Health Insurance Marketplaces: An Overview

The Affordable Care Act (ACA) created health insurance marketplaces, sometimes called exchanges, which provide individuals and small business owners with a "one-stop-shop" online marketplace to shop for, compare and purchase health insurance. Qualified individuals may be able to obtain premium tax credits and cost-sharing reductions to make marketplace coverage more affordable.

The marketplace for small businesses is called the Small Business Health Options Program, or SHOP, and is open to businesses with 2 to 50 employees (up to 100 employees in some states). Eligible small businesses may qualify for tax credits to lower the employer's cost of buying coverage for employees.

Each state has a marketplace for individuals and families, and a SHOP for small businesses to buy coverage. Marketplaces may be operated by the federal government, the state government, or by a partnership of both. In most ways, the marketplaces won't differ based on who operates the marketplace; they all must perform the same functions and plans will have to meet a minimum set of standards set by the federal government. However, state-based marketplaces may apply more consumer-protective requirements for participating plans, such as a requirement to offer standardized benefit designs, or offer different tools for consumers, such as decision support tools.

Eligibility for Marketplace coverage: Consumers are eligible to purchase health insurance coverage through the marketplace if they:

- Live in the state in which they are applying;
- Are a citizen of the U.S. (or are lawfully present); and
- Are not currently incarcerated.

Consumers will need to go through additional eligibility screening to determine whether they are eligible for premium tax credits or cost-sharing reductions to help make their marketplace plan more affordable.

Marketplace plans: Federal rules establish: minimum standards for benefits and cost sharing, limit the factors that may be used to set premiums, and require plans to meet network adequacy standards.

All marketplace plans must meet the following requirements (states can apply stronger standards):

- **Essential Health Benefits (EHBs):** Insurers are required to cover a minimum set of benefits within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care.
- **Key patient services and protections:** Health plans must cover recommended preventive care at no cost-sharing (co-payments, coinsurance and deductible), and allow individuals to use emergency services without prior authorization or higher cost-sharing for out-of-network emergency room care.
- **Prohibition on discrimination based on health status:** Insurers cannot refuse to accept applicants, omit benefits for a pre-existing health condition, or impose a waiting period based on health status.
- **Standardized tiers of coverage:** Plans must provide a minimum level of financial protection for health costs, at least 60 percent of total average costs for covered benefits. In addition, plans must be offered at specified coverage levels, known as "metal levels," so that individuals can more easily compare them. The lowest level of coverage (60 percent) is called the bronze level. A silver level plan will cover 70 percent of total average costs for covered benefits, a gold plan covers 80 percent, and a platinum plan covers 90 percent. Individuals under age 30 or who cannot find "affordable" coverage are eligible to purchase catastrophic coverage.

- **Modified community rating:** Insurers are no longer allowed to charge higher premiums based on the health status or claims experience of an individual. However, insurers may charge more if the individual is older than average (up to three times more) or if he or she uses tobacco products. Premiums can also vary by geography.
- **Prohibition on annual and lifetime limits:** Health plans can no longer impose annual or lifetime dollar limits on essential health benefits (EHBs).
- **Limits on out-of-pocket costs:** Health plans must limit out-of-pocket costs for essential health benefits obtained in-network to no more than $6,850 for an individual or $13,700 for a family in 2016 (this amount will grow each year to track increases in medical costs).
- **Dependent coverage to age 26:** Health plans must allow families to keep their adult children on the family plan up to age 26. This applies even if the child isn't a student, doesn't live at home, or is not financially dependent on his or her parents.
- **Sufficient access to providers:** Marketplace plans must meet federal standards for network adequacy, ensuring access to primary care doctors, specialists, and "essential community providers" such as community health clinics and hemophilia treatment centers (HTCs) without unreasonable delay.

Tools available to Marketplace shoppers: The tools available to consumers shopping for coverage will vary depending on whether the state or federal government is operating the exchange. All federally run Marketplaces allow consumers to estimate annual out-of-pocket costs using a cost calculator, to look up which plans include a consumer's preferred providers, and search plans based on covered prescription drugs. Many state- administered Marketplaces offer similar tools.

Note that the metal levels of coverage provide a rough way to evaluate the relative generosity of a plan; individual costs will vary based on actual health care use. The out-of-pocket cost calculator will help refine the comparison of plans based on an individual's expected health care use, based on high, medium and low levels of health care use. However, for a more precise comparison, use the Health Plan Cost Comparison Worksheet in this toolkit.

Buying coverage in the Marketplace vs. shopping in the outside market: In most states, consumers will continue to be able to buy health coverage outside the Marketplace. For the most part, health insurers selling coverage outside the Marketplace will have to provide many of the same consumer protections that insurers inside the health insurance Marketplace provide. However, some types of coverage sold outside the Marketplace are exempt from the new rules, and consumers should fully review the terms of their coverage to ensure it provides adequate protection. For example, some plans sold outside the Marketplace may still discriminate based on health status, won't provide essential health benefits, and may not meet the federal limit on out-of-pocket costs. In addition, not all coverage sold outside the Marketplace meets the federal standard for "minimum essential coverage" and consumers could face a tax penalty if they do not have this minimum coverage.

Furthermore, financial assistance can only be obtained with Marketplace plans, and some special enrollment periods (SEP) for enrolling in or changing plans outside the open enrollment period are only available to Marketplace plan enrollees.

However, plans sold outside the Marketplace that comply with the ACA's consumer protections may be a better option for some consumers, particularly if a preferred provider is not part of any Marketplace plan network and/or the consumer is ineligible for financial assistance and doesn't expect a mid-year drop in income (which, if enrolled in the Marketplace, would qualify them for a SEP to enroll in coverage with financial help).