HEALTH INSURANCE MARKETPLACES
and Your Practice

The 2010 health reform law, the Affordable Care Act (ACA), provided for the creation of health insurance marketplaces, also known as “exchanges”, where individuals without employer-provided insurance and small businesses that want to offer coverage to their employees can purchase coverage. States and the federal government are currently in the midst of establishing these marketplaces, so many details are still being determined. This document provides a summary of known health insurance marketplace information that may impact your practice and your employees.

BACKGROUND

- The ACA requires each state to have an individual marketplace and a small business health options program (SHOP) marketplace operational by January 1, 2014.

- The marketplaces will feature an Internet-based, centralized hub from which residents can select a healthcare plan that meets their needs from a menu of available health plans that fulfill minimum federal requirements.

- Only plans that meet minimum coverage requirements, in addition to any state-mandated requirements, will be designated as qualified health plans (QHP) and offered within the marketplace.

- Individuals and small businesses (50 or fewer employees) must purchase coverage through the marketplaces in order to receive individual premium subsidies or small employer tax credits.

- States have options on how they can set up their marketplaces:
  - Administrative only marketplace – serves as an open marketplace where any plan that meets certain state defined criteria can participate
  - Active purchaser – the marketplace selects plans to participate in the marketplace

MANDATED COVERAGE/ESSENTIAL HEALTH BENEFITS

The ACA requires all QHPs offered within a marketplace, and all non-grandfathered individual and small group plans outside the marketplace, to cover a group of benefits referred to as essential health benefits (EHBs). At a minimum, EHBs will include the following general categories:

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

1 Note: The Department of Health and Human Services (HHS) has delayed the implementation of certain options of the federal SHOP marketplaces until 2015, with full implementation expected in late 2014. In the interim, small businesses can still offer coverage to their employees through the SHOP marketplaces, but their options will be limited to offering all employees the choice of one health plan in addition to a stand-alone dental plan. State-based SHOP exchanges are permitted to move forward, if they chose to, with allowing employers to offer multiple plans for their employees to choose amongst despite the federal delay.
- A qualified health plan does not have to offer pediatric dental care if there is a stand-alone dental plan available offering the benefit.

- HHS gave states the authority to define the scope of benefits covered under each of the aforementioned EHB categories through the development of a benchmark EHB package. HHS directed states in 2012 to develop their EHB benchmark plan based on the benefits package offered by one of the three largest small group plans offered in their state as determined by the total number of enrollees.

- Since no state’s model health plan included pediatric dental benefits, states were directed by HHS to use the dental benefits package provided through either their state’s Children’s Health Insurance Program (CHIP) or the Federal Employee Dental and Vision Insurance Program (FEDVIP).

- If a state chose not to select an EHB benchmark plan the state’s QHPs’ benchmark coverage defaulted to the scope of the health benefits provided by the largest small group plan offered in the state plus the pediatric oral and vision benefits offered through FEDVIP.

- For a full list of what each state has chosen as its essential health benefits, visit http://www.statereforum.org/analyses/state-progress-on-essential-health-benefits.

- In addition to these benefits, all plans offered within a marketplace also must limit the cost sharing incurred by enrollees towards the cost of their health plans and provide plans that meet specified actuarial value.

**DENTAL BENEFITS UNDER THE ACA**

- The definition of “pediatric” includes individuals up to age 21 for health benefits and up to age 19 for oral health benefits. States may increase the oral health benefit age to 21 if they wish. States also have the option of covering adult oral care by declaring it an essential health benefit; however, states would bear the additional cost for these services. To date, no state has opted to provide adult dental benefits.

- Both within and outside the marketplace, pediatric oral health benefits must be offered either as part of the QHP or separately in the form of a standalone dental plan.

- Like QHPs, stand-alone dental plans must offer the pediatric oral essential health benefit, without coverage limits, and meet certain marketing and performance requirements.

- Within the marketplace, a loophole in the ACA does not require consumers, including those with children, to actually purchase pediatric dental benefits. States, however, are considering mandating such purchase.

- For individual and small group plans offered outside the marketplaces, individuals, including those without children, must purchase the pediatric dental benefit. The ACA requires all health plans to include pediatric dental benefits unless the health plan is “reasonably assured” that the consumer has purchased pediatric dental benefits via a separate standalone dental plan. This premise is shown in the diagram below.

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2 It is important to note that the EHB determines benefit coverage, not provider reimbursement.
THE IMPACT ON YOU

AS AN INDIVIDUAL

- The ACA requires all individuals, with some exemptions, to purchase minimal health insurance coverage by January 1, 2014.

- Also starting in 2014, premium tax subsidies will be available to assist those who earn less than 400% of the federal poverty level (FPL) and who purchase coverage through the health insurance marketplaces.

- Any individual who fails to obtain the necessary coverage will be penalized the greater of a flat dollar amount or a percentage of their income, as specified by the ACA. Other coverage, such as employer-sponsored insurance and Medicaid, is considered minimum essential coverage for the purpose of the individual mandate.

AS AN EMPLOYER

- The ACA does not require small businesses (defined as having fewer than 50 employees) to offer coverage to their employees. Nor does it require small business employers who do provide insurance for their employees to obtain such coverage through the SHOP.

- The law does, however, encourage small businesses to offer coverage by providing tax credits to employers with 25 or fewer employees and average annual wages of less than $50,000 to help them purchase health insurance for their employees. Employers must purchase such insurance through the SHOP to obtain the tax credits.

- The tax credits are being provided in two phases — one, which is currently underway, before the establishment of the new marketplaces and one after they are established.
  - The first phase (2010-2013) provides a tax credit of up to 35% of the employer’s contribution toward insurance, if the employer contributes approximately 50% of the total premium cost. The credit is provided on a sliding scale based on business size and average wage increases.
  - In the second phase (2014 and later), the tax credit is available to eligible small businesses that purchase coverage through the SHOP and contribute at least 50% of the total premium cost. However, the credit is only available for the first two years of enrollment through the marketplace. These credits are also provided on a sliding scale basis, depending on firm size and average wages. For more information on the Small Employer Tax Credit, please consult the Internal Revenue Service and your own tax advisors.

HOW THE SMALL BUSINESS HEALTH OPTIONS PROGRAM WILL WORK FOR YOU AND YOUR EMPLOYEES

Any qualified small group employer who elects to make, at a minimum, all full-time employees eligible for coverage offered through a marketplace may utilize a SHOP marketplace. After the employer submits an application to the SHOP, the marketplace, in theory, will operate like any other online shopping Web site.

A small business employee visits the state's health insurance marketplace. After completing an application, the marketplace verifies the individual’s eligibility.

The employee compares available plans based on cost and coverage options, which may or may not be limited by the employer, depending on state law. Some states and employers may allow add-ons such as dental coverage.

The individual checks out of the marketplace and obtains coverage.
Employers who choose to have employees secure their insurance coverage through a SHOP marketplace may limit the number of plans from which an employee may choose. (NOTE: For the 2014 plan year, federally facilitated SHOP marketplaces will not allow employers to offer their employees a choice of health plans at a single level of coverage but instead will allow employers to choose a single health plan for their employees from the choices available.) Additionally, an employer who uses the SHOP is not required to contribute to employees' premiums, although employers with over 50 employees will be penalized beginning on Jan. 1, 2015 for failing to provide employee coverage. Neither the ACA nor any other current regulations specify whether a SHOP can require a minimum contribution from employees towards their coverage.

Employers may purchase coverage for employees at any time during the year, but the plan must consist of a 12-month period beginning with the employer's effective date of coverage. Employees must also still adhere to annual open enrollment periods as determined by the SHOP with special allowances for newly qualified employees. The enrollment period within a SHOP marketplace will be 30 days following a triggering event such as the loss or gain of a dependent.

QUESTIONS?

Still have questions on insurance marketplaces or how the ACA will affect you? Contact AAOMS Governmental Affairs staff at 800/822-6637 or visit www.healthcare.gov.