# Health Insurance Exchange Marketplaces

[Other Information](#_Toc201129340)

[Health Care Reform and the Affordable Care Act (ACA)](#_Toc201129341)

[Health Insurance Exchange Marketplace Need to Know](#_Toc201129342)

[Health Insurance Exchange Marketplace and the American Indian (AI) and Alaska Native (AN) Communities](#_Toc201129343)

[Key Plan Design Features and Offerings](#_Toc201129344)

[Grace Period](#_Toc201129345)

[Frequently Asked Questions - Integrated Deductible/Maximum Out of Pocket](#_Toc201129346)

[Frequently Asked Questions - Healthcare Reform](#_Toc201129347)

[Frequently Asked Questions - General](#_Toc201129348)

[Related Documents](#_Toc201129349)

**Description****:** Information about Health Insurance Exchanges the online marketplaces where consumers and employers and employees of small businesses can shop for health insurance. On these websites, they can compare the plans available to them and then purchase online.

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| Other Information |

Open enrollment generally begins November 1st of each year. January 1st is the first date coverage can begin unless they qualify for coverage through a Special Enrollment Period or they qualify for CHIP. The last day of open enrollment may vary year to year.

Many of our health plan clients will offer plans through the health insurance exchanges. We provide PBM services for these plans, in much the same way as we do today for our other plans. Internally, the plan names provided in PeopleSafe and theSource CIFs may be referred to as Marketplaces, Exchanges or HIX (Health Insurance Exchange).

[Top of the Document](#_top)

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| Health Care Reform and the Affordable Care Act (ACA) |

There have been significant changes to the way health care is delivered in the U.S. due to Health Care Reform also known as ACA. As mentioned in the Introduction to Health Insurance Exchanges training, government-regulated Marketplaces are available and offer standardized health care plans that anyone can access to purchase health insurance.

Some people, based on household income, may also be eligible for a federal subsidy to help pay for this coverage. The introduction of Health Insurance Exchange Marketplace plans will make shopping for health insurance like the way we shop for car insurance today.

This document focuses on the Health Insurance Exchange Marketplaces, many of the features provided by these plans will become requirements for all health insurance plans in the future, not just the marketplaces.

[Top of the Document](#_top)

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| Health Insurance Exchange Marketplace Need to Know |

Many Health Insurance Exchange Marketplace members may be obtaining insurance for the first time and need guidance about basic use of their benefit plan. Members may need education regarding basic use of formulary alternatives, in-network pharmacies, Maintenance Choice, Minute Clinic, the ExtraCare Health benefit and Home Delivery service. For open enrollment calls, use Universal IDs provided in the clients’ CIFs to process Test Claims to address drug coverage and pricing inquiries. Be mindful of deductible and out-of-pocket levels, and how the test claim may impact them.

Marketplace plans will include an integrated medical and prescription maximum out-of-pocket (MOOP). In addition, any out of pocket (OOP) costs the member pays for Essential Health Benefits will apply to MOOP accumulation.

Refer to the CIF for instructions if the member has questions about premium billing and subsidies.

* If a member falls behind on premium payments, there will be a grace period of 30 days during which the member will continue to have coverage. After that point, between days 31-90, the plan determines if the member continues with the same benefits or cease to have coverage and must pay the full price for services (including prescriptions, at the contracted rate).

[Top of the Document](#_top)

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| Health Insurance Exchange Marketplace and the American Indian (AI) and Alaska Native (AN) Communities |

The implementation of Health Insurance Exchange Marketplace plans does **not** impact AI and AN Indian Health Service (IHS) eligibility. AI/AN’s who purchase coverage through the Exchanges can continue to receive IHS services. The IHS, an agency within the Department of Health and Human Services, provides a comprehensive health service delivery system for approximately 1.9 million American Indians and Alaska Natives. IHS is the principal federal health care provider and health advocate for Indian people.

The Affordable Care Act (ACA) includes several special provisions for AI/AN purchasing Marketplace coverage:

* AI/ANs with household incomes below 300% of the federal poverty level who are enrolled in a Marketplace plan do not have to pay any cost-sharing (**Examples:** Copayment/coinsurance).
* When an AI/AN is enrolled in a Marketplace plan receives services directly from Indian Health Services (IHS), Indian tribe, tribal organization, urban Indian organization or through the Contract Health Service program, the individual will not have to pay any cost sharing for those services.
* Marketplace plans are to provide special monthly enrollment periods for AI/ANs (**Examples:**  AI/ANs are not restricted to the standard Health Insurance Exchange Marketplace enrollment period)
* Members of Indian tribes are exempt from the individual shared responsibility penalty for not complying with the requirement to maintain minimum essential health coverage.

[Top of the Document](#_top)

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| Key Plan Design Features and Offerings |

Below are some of the key features and offerings that may be present in the Health Insurance Exchange Marketplace plans. Review the CIF and run Test Claims to confirm drug coverage and costs.

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| **Plan Design Feature or Offering** | **How it applies to Health Insurance Exchanges** | **Reference Documents** |
| Integrated Out-of-Pocket Maximum (MOOP) | All exchange plans will include an integrated medical and prescription out-of-pocket maximum. In PeopleSafe, these will look the same as the HDHP plans, although integrated deductibles are not required.  In addition, any out of pocket costs the member pays for **Essential Health Benefits** will apply to the MOOP accumulation.  **What does NOT apply to the MOOP:**   * Insurance premiums paid to the plan for coverage * Cost differences, such as DAW, Pre-certification or Out of Network for drugs related to EHB\* * Out of Network (OON) purchases for drugs related to EHB   \*Except for emergency services | [High Deductible Health Plans (HDHP) (038546)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=91ada5ca-68dd-4fcf-a6a4-a13b33923759)  **Accumulators**  [Accumulators or Accumulations (Deductible, Account Balance, MOOP, MAB) (064862)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=a22d707e-1643-448e-9968-f44d1a828038) |
| Step Therapy | Marketplace plans will promote the use of generic drug usage through plan design features such as step therapy. Generic drugs are not only cost effective for the client but also provide a huge cost savings to the member. | **Step Therapy**  [PeopleSafe - Generic Step Therapy Plans (GSTP (025481)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=ad06cd65-d45c-478c-b05e-01c531a8b19a) |
| 3, 4 or 5+ Tier copay structures | One of many potential differences is that Marketplace plans may have a larger number of cost-sharing tiers. You normally may see three or four tiers. Marketplace plans may have five or more tiers. | [PeopleSafe - Plan Summary Screen Field Descriptions (Accumulations, Override and Specialty) (040585)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=d339dc13-3fb0-4611-a7c2-78a417ba79eb) |
| Formularies | These plans may include custom formularies instead of our formularies. Each state has a set of requirements for Marketplace plans. In turn, the Marketplace plan will be required to follow the state guidelines when developing a formulary drug list to be sold within each state.  Rely on Test Claims to determine whether a drug is considered formulary or non-formulary. In addition, the formulary drug list is generally accessible via the CIF. | N/A |
| Preventative Drug Lists | The following guidelines apply to claims processed for drugs on the Preventive Drug List:   * Automatically bypass the deductible * Process with the applicable copay or coinsurance * Copays/Coinsurance accumulates toward the Maximum-Out-of-Pocket (MOOP) limit | N/A |
| Prior Authorizations and Appeals | Marketplace plans may require prior authorization for some medications. As always, check the CIF to determine if we handle the prior authorization and/or appeal process.   * If a prescription is denied for no coverage, review the Appeals Process section in the CIF. Some plans may offer a onetime override to allow the member time to follow the outlined appeals process. The direction in the Appeals section of the CIF will provide details if it applies for the members’ plan. | **Prior Authorization/Initial Benefit Review**  [Compass - Prior Authorization, Exceptions, Appeals Guide (063978)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=657ddfe3-27d1-4a21-8f51-8cbd3961001c)  **Appeals**  [Appeals (007339)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=cd7126d2-19b7-4743-913c-8e9dd7329c08) |

[Top of the Document](#_top)

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| Grace Period |

When Marketplace plan members receiving premium subsidies fall short on paying their monthly premiums, a Qualified Health Plan is required to provide a 90-day grace period.

There are two Grace Period options the plan may choose:

**Grace Period Claim Payment Option 1**

* Month One: Claims will be paid according to normal plan setup, with members responsible for their normal prescription cost share (**Example:** Copayment)
* Months Two-Three: Claims continues to be paid according to normal plan setup
* After Three Months: Plan may terminate coverage and collect on paid claims from member

**Grace Period Claim Payment Option 2**

* Month One: Claims will be paid according to normal plan setup, with members responsible for their normal prescription cost share (**Example:** Copayment)
* Months Two-Three: Claims are paid with 100%-member coinsurance
* After Three Months: Plan may terminate coverage

The main difference between Grace Period Options 1 and 2 occurs during months (2) two and (3) three.

During the Grace Period days 31-90:

* For option one (1) , claims will continue to be paid according to the normal plan setup.
* For option two (2) , members are responsible for a 100% coinsurance.

**Note:** The Grace Period Option is selected by the plan, not the member, and is applied to all members of that plan.

Refer to the following scenarios and instructions for assisting a Marketplace member in the Grace Period.

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| **Scenario** | **Instructions** |
| Confirm member is in Grace Period | The PeopleSafe **Main Screen** displays a **“Grace Period”** indicator under the Member Eligibility drop-down box when the member is in the Grace Period.  **Note:** When a member is ineligible, the Grace Period indicator does not display on the Main Screen.     1. From the PeopleSafe Main Screen, click on the **Eligibility** button to view the Additional Eligibility screen. 2. Click the **Grace Period** button.   C:\Users\UJ30FJ4\AppData\Local\Temp\SNAGHTML2388263.PNG  **Result:** The **Grace Period Audit Trail** opens in a new window. This screen provides the details of the current and any previous Grace Period updates.   * **Status:** The row marked “A” (Active) is the current Grace Period. Any rows marked “I” (Inactive) are previous records. * **Grace Period:** Y (Yes) or N (No). * **Effective Date:** The date in which the Grace Period indicator began to display in PeopleSafe. For Option 2, this is typically at the beginning of the second month of the Grace Period when claims will begin paying at 100%. * **Date Added:** The date the Grace Period record was added to the member’s profile. * **Change Date:** The date the Grace Period record was modified, typically when the status is changed to inactive. |
| Determine which Grace Period Claim Payment Optionthe plan has chosen | The **Plan Summary** screen will display in the **Grace Period Payment** field which option the plan has selected.   * 1 - Member pays standard copays up to 3 months during the Grace Period * 2 - Member starts paying 100% based on Grace Period effective date   C:\Users\UJ30FJ4\AppData\Local\Temp\SNAGHTML239618b.PNG |
| Understand how the Grace Period impacts a member’s pharmacy claims | The following describes the typical order of events for a claim processed while in the Grace Period.   1. The client notifies us that the member is in the Grace Period. 2. We change the member’s Grace Period Status indicator in the Additional Eligibility screen to ‘A’ to indicate the member is actively in the Grace Period. 3. The member takes a prescription to the local pharmacy while in month two of the Grace Period to obtain a fill. 4. The pharmacy adjudicates the claim towards the member’s Marketplace plan. 5. The claim adjudicates according to the normal plan setup for Grace Period Option 1 or at 100% of the cost for Option 2. The way claims pay during Grace Period months 2 and 3 depends on the Grace Period option the plan chose.   The Grace Period Settlement Code displays on the Prescription Details screen and the Test Claim Results for both Mail Order and POS:   * **100% Patient Coinsurance (GPC) – Patient should contact Health Insurance Plan with questions.**        1. Once out of the grace period (occurs after member pays their plan premium), the health insurance plan sends an eligibility update to remove the grace period. Claims begin to pay according to normal plan setup. Eligibility updates do not have a set turnaround time due to each plan having different internal time frames for sending the eligibility file. Member should contact health insurance plan with any questions. |
| Assist with Home Delivery payment exceptions | For prescriptions filled by Mail Order pharmacy, the following payment exception displays if the member’s cost exceeds the order or cardholder limit, initiating an automated call to the member:   * Affordable Care Act **(ACA) 100% Copay**   This [payment exception (021319)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=445b2dd4-59b7-4ddb-bd4e-b15b3b665989) should be handled similar to high copay warnings and other courtesy calls. The member may choose to send the order and pay the 100% copay, place the order on hold, or cancel it entirely. |
| Assist a member with obtaining reimbursement for claims paid at 100% during Grace Period | Once a member is released from the Grace Period after bringing premium payments up to date, they may seek reimbursement for claims paid at 100% during the Grace Period. The best option is for the pharmacy to reverse and reprocess the claim.   * **Retail POS claims:** Advise the member to check with the pharmacy about resubmitting the prescription claim, to receive reimbursement directly from the retail pharmacy. * **Mail Order pharmacy claims:** Follow process for the Mail Order pharmacy to [reprocess the claim (021894)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=5d4876c1-e43f-41d8-ba45-0e4a72aee882).   + If reverse and reprocess is not an option, the member may submit a [Paper Claim (042914)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=1f72603c-4632-4e85-8d97-16cb51a3be1f) for reimbursement if allowed by the client. Review the CIF. |

[Top of the Document](#_top)

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| Frequently Asked Questions - Integrated Deductible/Maximum Out of Pocket |

Use as needed:

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| **Question** | **Answer** | |
| **What is an integrated benefit – deductible or maximum out of pocket?** | It is a combined single deductible and maximum out of pocket which includes both medical and prescription costs that must be met before benefits are paid. | |
| **Does the member have to meet a family or individual deductible/maximum out of pocket?** | It depends on if the deductible/maximum out of pocket is embedded or non-embedded.   * **Embedded:** Accumulations are based on each individual member. When each member's accumulation is met, benefits/copays apply to that member. When the entire family accumulation has been met, benefits/copays apply to all family members (even if one or more members have not met their individual accumulators). * **Non-Embedded**: The entire family accumulation must be met before benefits/copays apply to any individual family member.   To determine if the member must meet the individual/family deductible, refer to:   * **CIF:** Need to Know or Plan Design Highlights sections * **PeopleSafe Plan Summary:** Basis Code description | |
| **What happens once the member meets the maximum out of pocket?** | Once the maximum out of pocket (MOOP) is met, the member will be charged $0 for their prescriptions for the remainder of the benefit year (unless otherwise specified in the CIF for instance the member may still pay for DAW cost differences, out of network claims, etcetera). | |
| **What happens if the member overpays on medication due to integrated deductible or maximum out of pocket accumulations not being updated timely?** | Advise the member to contact their medical plan.   * If the member disputes the accumulations, they become escalated, or insists they will not pay for anymore prescriptions, submit an Account Executive Consideration task. | |
| **Will my deductible apply towards my MOOP?** | It depends. Check the Account Balance screen for “MOOP-IN DED” or “MOOP-EX-DED” in the Account Class. | |
| **If the Account Class is…** | **Then the Deductible is…** |
| MOOP-IN-DED | Included/applied in the MOOP amount |
| MOOP-EX-DED | Excluded (does not apply) in the amount needed to reach the MOOP amount.  **Example:** In the below example the member’s deductible is not applied to the maximum out of pocket (MOOP) expenses. Therefore, the accumulated amount to date is only $622.99. |
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[Top of the Document](#_top)

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| Frequently Asked Questions - Healthcare Reform |

This section contains additional guidance to assist Customer Care representatives when callers ask certain health care reform questions that are not appropriate for our PBM to address in any specific way. This includes:

* Questions from people who oppose the health care reform law, object to complying with its requirements or challenge the authority of the government to implement the Affordable Care Act. For **Example:** “Isn’t health care reform unconstitutional?”

“Why am I being forced to buy (or have) coverage?” or “Why should the government be able to tell me what to do?”

* Questions about the health insurance exchange that are beyond the scope of the training provided to Customer Care. For **Example:** “How should I decide which Exchange plan is best for me?” or “How do I enroll for coverage where I live?”

The approach for such questions is to:

* Listen with empathy.
* Acknowledge the question.
* Redirect the caller.

**Note:** These are a few sample questions to help you anticipate what some callers may want to know. The responses provided here are meant to guide you in responding to these and other similar questions that are beyond the scope of the training you have received or are receiving.

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| **Question** | **Answer** |
| **Isn’t health care reform unconstitutional? Why should I have to comply with it?** | It sounds like you are unhappy with the health care reform law. I hear your concern and that you do not want to comply with the law’s requirements.  The Affordable Care Act became law in 2010 and continues to be in place. If you would like to learn more about the law and how it applies to you, go online to www.healthcare.gov. That website has lots of information about health care reform, how the Affordable Care Act works and how it affects Americans. |
| **I should not be forced to have health coverage. Why should the government be able to tell me what to do?** | It sounds like you are unhappy with the health care reform law. I hear your concern and that you do not want to be told what to do.  The Affordable Care Act became law in 2010 and continues to be in place. If you would like to learn more about the law and how it applies to you, go online to www.healthcare.gov. That website has lots of information about health care reform, how the Affordable Care Act works and how it affects Americans. |
| **How should I decide what plan offered through a health insurance exchange is right for me?** | It sounds like you have some big decisions to make about your health care coverage. I hear that you are trying to choose among the many plans available in your state’s health insurance exchange. If you would like to learn more about the Affordable Care Act and how it applies to you, go online to www.healthcare.gov. That website has lots of information about health care reform, how the Affordable Care Act works and how it affects Americans.  For information specifically about health insurance plans available in your state, please visit; www.finder.healthcare.gov.  **CCR:** If it is not open enrollment season, provide this website [www.healthcare.gov/get-coverage/](http://www.healthcare.gov/get-coverage/) |
| **How do I enroll for coverage where I live?** | It sounds like you have some big decisions to make about your health care coverage. I hear that you want to know how to enroll in health plan coverage offered in your state’s health insurance exchange. If you would like to learn more about the Affordable Care Act and how it applies to you, go online to www.healthcare.gov. That website has lots of information about health care reform, how the Affordable Care Act works and how it affects Americans.  For information specifically about health insurance plans available through your state’s exchange, go to www.finder.healthcare.gov.  **CCR:** If it is not open enrollment season, provide this website [www.healthcare.gov/get-coverage/](http://www.healthcare.gov/get-coverage/) |

[Top of the Document](#_top)

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| Frequently Asked Questions - General |

Use as needed:

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| **Question** | **Answer** |
| **What are public exchanges?** | Exchanges are online marketplace sites where consumers and small group employers can go to shop for health insurance. On these sites, they can compare the plans available to them and then purchase online. |
| **Who can shop on public exchanges?** | Public exchanges are designed for Individuals and Families and Small Group Employers |
| **Who is eligible to shop in an individual exchange?** | To be eligible to shop on an individual exchange, the following criteria must be met:   * US citizen or legal alien * Not incarcerated * Resident of the state in which exchange is based |
| **Who is eligible to shop on a small group exchange?** | SHOP (Small Business Health Options Program) is the exchange where small group employers may purchase coverage for their employees, and where their employees then will go to shop for their coverage. Eligibility for SHOP includes:   * Full-time employees of small businesses from 2 (two) to 100 employees * States have the option to limit businesses of 50 or less until 2016 * Beginning in 2017, states opened the exchanges to large employers |
| **Are states required to offer both individual and SHOP exchanges?** | Yes, all states have both an Individual and a SHOP exchange. It is provided by either the state’s government, or the federal government on behalf of the state, if they did not build one (or both) of these exchanges themselves. |
| **Can individuals purchase insurance on a public exchange anytime they want?** | Open enrollment generally begins November 1st of each year. January 1st is the first date coverage can begin unless they qualify for coverage through a Special Enrollment Period or they qualify for CHIP. The last day of open enrollment may vary year to year.  **CCR:** If it is not an open enrollment period, provide this website: [www.healthcare.gov/get-coverage/](http://www.healthcare.gov/get-coverage/) to help determine if someone qualifies outside of open enrollment. |
| **Who runs the public exchanges?** | Each state had the option to create and operate its own exchange. If the state opted not to offer an exchange, a federal exchange is available. Private exchanges also exist; however, a member would only have access to them if their employer opted in. |
| **Does every state offer a public exchange?** | Every state has a public exchange available to its residents. What will vary is who operates the exchange – the state or federal government. |
| **What is the difference between public and private exchange?** | The major difference is who operates the exchange. A public exchange is operated by the state or federal government, for the public to buy insurance. Private exchanges are operated by third parties, like consulting houses and health insurance carriers, for employers to make available to their employees. |
| **Can individuals get subsidies if they shop on a private exchange?** | No, subsidies are only available via the public exchanges. |
| **Where can members get more information about public exchanges?** | Members can obtain more information on www.healthcare.gov. |
| **Who is running the Health Insurance Exchange Marketplace Call Center (for federally facilitated exchanges)?** | CMS (Centers for Medicare and Medicaid Services) is operating the Marketplace call center. 1-800-318-2596, (TTY: 1-855-889-4325) |

[Top of the Document](#_top)

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| Related Documents |

[Customer Care Abbreviations, Definitions and Terms Index (017428)](https://thesource.cvshealth.com/nuxeo/thesource/#!/view?docid=c1f1028b-e42c-4b4f-a4cf-cc0b42c91606)

[Top of the Document](#_top)

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