The Health Insurance Exchanges:

What you need to know

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The Patient Protection and Affordable Care Act (ACA) calls for the creation of health insurance exchanges; organized, online marketplaces where individuals and small businesses can purchase health insurance. Most uninsured will be required to have health insurance beginning in 2014, with as many as 24 million Americans expected to enroll in the exchange by 2023.

This guide is designed to expand your understanding of the exchange in order to facilitate and enrich your discussions with customers.

Click on a topic below to jump directly to that section.

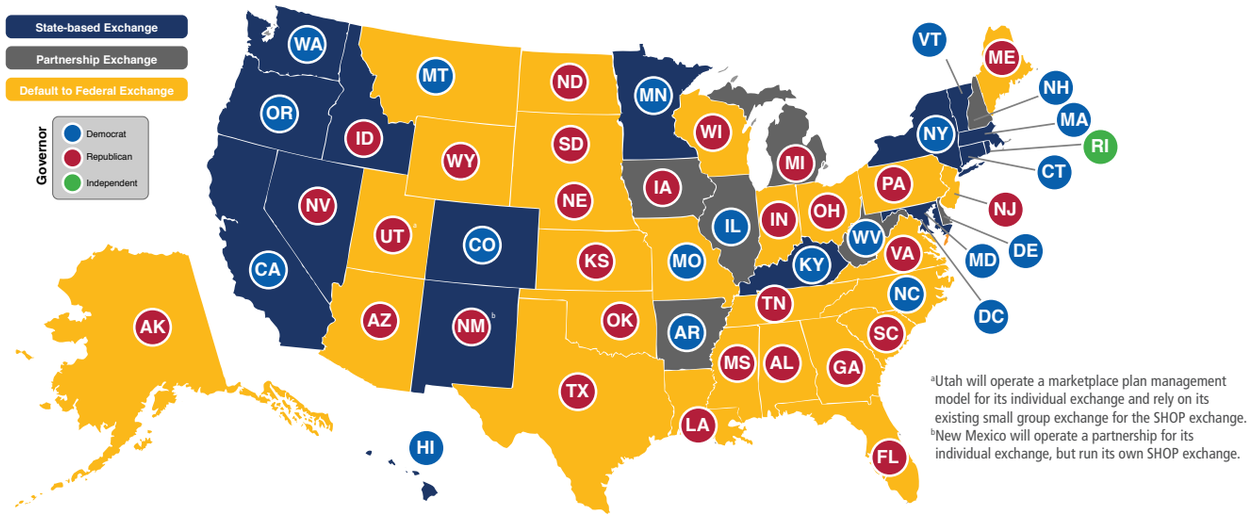
1. Background information

1.1. What are the health insurance exchanges?

They are organized online marketplaces authorized by the ACA, where individuals and small businesses (fewer than 50 or 100 employees, depending on state) can purchase health insurance beginning October 1, 2013 (for coverage that will go into effect on January 1, 2014).

The exchanges will be run on a state-by-state basis, and all states are required to have an exchange (1 for the individual market and 1 for the small group market, although states can and most likely will combine them).

If a state declines to develop its own exchange, the US Department of Health and Human Services (HHS) will step in to manage the exchange on behalf of the state. As of July 15, 2013, 15 states (plus Washington, DC) are likely to run their own exchange in 2014, 28 states will defer to the federal government (known as a federally facilitated exchange, or FFE), and 7 states will form a partnership exchange, which will allow the state ownership over certain functions and will leave others to the federal government.



[a]Utah will operate a marketplace plan management model for its individual exchange and rely on its existing small group exchange for the SHOP exchange.
[b]New Mexico will operate a partnership for its individual exchange, but run its own SHOP exchange.

Source: Center on Budget and Policy Priorities. Status of state health insurance exchange implementation. Updated August 6, 2013. Accessed August 19, 2013.

The exchanges are not insurers themselves, but rather they are a marketplace that will allow private insurers to offer coverage. The exchanges must serve a number of functions, including contracting with health plans, providing consumer outreach, education and assistance, and building the necessary technology infrastructure to determine eligibility and process member enrollment.

The exchanges are not a new concept, and the way they are being constructed today is in part based on existing exchanges in both Massachusetts and Utah (although both will have to adapt to meet the requirements of the ACA). Additionally, some private insurers are setting up their own exchanges to help facilitate the purchase of insurance, although these will be entirely separate from the state exchanges.

Note that the health insurance exchanges are sometimes referred to as the "health insurance marketplace," and these terms are interchangeable.

1.2. What are the major health insurance exchange milestones over the next few years?

Several major exchange milestones exist, including:

- **Spring/early Summer 2013:** Plans must declare interest in becoming certified to participate in an exchange. Plans were required to file an application for review and approval and are approved in late August or September
- **October 1, 2013:** Open enrollment begins and runs through March 31, 2014
- **January 2014:** Health insurance exchanges go live
- **January 2017:** States have a choice to permit larger businesses (>100 employees) to move lives to the exchanges

Please see **SECTION 6** for a complete timeline of important dates.

1.3. What are the different types of health insurance exchange models?

The exchanges will have 1 of 3 different management structures: state, federal-state partnership, and FFE. These exchange types will have differing levels of federal and state responsibility, as outlined below. Most likely, the exchanges will look different based on the model chosen, and these differences may increase in future years. For example, the state-based exchanges have the highest funding and will likely have the most robust set up, including marketing campaigns. The FFEs, at least in 2014, are likely to be the most bare-boned of the exchanges.

While the FFE will act as a passive clearinghouse that accepts all Qualified Health Plans in 2014, states operating their own exchanges will have a choice as to whether to actively regulate the marketplace (called an active purchaser) or allow any qualifying plan to compete. For example, active purchaser states such as California, New York, Massachusetts, Rhode Island, and Vermont will have a competitive bidding process, potentially limiting the number of plan offerings by each issuer, dictating rates or requiring certain benefits to be covered. After 2014, the FFEs and other states may also become active purchasers. While plans are primarily making state participation decisions based on current market presence, the state's exchange model may become a more significant factor in future years.

State-based	Federal-state Partnership[a]	Federally Facilitated Exchange (FFE)
• State operates all exchange activities • State can use federal services for certain specific exemption and credit determinations and programs	• Plan management • Consumer assistance	• HHS performs key exchange functions • State provides regulatory oversight (traditional role)

[a]The federal government will perform other exchange functions, including eligibility determination, enrollment, and financial management.

2. Qualified Health Plans (QHPs)

2.1. What is a QHP and what steps must a plan take to qualify for certification?

A QHP is any plan that has been approved to participate in the exchange by meeting certain criteria, which include:

- Offered by an issuer that is licensed by the state and in good standing
- Covers essential health benefits (EHBs), as discussed in **SECTION 3.1**
- Offers at least one plan each of the "silver" and "gold" levels of cost sharing, as discussed in **SECTION 3.2**
- Does not use benefit designs or marketing practices that discourage enrollment of individuals with significant needs, as determined by the appropriate exchange authority
- Complies with distribution and cost-reporting rules for prescription drugs
- Agrees to charge the same premium rate whether offered inside or outside the marketplace, and to submit rate increase justification to the appropriate exchange authority prior to implementation

2.2. Which type of health plans may participate in each state?

Plans will make participation decisions on a state-by-state basis, depending on the expected market opportunity. They will participate in states where they have a current presence, network, and familiarity. Generally, we expect regional players (eg, Blue Cross Blue Shield), followed by national insurers and Medicaid managed care plans, will be most active. The majority of states have already announced their 2014 exchange participants, and the rest are expected to be announced shortly. More than half of all state exchanges will have 4 or more issuers participating in 2014.

2.3. What are CO-OPs?

The ACA created a new type of health insurance plan called a Consumer Oriented and Operated Plan (CO-OP). A CO-OP is a private, nonprofit health insurer whose board of directors is comprised mainly of its members. It is designed to provide quality, affordable, consumer-friendly health coverage, and will be available to purchase on the health insurance exchange as an alternative to private plans. While subject to the same rules as other health insurers, a CO-OP is different from private plans in a few ways:

- Members elect the board of directors
- Profits benefit enrollees
- Member education is essential to determining the plan's direction
- There is no direct federal funding, although federal loans will be given to nonprofits to encourage the establishment of CO-OPs

The federal government has awarded grants to 24 new CO-OPs in 24 different states.

3. Benefit design

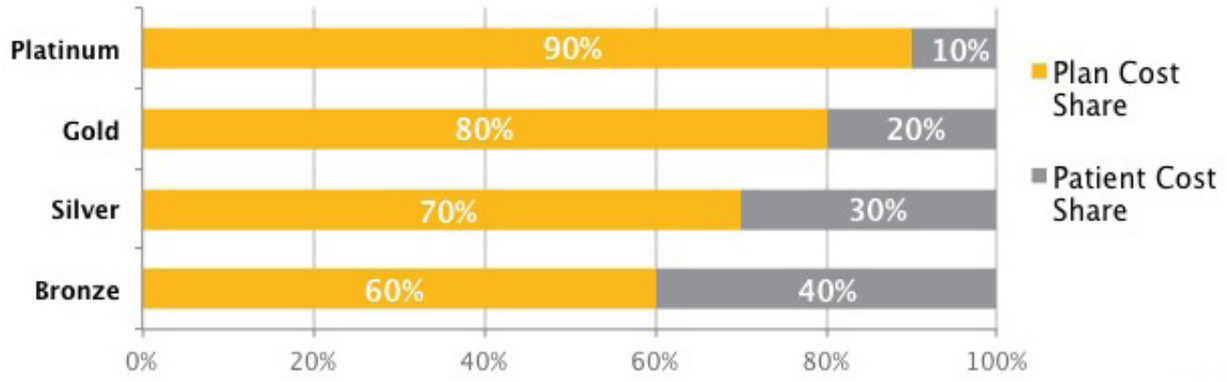
3.1. What is an EHB and what mandatory medical and pharmacy benefit must be provided by a plan in a health insurance exchange?

Insurers that participate in the exchanges will be required to offer a uniform benefits package, known as the EHBs. States will define EHBs by selecting a benchmark plan (see **SECTION 3.3**), which the exchange plans will need to parallel. The EHBs that all exchange plans must cover include these 10 categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance use disorder services, including behavioral health treatment
6. Prescription drugs, as discussed in **SECTION 4.1**
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventive and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

3.2. What are the different levels of coverage?

HHS has established 4 actuarial levels referred to as "metal tiers," which all insurers must adhere to and which vary depending on how much the insurer pays. For example, in the Bronze level, benefit coverage is actuarially equivalent to 60% of the full actuarial value of the Essential Health Benefit package. The 4 levels of coverage include:



Some states are mandating plans follow certain benefit structures within these metal tiers, although most are not. For example, there are 4 co-pay tiers within the Silver plan in California, New York, Connecticut, and Vermont.

3.3. What are benchmark plans and how do they relate to benefit design?

The health insurance exchange plans were intended to represent "benefits offered by a typical employer plan." In order to define a typical employer plan, HHS requested that each state select a benchmark plan, upon which any exchange plan in that state would model its benefit package.

In most states, the benchmark plan selected was the largest small group plan in that state.

The benchmark was meant to provide guidance to plans offering a product in that state's exchange, but plans still have considerable discretion when designing their benefit. Accordingly, benefits covered (including formulary coverage) and out-of-pocket costs may differ significantly from the benchmark plan, and will vary dramatically across plans within the state.

According to NNI market research, concerns about the exchange beneficiary pool and risk of adverse selection are top-of-mind for payers. Mitigating this risk, particularly via more restrictive benefit design, will be important for some health plans.

3.4. What are the subsidies by plan type depending on the federal poverty line (FPL)?

The ACA provides 2 forms of subsidies to help pay for health insurance in the exchanges:

- A monthly premium assistance tax credit will lower the premium amount an individual or family must pay (individuals with incomes up to 400% FPL will qualify)
- Cost-sharing assistance will limit a person's maximum out-of-pocket costs, and for some it will also reduce other cost-sharing requirements (ie, deductibles, co-insurance, co-payments) (individuals with incomes up to 250% FPL will qualify)

Individuals will be eligible for subsidies for health insurance premiums if their income is less than 400% FPL, and premium and cost-sharing subsidies if their income is less than 250% FPL (refer to the table below). For example, a family of 4 would qualify with an income of $94,200 in 2013. Given the expected exchange enrollment, most of the exchange enrollees will qualify, with an average subsidy of $4,600 per person in 2014. This will not cover the entire cost of coverage, which may result in thousands of dollars of expenses for these newly insured. Of additional concern, many subsidy-eligible individuals will "churn" between Medicaid and the exchanges, meaning income variations over the course of the year will result in differing eligibilities in the programs. With Medicaid, eligibility is likely to be valid for a year, but on a year-to-year basis, people may churn between Medicaid and exchanges, which offer very different medical and pharmacy benefits. Additionally, within the exchanges, an individual's subsidy level may change in a given year (for example, as a result of a pay increase or a job loss). Any overpayment or underpayment of subsidies will be reconciled through an individual's taxes.

Coverage and the FPL in 2013 under Medicaid Expansion			
Household Size	**Medicaid** up to 138% FPL	**Income**	**Unsubsidized Exchange Coverage** above 400%
1	$15,856	Subsidized exchange coverage between 138% and 400% FPL	$45,960
2	$21,404		$62,040
3	$26,951		$78,120
4	$32,499		$94,200

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3.5 How will the ACA impact premiums?

Premiums can vary by type of plan (eg, individual or family coverage) and geographic location. Insurers won't be able to charge more based on gender or health status, although they will be able to charge older people up to 3 times more than younger ones based on a sliding scale. This likely means that younger and healthier individuals will experience higher premiums than expected, and older or sicker individuals will see lower premiums than expected (in the exchange market). More specifically:

- **Current coverage:** With the expansion of required benefits, many people will now purchase coverage that is more comprehensive and potentially more expensive than what they currently have
- **Income:** Low- and moderate-income individuals and families will be eligible for new premium tax credits to help pay their premiums
- **Health status:** People with pre-existing medical conditions will not have to pay higher premiums. This will result in higher premiums for the healthy and lower premiums for the sick to maintain balance
- **Age:** New restrictions on how much premiums can vary based on age will result in higher premiums for individuals in their 20s, 30s, and early 40s, and lower premiums for older individuals
- **Location:** Premium rates will vary depending on a state's existing regulations or where a consumer lives within a state
- **Gender:** This will no longer be a factor in premium cost determination

4. Drug formulary management

4.1. How will prescription drugs be covered?

Every exchange plan will be required to cover prescription drugs, although they have some discretion as to which drugs they cover and how those drugs are covered. This is impacted by the state's benchmark plan, state regulations (in a few cases), and most importantly, benefit design decisions that the plan selects.

To be approved to operate in the exchange, the plan must cover the greater of: 1 drug per United States Pharmacopoeia (USP) category or class, or the number of drugs in a USP category or class covered by the state's benchmark plan (at a minimum). For diabetes products, the latter requirement will take precedent. Note that CMS is only counting chemically distinct drugs, such that a pen and vial of the same drug would count only once. In addition, regulations do not address treatment of medical benefit drugs, such as NovoSeven®.

This drug coverage requirement dictates coverage only, and the individual plans have flexibility to use whatever cost-sharing or utilization management parameters it wishes. Therefore, coverage of drugs will vary greatly by state (depending on the benchmark plan), and access to those drugs will vary greatly plan-by-plan.

Note that according to NNI market research, while a minority of (typically commercial) payers will narrow their formularies to fewer on-formulary brands, most payers will offer exchange formularies similar to their existing books of business. However, patient access to those branded drugs may be more difficult in the exchange plans, as many plans will require patients to bear a higher portion of the costs (tiering) and/ or go through more steps (utilization management), in order to mitigate adverse selection risk and lower potential costs.

4.2. What kind of access will diabetes drugs be given?

According to NNI market research, diabetes will be a highly watched therapeutic area and a potential major cost driver for your customers participating in the exchange. Diabetes will be seen as a predictor for undiagnosed conditions among exchange members, and some payers will eschew market-leading brands.

While specific formulary information is still being determined (and likely will not be made publicly available until October 1, when open enrollment begins), we know that exchange plans will be required to include the number of diabetes drugs in a USP category or class covered by the state's benchmark plan. USP's classification of diabetes products is listed in the table on the next page.

USP's current classification of select therapeutic categories

Blood Glucose Regulators	**Antidiabetic Agents**	**Acarbose**	**Nateglinide**
		Miglitol	**Repaglinide**
		Pramlintide	**Chlorpropamide**
		Metformin	**Glimepiride**
		Colesevelam	**Glipizide**
		Saxagliptin	**Glyburide**
		Sitagliptin	**Tolazamide**
		Bromocriptine	**Tolbutamide**
		Exenatide	**Pioglitazone**
		Liraglutide	**Rosiglitazone**
	Glycemic Agents	**Diazoxide**	
		Glucagon	
	Insulins	**Insulin Aspart**	**Insulin Glargine**
		Insulin Glulisine	**Insulin Aspart Rapid-acting and Insulin Aspart Protamine**
		Insulin Lispro	**Insulin Lispro Rapid-acting and Insulin Lispro Protamine**
		Insulin Human (Regular)	**Insulin Human Regular and Isophane Insulin**
		Isophane Insulin (Human)	
		Insulin Detemir	

Keep in mind that under the ACA, plans are no longer able to discriminate against members with pre-existing conditions. In addition, the health insurance exchanges will provide coverage to populations that were largely previously uninsured, and that are more likely to suffer from chronic conditions and require more drugs than the average individual. Indeed, it is estimated that 6% of exchange beneficiaries will have diabetes.

For more on the implications of the exchange for NNI, please see **SECTION 7**.

4.3. What is the drug formulary process for states with an FFE?

Currently, the federal drug formulary process will follow the same protocol as an exchange administered by the state, although this may change.

5. Member enrollment

5.1. Who will enroll in the exchanges?

The ACA requires most uninsured to have health insurance beginning in 2014, with penalties for those who opt not to purchase. This is known as the individual mandate. Additionally, the ACA provides subsidies to help individuals purchase insurance in the exchange (there will be cost-sharing subsidies for individuals making up to 250% of the FPL, and premium subsidies for individuals with incomes up to 400% FPL). As a result, as many as 24 million Americans are expected to enroll in the exchange marketplace by 2023.

Most new enrollees will be previously uninsured, although approximately one-third are likely covered by commercial insurers today. Of these new enrollees, 6% are expected to have diabetes, which is roughly the rate of diabetes in employer-sponsored insurance.

The exchanges will be open to individuals purchasing insurance on their own, as well as to small businesses (generally, up to 100 employees, although states can limit the exchange to employers with less than 50 employees prior to 2016. In 2017, states have the option of allowing businesses with more than 100 employees to enter the exchange). Enrollment in the exchanges is likely to begin slowly—the federal government suggests 7 million people will enroll in 2014, although NNI estimates a marketplace of about 5.5 million in the first year—but will pick up steam in subsequent years. Open enrollment begins October 1, 2013. Individuals can enroll via www.healthcare.gov or on the individual state's exchange Web site. Applications may also be submitted by phone, mail, or in person.

5.2. What is the enrollment period to enroll in a health insurance exchange product?

Open member enrollment begins October 1, 2013 and runs through March 31, 2014. In subsequent years, open enrollment will align with Medicare Part D (October 15-December 7). While enrollment in plans will generally be limited to that time frame, in addition to the open enrollment period, there will be certain "special enrollment" time frames depending on specific circumstances (eg, loss of job). Groups will be able to purchase insurance in the Small Business Health Options Program (SHOP) year around.

5.3. What will the exchange enrollment process look like for individuals?

Generally, individuals will complete 1 streamlined application to enroll in either a QHP through the marketplace, Medicaid, or the Children's Health Insurance Program (CHIP), a children-only plan. Applications may be submitted online, by phone, by mail, or in person. Each exchange will have assisters or navigators in place to help guide consumers through the exchanges. Insurance agents and brokers may also help sell exchange plans (there are different requirements for assisters, navigators, and brokers).

5.4. What are Navigators?

Under the ACA, each marketplace will have a grant-funded Navigator Program. Navigators are trained to facilitate consumer participation in the health insurance exchanges. In certain states, Navigators may also be referred to as "in-person assisters." Agents or brokers may act as Navigators if certain standards are met, although they cannot be paid by an issuer for member enrollment. Navigators perform the following functions:

- Raise awareness about the marketplace
- Provide unbiased, culturally, and linguistically appropriate consumer information
- Help consumers understand health plan differences and submit plan selection
- Give referrals
- Field consumer complaints

5.5. What will the exchange enrollment process look like for small businesses?

In addition to the individual exchange, the SHOP exchanges will begin on January 1, 2014, providing insurance to businesses with fewer than 50 or 100 employees (depending on the state). While the ACA envisioned the SHOP exchanges would offer "employee choice" in 2014 (where an employer would offer a subsidy and the employee could select the best plan for them through the exchange), HHS has delayed the requirement that SHOP exchanges offer "employee choice" until 2015. Nonetheless, at least 10 states are moving forward with "employee choice" (including California, Colorado, Connecticut, Maryland, Minnesota, Nevada, New York, Oregon, Utah, and Vermont), while the FFE states will only have the "employer choice" option in 2014 (where the employer selects the offerings available to the employee).

5.6. What enrollment assistance is available for consumers?

In addition to Navigators, additional enrollment assistance is available in each marketplace via a toll-free call center and Web portal, enrollment counselors, community-based organizations, and in some states, agents and brokers. Healthcare.gov is the official Web site of the exchange and offers consumers an Insurance Finder tool to sort through insurance options and pick the most appropriate choice.

6. Implications for NNI

6.1. NNI formulary drug coverage

6.1.1. What will NNI's drug coverage look like, and when will NNI Products Exchange Formulary Status be known?

Formulary status and benefit design are still being determined. Announcements should be made about plan participants in each state over the next few months, but it is likely that formulary decisions will not be known until open enrollment begins on October 1, 2013.

6.2. NNI contracting strategy

6.2.1. What insights do we have on contracting strategy for exchange customers?

Contracting strategy will entail the following for your exchange customers:

- If your customer is participating in the exchange, inquire about formulary design and share NNI approach to secure access
- Exchange customers should be treated like any existing/new contracting entity
- Contract can be separate or an amendment under the commercial agreement
- Contracted and non-contracted customers can obtain co-preferred commercial rates

6.3. Opportunity for AEs to provide leadership and direction

6.3.1. How can the account team help the field navigate this evolving environment?

AEs are encouraged to take a grounded yet opportunistic approach to the exchanges:

- Continue to focus on Medicare and commercial business
  - Stay focused on brand messages during day-to-day interactions
- Track potential opportunities and risks
  - Stay informed on regulatory developments
  - Understand how your customers prioritize exchanges and their approach
  - Collaborate with your customers to identify potential opportunities and risks on exchanges. For example, NNI market research indicates that AEs can explore pockets of opportunity to collaborate with willing exchange plan sponsors on patient-centric initiatives, particularly around disease education and medication adherence