is defined as an employer that meets three requirements:
  - is a small employer;
  - elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and
  - either has its primary office in the Exchange service area and offers all its employees coverage through that SHOP, or offers coverage to each eligible employee through the SHOP servicing the employee's primary worksite.

Employers and Employees Eligible for a SHOP

- A “small employer” is an employer that employed an average of at least one but not more than 100 employees on business days during the preceding calendar year, and employs at least one employee on the first day of the plan year.

- A qualified employee is an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

Qualified Employer Participation Rules

- The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year.
- The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage.
- The SHOP must provide qualified employers with a period of no less than 30 days prior to the completion of the employer's plan year and before the annual employee open enrollment period (discussed below), in which the qualified employer may change its participation in the SHOP for the next plan year.
- If an employer remains eligible for coverage and does not take action during the annual employer election period, the employer will continue to offer the same plan, coverage level, or plans selected the previous year for the next plan year unless the QHP or QHPs were no longer available.

Qualified Employer Participation Rules

- Qualified employers are required to provide the SHOP with information about individuals or employees whose eligibility to purchase coverage through the employer has changed.
- This notice would apply both to newly eligible employees and dependents as well as to those no longer eligible for coverage.
- The employer would retain all notice responsibilities under state and federal law for these individuals (including, for example, COBRA election notices).

Qualified Employee Enrollment Rules

- HHS regulations established standards for annual and special enrollment periods for individuals enrolled through an Exchange or SHOP.
- SHOPs are required to adhere to the open enrollment period requirements for Exchanges and provide the special enrollment periods of an Exchange, with a few exceptions.
- The SHOP must establish a standardized annual open enrollment period of no less than 30 days for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

Qualified Employee Enrollment Rules

SHOPs also must allow qualified individuals and enrollees to enroll in a QHP or change from one to another as a result of the following triggering events:

- A qualified individual or dependent loses minimum essential coverage;
- A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, or placement for adoption;
- A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of the Exchange or HHS;
- An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;
- A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;
- An Indian may enroll in a QHP or change from one to another one time per month; and
- A qualified individual or enrollee demonstrates to the Exchange that the individual meets other exceptional circumstances (as defined by the Exchange).

Employer Contributions

- Employers in the SHOP may elect a variety of ways to contribute toward health coverage.
- Because employees in the SHOP may be choosing their own coverage and will need to know the net cost to them after the employer's contribution, each employer must choose a contribution method before its employees select coverage.
- To facilitate this, each SHOP will define one or more standard methods by which employers contribute toward employee coverage.
- In the FF-SHOP, the employer will be required to define a percentage contribution toward premiums for employee-only coverage under a specific reference plan and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage under the reference plan.

Individual Mandate

- Beginning in 2014, taxpayers (with certain exceptions) will be assessed a “shared responsibility” penalty for any months during which they or their spouse or dependents lack “minimum essential coverage.”
- Because this tax penalty has the effect of “requiring” individuals to have coverage (i.e., to avoid the penalty), this aspect of health care reform is sometimes referred to as the “individual mandate.”
- Health care reform authorizes states to apply for an “innovation waiver” from the individual mandate and certain other requirements for plan years beginning on or after January 1, 2017.

What is “Minimum Essential Coverage”?

- The tax penalty is assessed against any “applicable individuals” who, after 2013, do not have “minimum essential coverage.”
- The term “minimum essential coverage” means coverage under any of the following:
  - a government-sponsored program, including coverage under Medicare Part A, Medicaid, the CHIP program, and TRICARE;
  - an “eligible employer-sponsored plan”;
  - a health plan offered in the individual market;
  - a grandfathered health plan; or
  - other health benefits coverage (such as a State health benefits risk pool) as HHS recognizes.

Calculating the Penalty

- U.S. citizens and legal residents are required to have qualifying health coverage.
- Those without coverage pay a tax penalty of the greater of $695 per year up to a maximum of three times that amount ($2,085) per family or 2.5% of household income.
- The penalty will be phased-in according to the following schedule: $95 in 2014, $325 in 2015, and $695 in 2016 for the flat fee or 1.0% of taxable income in 2014, 2.0% of taxable income in 2015, and 2.5% of taxable income in 2016.

Exceptions for Certain Individuals

- The shared responsibility payment requirement applies to “applicable individuals.”
- For this purpose, the term “applicable individual” means any individual unless that individual falls within a specific exception or they are exempt.
- There are exceptions for (1) religious conscience objectors under PPACA 1311(d)(4)(H); (2) members of a health care-sharing ministry; (3) individuals who are not citizens, nationals, or an alien lawfully present in the United States; and (4) incarcerated individuals.

Exceptions for Certain Individuals

Certain individuals (even if they qualify as "applicable individuals") are exempt from the penalty:

- individuals who cannot afford coverage—defined as individuals for whom a required contribution for coverage would cost more than 8% of their household income;
- individuals whose household income does not exceed the threshold for filing a federal income tax return;
- members of certain Indian tribes;
- individuals who have a gap in coverage for less than a continuous three-month period. This exemption may only be used for one period without coverage in a year; and
- individuals who are extended a hardship exemption as determined by HHS).

Credits and Subsidies

Overview

- Beginning in 2014, individuals who purchase health insurance coverage through one of the new health insurance exchanges will be eligible for financial assistance if their income is no more than 400% of the federal poverty line.

Two forms of financial assistance will be provided:

- A premium assistance tax credit will be provided monthly to lower the amount of premium the individual or family must pay for their coverage.
- Cost sharing assistance will limit the plan's maximum out-of-pocket costs, and for some people will also reduce other cost sharing amounts (i.e., deductibles, coinsurance or copayments) that would otherwise be charged to them by their insurance plan.

Premium Assistance

- The premium assistance tax credit is calculated to limit the amount that an individual or family must pay for health insurance coverage in the exchange as a percentage of income.
- A sliding scale is used to determine the amount of the tax credit.
- For those at the lowest incomes (less than 133% of the poverty level) the tax credit amount is based on limiting the individual's premium contribution to no more than 2% of income.
- For those between 300% and 400% of the poverty line, the tax credit is amount is based on a limiting the contribution amount to 9.5% of income.

Cost Sharing Assistance

- People who qualify for the premium assistance tax credit will also be eligible for cost sharing assistance if they enroll in a silver plan.
- This assistance will further reduce the limit on the out of pocket maximum that can apply to their coverage, with the amount of the reduction depending on income.
- For those with incomes between 100% and 200% of poverty, a 2/3 reduction applies.
- For others, the reduction in the limit is either ½ or 1/3, depending on income.

Employer Credits

- For tax years beginning in 2014 and later, the maximum small business health care tax credit available to eligible small employers increases to 50% of nonelective contributions, but the requirements for the contribution arrangement are different from those applicable to earlier tax years.
- The nonelective contributions for 2014 and later tax years must be made on behalf of employees who enroll in a qualified health plan offered to employees by the employer through an Exchange.

What is a Small Employer

In order to qualify to receive a small business health care tax credit in any tax year, an employer must be either an eligible small employer or a tax-exempt eligible small employer, as defined in Code 45R.

Definition of Eligible Small Employer:

- There are three requirements that an employer must satisfy to be an “eligible small employer.” With respect to any tax year—
- the employer must have no more than 25 full-time equivalent (FTE) employees for the tax year;
- the employer's FTEs must have average annual wages that do not exceed $50,000 (for 2010 through 2013); and
- the employer must have a contribution arrangement in effect that meets the requirements of Code 45R(d)(4).

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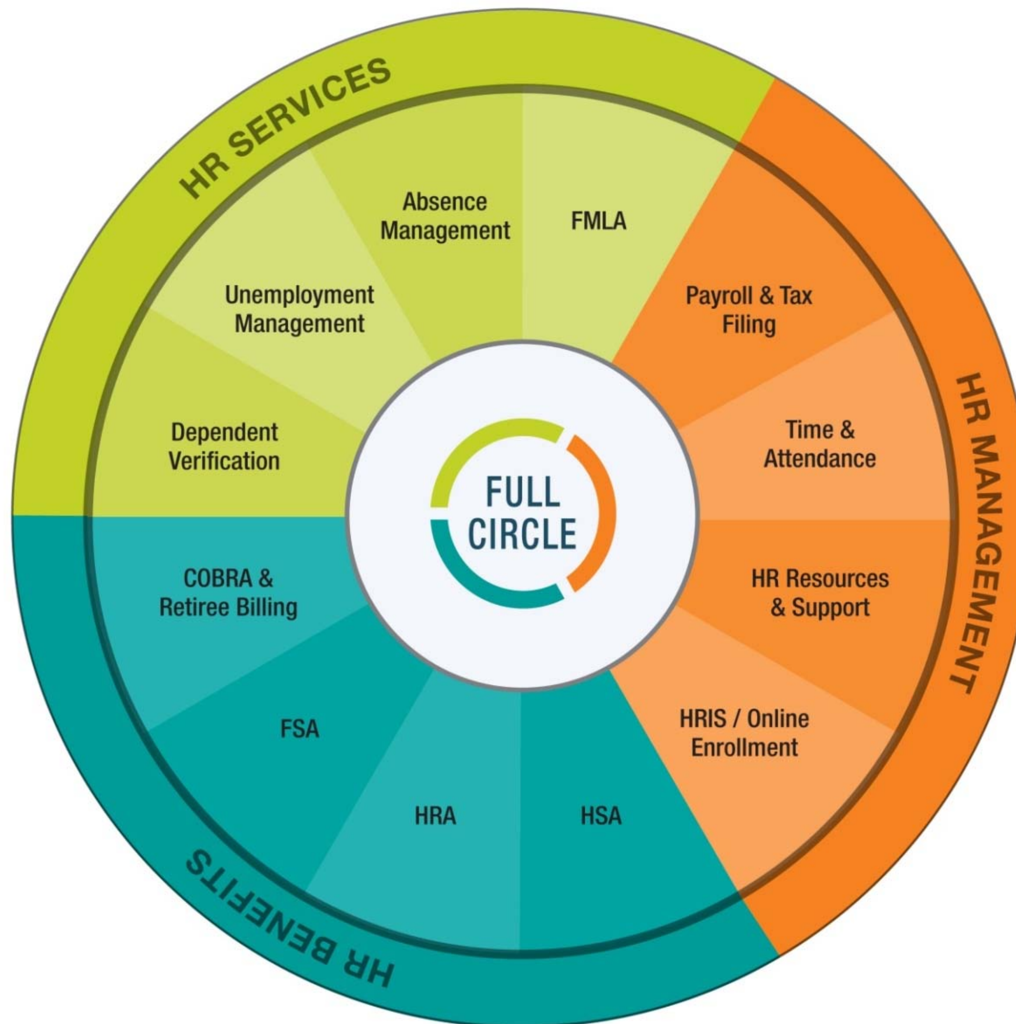

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