# State Health Insurance Exchanges: 2014 is Around the Corner

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The US Supreme Court made the decision in June 2012 to uphold the majority of the Patient Protection and Affordable Care Act[1] (PPACA) that Congress and the president enacted in 2010. The individual mandate is central to the broader picture of health care reform in the United States.

A substantial part of the PPACA is the mandate to establish health insurance exchanges, or marketplaces, in all 50 states. Prior to the PPACA, there were 2 states—Massachusetts and Utah—that already had state-based exchanges. The idea behind these exchanges is to establish 1-stop shopping by way of a Web-based portal for health care consumers, which would give individual health care consumers and small businesses the ability to access qualified health plans and select the plan that best fits their needs. Federal subsidies will be provided to individuals with low and moderate incomes to offset the insurance costs.

The PPACA authorizes states to create exchanges to serve individuals and small businesses. The American Health Benefit Exchange will serve the individual market. Individuals who purchase health insurance through the exchange and earn between 133% and 400% of the federal poverty level will be eligible for credits and subsidies. The Small Business Health Options Program (SHOP) will allow employees of businesses with up to 100 employees to purchase health coverage, with the option to expand the exchanges to large businesses in 2017.[1]

Starting on January 1, 2014, health insurance exchanges will go live with coverage, with enrollment starting 3 months prior on October 1, 2013. Realistically, the exchanges will be a work in progress even after the start deadline. As of mid-January 2013, 25 states will allow the federal government to run an exchange, 18 states as well as the District of Columbia have decided to operate a state-based exchange, 6 states have declared they will partner with the federal government to run an exchange, and 1 state (Utah) is still undecided.

## Categories for Exchanges

There are 3 major categories for state exchanges: the declared state-based exchange, the planning for federal partnership exchange where the state has indicated it will partner with the federal government to operate an exchange, and the federal exchange. The majority of states have opted for the federally facilitated exchange under which the US Department of Health and Human Services assumes the primary responsibility for operating the exchanges by default. All indicators point to a clearinghouse model in federal exchanges that will allow contracting with any qualified health plan (QHP). States that opt for a federal exchange will have the option to transition into a federal-state partnership exchange. The state-based exchanges will either accept all QHPs or actively purchase and selectively contract with QHPs. The active purchase model is designed to create competition in the insurance industry and foster a higher quality plan, optimal coordination of health care, and price controls. Both state and federal plans will offer consumers 4 coverage levels: bronze, silver, gold, and platinum. There also will be a young adults plan.

## Structure of Exchanges

States have the option of establishing exchanges as part of an existing state agency or office, as an independent (ie, quasi-governmental) public agency, or as a nonprofit agency. Appointed boards or committees will govern the state-based exchanges in each state within each of these structures, which may be the

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point at which specialties including dermatology will need to have a voice in policy making. Key dates in 2013 and 2014 for the health insurance exchange are provided in the Table.

Under the PPACA, QHPs must meet certain basic minimum standards. They must offer a minimum level of essential health benefits, follow established limits on cost sharing, and meet other state-mandated requirements. To protect against the selection of only the healthiest patients, QHPs will be restricted to tailoring pricing based on 4 criteria: geographic location, family size, age, and smoking status.[2]

**Key Dates in 2013-2014 for Health Insurance Exchange**

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| January 1, 2013 | HHS approval of state-based exchanges |
| February 15, 2013 | Plan due to HHS for states opting into federal-state partnership |
| March 1, 2013 | HHS begins rolling approval of federal-state exchanges |
| October 1, 2013 | Exchange enrollment begins in every state |
| January 1, 2014 | Exchanges need to be operational |

Abbreviation: HHS, US Department of Health and Human Services.

## Future Challenges

As the exchanges are developed, there will be challenges and opportunities. It will be important for physicians to have a strong voice in the process. Currently, as part of the exchange process, states are required to consult with a number of stakeholders, including health care consumers enrolled in QHPs, experts in QHP enrollment, representatives of small businesses, state Medicaid offices, and advocates for enrolling hard-to-reach populations.[1] Although physicians are left out of this equation, the US Department of Health and Human Services has proposed regulations to add health care providers to the stakeholder list.[3]

To preserve our ability to practice and care for our patients, it is critical that physicians become engaged in the governance of health insurance exchanges. The exchanges themselves will have substantial power over individual insurance companies, including the determination of premiums. Success for all physicians will hinge on plans that provide strong provider networks and fair compensation. Any quality measures and physician rating scales need to reflect meaningful criteria rather than arbitrary cost-containment measures. Lastly, physicians will need immediate access to patient enrollment and coverage status.

## REFERENCES

1. Patient Protection and Affordable Care Act, HR 3590, 111th Cong, 2nd Sess (2010).
2. Hoffman SM. Health insurance exchanges under the patient protection and affordable care act: regulatory and design challenges. *J Am Coll Radiol*. 2012;9:881-886.
3. Patient Protection and Affordable Care Act: establishment of exchanges and qualified health plans. *Fed Regist*. 2011;76(136):41866-41927. To be codified at 45 CFR §155 and 156.