The Federally Facilitated Marketplace

Issue Brief

(Updated 10/7/14)

One of the major tenets of the Patient Protection and Affordable Care Act (ACA) is the establishment of healthcare marketplaces through which lower income individuals and small businesses can purchase affordable, high-quality commercial insurance specifically related to the individual and family market. This Issue Brief provides background and current information on the status of the Marketplaces.

The marketplaces are designed to streamline the purchasing process by creating a centralized, online shopping experience that allows access to competitive, standardized plans.

Requirements for Plans on the Marketplaces

All health plans sold in the marketplace must meet certain criteria and be certified as Qualified Health Plans (QHP) to ensure that all consumers are purchasing a product of value by establishing a set of benchmarks that will streamline all plans in the marketplace. The criteria to be a QHP includes meeting:

- Certain coverage requirements;
- Actuarial value requirements; and
- Conformity to all necessary financial requirements i.e., subsidies and cost-sharing limits.

First, every plan is required to cover 10 specific benefit categories, otherwise known as essential health benefits (EHB). The 10 benefit categories are ambulatory care, emergency care, hospitalization, maternity and newborn care, mental health and substance abuse care, prescription drug coverage, rehabilitative and habilitative services and devices, laboratory services, preventive and wellness services, chronic disease management and pediatric services, including oral and vision care.

Specifics concerning the levels at which these benefits are offered varies among states. The U.S. Department of Health and Human Services (HHS) required that states to identify an existing "typical" employer plan to use as a benchmark to model the design specifics. In New Jersey, the benchmark health plan is the largest small group plan: the Horizon Blue Cross Blue Shield of New Jersey Health Maintenance Organization (HMO) plan.

Second, the ACA requires that all QHPs meet certain actuarial value, meaning the plans must pay for a certain percentage of expected medical costs. There are four categories of actuarial value requirements, sometimes referred to as metal tiers to afford individuals a choice of coverage levels that are clearly delineated and understandable with regard to their potential liability. The actuarial values are as follows:

- Bronze – Plan pays 60 percent of expected medical costs/Individual pays for 40 percent.
- Silver - Plan pays 70 percent of expected medical costs/Individual pays for 30 percent.
- Gold - Plan pays for 80 percent of expected medical costs/Individual pays for 20 percent.
- Platinum - Plan pays 90 percent of expected medical costs/Individual pays for 10 percent.

Finally, all QHPs must offer certain affordability programs. These programs include access to premium subsidies as well as cost-sharing subsidies in the form of adjustments to out-of-pocket maximums. The availability of premium credits are calculated based on income level.

Income	**Premium Limit**
Up to 133% FPL	2% of income
133 - 150% FPL	3 - 4% of income
150 - 200% FPL	4 - 6.3% of income
200 - 250% FPL	6.3 - 8.05% of income
250 - 300% FPL	8.05 - 9.5% of income
350 - 400% FPL	9.5% of income

Cost-sharing subsidies in the form of a cap on out-of-pocket expenses are implemented based on income level.

Income	**Out-of-Pocket Limit (based on 2011 Health Savings Account limit)**
100 - 200% FPL	1/3 HSA limit ($1,983/individual; $3,967/family)
200 - 300% FPL	1/2 HSA limit ($2,975/individual; $5,950/family)
300 - 400% FPL	2/3 HSA ($3,967/individual; $7,933/family)
Above 400% FPL	100% HSA limit ($5,950/individual; $11,500/family)

New Jersey's QHPs

In New Jersey, three health insurers are certified to meet these requirements and become QHPs. The three insurers are Amerihealth, Horizon Blue Cross Blue Shield of New Jersey and Health Republic Insurance of New Jersey, which is a Consumer Operated and Oriented Plan. In 2014, these three payers are offering 29 QHPs on the marketplace for individuals and families in New Jersey.

In a report released by HHS, the average cost for the lowest-cost option bronze plan in New Jersey is $332, compared to a national average of $249 a month. New Jersey's low level of competition is one of the reasons given for higher-than-average premiums.

HHS had estimated about 901,000 New Jersey residents were uninsured and eligible to use the health insurance marketplace to purchase insurance. HHS also estimated that about 790,000 people in New Jersey would be eligible for subsidies to purchase insurance or would qualify for coverage through the state's expansion of Medicaid, which was authorized by the New Jersey Assembly and signed into law by Gov. Christie.

At the end of the first annual open enrollment period, enrollment in the Marketplace was approximately eight million people nationwide. In New Jersey alone, 161,775 individuals selected a Marketplace plan between October 1, 2013 and March 31, 2014 (including the additional special enrollment period activity through April 19, 2014). This figure does not reflect the actual enrollment as individuals must pay their first month's premium in order to be deemed enrolled.

In New Jersey, an additional 98,240 individuals enrolled in Medicaid through the end of March 2014, compared to enrollment before the Marketplace opened on October 1, 2013. Enrollment in Medicaid, known in New Jersey as NJ Family Care, is open all year.

Oversight of QHPs in FFM

By opting to allow the federal government to run the Marketplace, New Jersey only has limited oversight of the QHPs. The state is expected to provide HHS with information concerning certain specific state requirements such as licensure, rate and benefit review and network adequacy. However, it is unclear how the Marketplace is going to ensure that consumers are receiving accurate information with regard to their state-specific rights.

CMS has assigned each QHP a federal account manager for the duration of its participation in the Marketplace. Account managers are the primary point of contact for carriers with the Marketplace. Account managers assisting and overseeing carriers with issues related to its responsibilities and requirements for participating in the Marketplace. In a letter dated March 14, 2014, CMS indicated that all issuers participating in FFMs, including issuers participating in states that are performing plan management functions, will continue to have an assigned federal

account manager and newly certified issuers will be assigned a federal account manager in September prior to the start of the benefit year, however there is still no specific information on who has been assigned as New Jersey's federal account manager at this time.

Enrollment through the FFM

Similar to existing commercial health insurance, all individuals eligible for coverage through the FFM are able to enroll in insurance during certain prescribed times. Enrollment for health coverage had been extended for 2014, however the 2014 open enrollment period is now closed. Individuals with special circumstances may enroll in during a so-called Special Enrollment Period (SEP). For all other individuals, open enrollment for 2015 coverage will begin on November 15, 2014 through February 15, 2015.

For individuals enrolled in a 2014 Marketplace plan, the benefit year will end December 31, 2014. In order to continue health coverage in 2015, individuals must renew their current health plan or choose a new health plan through the Marketplace during the 2015 Open Enrollment period.

Special Enrollment Periods

Qualified individuals may be allowed a SEP under certain circumstances during which they can enroll in a QHP or change enrollment from one QHP to another outside of the open enrollment period. In order to qualify for the SEP, individuals will need to demonstrate the occurrence of either a qualifying life event or other special circumstances and make the plan selection within 60 days from the qualifying life event or other circumstance. Qualifying life event SEPs can be initiated through the HealthCare.gov website throughout the year.

Qualifying Life Events for Special Enrollment Periods

Qualifying Life Events include the birth or adoption of a child, marriage or divorce, release from incarceration, becoming a U.S. citizen, national, or gaining lawful status in the U.S, status as an Indian or loss of minimum essential coverage through job loss or an employer stopping coverage. Individuals must process these changes through the HealthCare.gov website throughout the year. Effective dates for new coverage through a qualifying life event are as follows:

Type of Consumer-Initiated Change	Plan Selection Date	Coverage Effective Date
Not eligible for an SEP **Note: Dates apply only during initial open enrollment in the individual market**	Between the 1st and 15th day of the month	First day of the following month
	Between the 16th and last day of the month	First day of the second following month
Eligible for the following SEPs: 1. **Move to a new exchange service area** 2. **Release from incarceration** 3. **Becoming lawfully present** 4. **Gain status as an Indian**	Between the 1st and 15th day of the month	First day of the following month
	Between the 16th and last day of the month	First day of the second following month
Loss of minimal essential coverage (MEC) – e.g. lost job, employer stopped coverage	Any day of the month	First day of the following month
Gaining a dependent through Marriage	Any day of the month	First day of the following month
Future loss of MEC (loss up to 60 days in the future)	Any day of the month	First day of the month following the date of the loss of MEC
Birth, adoption, or placement for adoption or foster care SEP	Any day of the month	Day the child was born, adopted, or placed for adoption or foster care

Source: Centers for Medicare & Medicaid Services (CMS)

Non-Qualifying Life Events for Special Enrollment Periods

Non-Qualifying Life Events include enrollment errors, (or exceptional circumstances such as a medical emergency or a natural disaster), misrepresentation by an entity providing formal Marketplace enrollment assistance, benefit display errors for a healthcare plan on the website that may have occurred during the initial Open Enrollment Period. In these events, individuals must call the Marketplace Call Center and speak to a Call Center Representative, who will determine whether an individual may be eligible for an SEP. Individuals will be responsible for contacting their existing insurance companies to terminate coverage. When an individual switches insurance in a special enrollment period, any out-of-pocket costs paid under the original plan will not count toward the maximum out-of-pocket limits in the new plan.

Coverage effective dates for non-qualifying life events will be for the first day of the next available month. Enrollments in the first half of a month will not require a change in effective date. Enrollments that occur after the 16th of the month are eligible for coverage by the first day of the second following month.

Two Additional 60-Day Special Enrollment Periods

CMS recently established two 60-day special enrollment periods for individuals who were unable to get their immigration related paperwork in before the September 5, 2014 deadline.

One special enrollment period applies to individuals who can attest that they tried to submit their documents by the deadline and for whom eligibility can be verified. Individuals falling under that category have 60 days to select a plan, and coverage will be retroactive to the date after their plan was terminated. A second enrollment period is available for those who cannot attest that they attempted to send in documents by Sept. 5, but who submit the needed documentation within the two-month time frame. For those individuals, coverage would be prospective, meaning it would go into effect the first day of the month following a plan selection. CMS also stated that the special enrollment periods are intended to accommodate time lags due to the mailing and processing of documents.

Conclusion

Individuals can now benefit from stronger coverage and consumer protections by easily accessing the Marketplace. Since open enrollment began on October 1, 2013, more than 8 million people have signed up for coverage through the Marketplace.