Law and the Public's Health

When health reform is fully implemented in 2014, more than half of all Health Insurance Exchanges will be federally facilitated, a significantly different approach to implementation from that initially envisioned under the Affordable Care Act. This installment of *Law and the Public's Health* examines key issues for public health policy and practice that can be expected to arise in a federally facilitated Exchange context.

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FEDERALLY FACILITATED INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT: IMPLICATIONS FOR PUBLIC HEALTH POLICY AND PRACTICE

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This installment of *Law and the Public's Health* examines the implementation of federally facilitated Health Insurance Exchanges[2] (FFEs), a key component of the Patient Protection and Affordable Care Act (ACA).[1] Following an overview of the law, this analysis discusses its implications for public health policy and practice.

BACKGROUND

Health Insurance Exchanges (renamed Health Insurance Marketplaces[2] by the Centers for Medicare & Medicaid Services [CMS]) are designed to make health insurance coverage accessible and affordable for individuals and small employer groups that traditionally have faced barriers in the market. The insurance products sold to qualified individuals and employers who meet Exchange eligibility requirements are known as qualified health plans (QHPs); QHPs must undergo a certification process prior to market entry and are subject to ongoing state and federal oversight.

Although the ACA originally envisioned a state-based Exchange system, the law gives states the option of either establishing their own Exchange or relying on the U.S. Department of Health and Human Services (HHS) Secretary to do so.[3] As of October 1, 2013, 15 states and the District of Columbia have been conditionally approved to operate a state-based Exchange (both the individual Exchange and the small business Exchange). Another six states have entered into formal Partnerships with an FFE (FFE-Partnerships) for both their individual and small business markets. Three states (Mississippi, New Mexico, and Utah) have elected to operate their own small business Exchanges while opting for an FFE in the individual market, and 26 states have chosen an FFE without any formal partnership arrangement.

Because the ACA originally envisioned states as the creators and operators of Health Insurance Exchanges, the emerging emphasis on an FFE model has the potential to create significant implementation issues, given the extent to which the new Exchange market is really an extension of the state-regulated health insurance market. Nothing about the Exchanges alters states' role as the primary regulators of insurance; instead, the Exchange system is designed to offer a special marketplace in which individuals and small employers can shop for coverage and in which federal coverage subsidies (through premium tax credits) can be secured.

Insurance reform lies at the heart of the ACA, which contains a broad slate of market-wide insurance policy reforms that apply to health insurance plans sold inside and outside of Exchanges. The first set of reforms, which already has taken effect, includes premium rate reviews aimed at controlling costs, coverage of young adults as dependents up to 26 years of age, a bar on annual and lifetime limits on coverage, coverage of certain preventive health services, a ban on unjustified rescissions, quality performance measurement and reporting, the use of uniform explanations of coverage, certain patient protections such as coverage of emergency care out of network, and new appeals procedures.[4]

The second set of market-wide insurance reforms, which is far more ambitious, is designed to take effect January 1, 2014, when the individual and employer responsibility obligations commence. These far-reaching reforms include a ban on preexisting condition exclusions and coverage discrimination based on health status (the law contains a limited exception for