ISSUE BRIEF

MARKETPLACE & ESSENTIAL HEALTH BENEFITS

Starting in 2014, individuals, families and small business will be able to purchase health insurance plans in a health insurance marketplace. A marketplace is technically not an actual place, but will be a virtual forum where you can go online and browse insurance offerings based on your personal information. There will also be an in-person option to apply and purchase a health insurance plan. For example, a person should be able to apply for coverage at a local health department or social service office using an in-person assistor.

People who might purchase insurance through the marketplace include:

- People who do not want to accept their employer's health insurance
- People whose partner or spouse has insurance through his or her employer, but the plan does not cover the other spouse or partner or their children
- People who are not eligible for Medicaid or another government health coverage program
- People who do not otherwise have access to health insurance (i.e., are uninsured) on January 1, 2014.

Every health insurance plan sold in the marketplace will offer comprehensive coverage, from doctors to medications to hospital visits. Health plans sold in the marketplace (and some plans sold outside the marketplace) must cover "essential health benefits" (see HFA's Essential Health Benefits issue brief). The essential health benefits requirement adds an element of standardization or predictability in the kinds of benefits offered to people.

In the marketplace, you will be able to compare all your insurance options based on price, benefits, quality, and other features that may be important to you, in plain language that makes sense. Enrollment in the marketplace begins in October 2013, with coverage beginning in January 2014.

People earning between 100% and 400% of the federal poverty level FPL ($23,550 to $94,200 for a family of four) will have access to premium tax credits in order to make purchasing insurance in the marketplace more affordable. Additionally, people earning between 100% and 250% FPL ($23,550 and $58,875 for a family of four) will have access to cost-sharing subsidies that will bring down their deductibles, copayments, and coinsurance. Here is a link to the 2013 federal poverty guidelines http://aspe.hhs.gov/poverty/13poverty.cfm.

Structure of an Exchange

Some states decided to create their own state-run marketplaces and already have taken major steps toward establishing a marketplace. Other states instead opted to use the marketplace created by the federal government. As yet a third option, some states decided to create a state/federal partnership model that combines state functions with federal functions. The health care reform law also allows states to band together to form combined, or regional, marketplaces.

In addition, the ACA gives states several options for how the marketplaces can be structured. They can be established within an existing or new state agency, as an independent public entity, or as a non-profit. States must have a marketplace fully established by 2014.

Health Plans

The federal government has established minimum criteria for certification of qualified health plans that can be offered in the marketplace. These standards include offering the essential benefit package; cost-sharing limits; being licensed and in good standing to offer health insurance; quality standards established in the law; offering at least one qualified health plan at the silver and gold benefit levels; offering a child-only plan for children under 21; and no discrimination on the basis of race, color, national origin, disability, age, sex, gender identity and sexual orientation. The law also requires HHS to establish provider network adequacy requirements to ensure health plan enrollees have sufficient choice of providers. A state can require that health plans sold in its marketplace also cover state mandated benefits; however, the state must then pay for the coverage of these benefits.

Consumer Perspective

Individuals with bleeding disorders and other rare diseases will definitely be looking to the marketplace for coverage. Because of their unique health needs, it is imperative that the set-up of the marketplace allow for the inclusion and recognition of these needs and in a way that allows for affordable insurance options and a benefit design that does not compromise quality care or access to specialists and specialty treatments. Here are some of the issues that will be important to individuals with bleeding disorders to consider:

- ✓ *Cost sharing*
- ✓ *Continuity of Care*
- ✓ *Restricting Patient Access to Medications and Treatments*
- ✓ *Navigator Program and Consumer Usability*
- ✓ *Medical Necessity and Appeals*
- ✓ *Access to Specialists and Treatments*
- ✓ *Monitoring Adverse Selection*

Cost Sharing

It is vital for individuals with rare diseases to choose a health insurance policy that will meet their unique needs. Therefore, plans should be required to disclose to all prospective and current members information about the deductible, co-payment and co-insurance amounts that are applicable to in-network and out-of-network covered services as well as any limitations on services. States should have oversight mechanisms allowing them to review plan benefit design ensuring that cost-sharing does not discriminate or unfairly target any individuals or rare disease groups.

Continuity of Care

It is common for low- to middle-income families and adults dealing with a bleeding disorder to experience frequent fluctuations in their incomes due to various factors, including the expense of treatment and the loss of wages because of complications due to the bleeding disorder. This may cause them to move to public programs like Medicaid and back again to employer sponsored coverage. States need to ensure

that changes in coverage have a minimal affect on the ability to access care. These protections must be in place so individuals are not required to re-establish treatment protocols.

States should look at aligning guidelines for health plans sold in the marketplace and Medicaid, establishing any willing provider rules, which may allow individuals to still see the same provider, or making sure a specific course of treatment is covered for the duration recommended, no matter the type of insurance coverage.

Restricting Individuals' Access to Medications and Treatments

Utilization management, prior authorization, and step therapy are all mechanisms some insurance companies use to limit individuals' access to treatments, particularly when the treatment is very costly. For individuals with bleeding disorders, their treatment is not only lifesaving but also very expensive, and there are no generic alternatives. States must have specific oversight mechanisms allowing them to review plans that choose these techniques to monitor individuals' care. Plans should be required to disclose to all prospective and current members if these guidelines are being used.

Navigator Programs and Consumer Usability

Robust, comprehensive navigator programs must be in place in each state to provide individuals with information and assistance when selecting a plan and accessing their health care benefits. Other consumer friendly marketplace characteristics states can include are: user friendly website, toll-free hotline, standardized enrollment forms, and making enrollee satisfaction ratings public.

Medical Necessity Determinations and Appeals

Marketplaces should require plans to use medical necessity criteria that are objective, clinically valid, and compatible with generally accepted principles of care. Plan denials, based on lack of medical necessity, should explain in clear language the criteria used to make the determination. There should also be a uniform exceptions and appeals process for plans that operate in the exchange.

Access to Specialists and Therapies

In state marketplaces, qualified health plans utilizing a provider network must provide an adequate number of in-network providers. For individuals with rare and chronic conditions such as bleeding disorders, access to specialists and treatments should be based on medical literature and treatment guidelines recommended by medical and patient organizations.

An example of such a standard for individuals with bleeding disorders is MASAC #188 from the Medical and Science Advisory Committee of the National Hemophilia Foundation. Comparatively, the marketplace should allow individuals access to needed specialists at the appropriate site of care, whether in the hospital, outpatient clinic, office of the physician, hemophilia treatment center (HTC), or the home setting.

It is important to note that specialized treatment facilities, such as the federally recognized HTCs, do not fit neatly into specific categories of services. HTCs provide comprehensive, multi-disciplinary services in a single setting, and have been shown through research at the Centers for Disease Control and Prevention (CDC) to improve quality and reduce morbidity and mortality of individuals living with bleeding disorders.

For more information, contact HFA at advocacy@hemophiliafed.org

ADDITIONAL RESOURCES

Hemophilia Federation of America – Legislative Action Center:
http://hemophiliafed.org/what-we-do/advocacy/legislative-action-center/

Kaiser Family Foundation:
- ✓ http://healthreform.kff.org/tags/exchanges.aspx
- ✓ http://statehealthfacts.kff.org/healthreformsource.jsp
- ✓ http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17&sub=205&yr=1&typ=5

Department of Health and Human Services:
http://cciio.cms.gov/resources/factsheets/index.html#hie

National Conference of State Legislators: http://www.ncsl.org/default.aspx?tabid=21393

National Association of Insurance Commissioners – American Health Benefit Exchange Model Act:
http://www.naic.org/documents/committees_b_exchanges_adopted_health_benefit_exchanges.pdf

The Commonwealth Fund: www.commonwealthfund.org