

HEALTH POLICY CORNER: PART IV

Health Insurance Exchanges and the Affordable Care Act

Patricia Harris, MD

Dr. Harris is a member of the Forum editorial board and can be reached at pfharris@usc.edu.

State-based health insurance exchange programs remain a key component of the Affordable Care Act (ACA). These exchanges will be the means through which low- and moderate-income individuals who currently do not have employee-sponsored health insurance will receive cost-sharing (premium and copay) subsidies designed to make health insurance coverage affordable. Small business employers are also expected to use the subsidies to purchase coverage for their employees. Enrollment is supposed to begin by October 1, 2013, and be fully operational by January 1, 2014.

The state deadline to submit an exchange blueprint to the Centers for Medicare and Medicaid Services (CMS) was November 16, 2012. States that established exchanges early (Rhode Island was first) have already received federal funding through exchange establishment grants (\$1 billion has been awarded to date). At the time of this writing, a survey conducted by the Kaiser Family Foundation showed that only 15 states and the District of Columbia had established state exchanges. Another three states have plans for an exchange, 16 were studying options,

nine have demonstrated no significant activity, and seven have decided not to participate. Many states, even some who have filed blueprints, continue to participate in lawsuits or have filed separate suits challenging the constitutionality of the legislation (see www.governing.com, www.kff.org).

States can design their exchanges within the framework of one of three models: 1) fully federally run, 2) fully state run, or 3) a partnership with CMS. Of the states that had made a decision by the end of August 2012, 17 had chosen a state-based exchange, eight had chosen a federal exchange, and one (Arkansas) had chosen a partnership.

The federal government plans to sponsor at least two national health insurance plans that will compete directly with private insurers. The new plans would be offered to individuals and small employers through the above exchanges in each state. Under the ACA, at least one plan must be offered by a nonprofit group, which will likely be the Government Employees Health Association. Additionally, at least one plan must exclude abortion services (or provide a separate opt-in account through which abortion funding would be provided).

These are uncertain times, and the states' responses toward implementation of the ACA reflect that uncertainty. Many states have complained that there has not been enough guidance by the federal government. Others feel that the federal multistate plans will undermine the ability of other qualified health plans to compete on a level playing field. Furthermore, insurance groups complain that the differences in plan offerings may be too confusing for the consumer, who will not be able to compare such disparate plans appropriately.

If we assume that there is no repeal of the ACA in upcoming months, or that certain programs under the ACA will continue even if other programs are repealed, providers of medical services remain unprepared for a large influx of newly insured patients requiring primary care. SGIM will continue to advocate for improved funding to primary care providers so that individuals entering the profession will see primary care as a viable career choice. We also continue to advocate for funding for primary care workforce training and for generalist-led health services research. We must stay alert during these uncertain times.