One of the goals of the Affordable Care Act (ACA) is to expand access to affordable private health insurance coverage to tens of millions of Americans currently lacking it. The ACA seeks to increase access to coverage through a number of health care reforms, such as: requiring insurance companies to allow young adults to remain on their parents’ health plans until age 26; prohibiting discrimination in health plan designs; expanding Medicaid eligibility; and establishing health insurance exchanges (HIEs) for individuals and employees of small businesses.

Beginning in 2014, health care coverage for individuals and small business employees will be available through HIEs – marketplaces designed to offer “one-stop shopping” for consumers to compare and purchase private health care coverage from those health plans that are certified as meeting specified federal and state law requirements. These exchanges will also enable Americans with low-to-moderate incomes to check their eligibility for enrollment in public health programs (such as Medicaid or the Children’s Health Insurance Program, CHIP) or for financial assistance (tax credits) to pay for health care premium costs.

Open enrollment for health insurance exchanges begins October 1, 2013 for coverage to take effect on January 1, 2014 – assuming Congress does not pass legislation delaying or otherwise changing the schedule for implementation.

This article provides an overview of health insurance exchange requirements and highlights issues that might impact psychologists who provide health services. A map on page 7 indicates the exchange model for which each state has opted.

**Key components of health insurance exchanges**

Health insurance exchanges must offer an integrated and simplified online system that allows consumers to submit a single application to determine eligibility, apply for and enroll in any of the eligible health plans certified to offer coverage through the exchange, or public programs such as Medicaid or CHIP. The system also will provide assistance to help consumers navigate the exchange.

The online system that consumers will access offers one-stop shopping. Consumers will be able to:

- view and compare plan choices through a standardized format
- determine their eligibility for coverage for any programs available through the exchange
- verify eligibility for federal tax credits to pay for coverage or for cost-sharing reductions, and
- enroll for coverage.

All health plans offered through the exchanges must be certified by federally recognized accreditors as a “qualified health plan (QHP).” To be accredited as a QHP, plans must meet certain criteria as defined by the Department of Health and Human Services (HHS). For example, QHPs must offer essential health benefits, which must include mental health benefits (as further described below), maintain cost-sharing limits (such as deductibles, copayments and out-of-pocket maximum amounts), and must meet federal requirements for parity in insurance coverage of mental health and physical health services.

In addition, a qualified health plan must demonstrate that it: does not market its plan in any way that would discriminate against people with serious or chronic illness; has sufficient numbers and types of providers for its networks; and offers coverage for the entire geographic area of the state covered by the exchange.

**Essential health benefits**

Beginning in 2014, all non-grandfathered health plans offering coverage in the individual and small group markets must offer essential health benefits (EHB) in ten categories defined by the ACA as well as any state-mandated benefits in effect prior to December 31, 2011. The EHB categories are:

- 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.

The essential health benefits required by ACA will be equal in scope to those benefits typically offered in employer health coverage.

States must identify a “benchmark plan” within the state that offers the defined essential health benefits as well as any state-mandated benefits. All plans eligible to offer coverage through the exchange must offer benefits substantially equal to those offered by the benchmark plan. However, if the identified benchmark plan lacks coverage in any of the ten categories, the state may supplement the benchmark plan in that particular category.

Consumer protection provisions
The ACA includes consumer protection provisions to enhance access to coverage, including:

- federal requirements pertaining to parity in insurance coverage of mental health compared to physical health services
- non-discrimination in plan design
- prohibitions against lifetime coverage limits and coverage rescissions for persons who become ill or whose insurance applications contain unintentional errors
- coverage for young adults through their parents’ plans until age 26, and
- no coverage exclusions for children with pre-existing conditions.

The federal Mental Health Parity and Addiction Equity Act

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of 2008 applies to essential health benefits. Plans that do not already include mental health and substance abuse services, or include these benefits but not at parity with medical/surgical benefits, must supplement their plans to comply with federal parity requirements. However, HHS does not specify the process by which plans should supplement behavioral health benefits.

In addition, health plans may not discriminate against persons with chronic conditions. The ACA prohibits cost-sharing structures, utilization management techniques and benefit designs that discriminate against beneficiaries based on race, age, disability status, health status, life expectancy, having extensive health care needs or other characteristics. States will be required to monitor and identify discriminatory health benefit designs.

Also beginning in 2014, health plans in the individual and small group markets must meet certain actuarial values (AV). Each AV level is assigned a metal level indicating differing levels of coverage: 60 percent for the bronze plan; 70 percent for the silver plan; 80 percent for the gold plan; and 90 percent for the platinum plan. The metal levels must all offer essential health benefits. However, there will be variability among the metal levels as to the percentage of costs covered. And within each metal level, there will be further coverage variability among the plans offered.

Nevertheless, these metal levels will enable consumers to compare plans within a similar level of coverage with comparable deductibles and copayments in order to make informed decisions about health care coverage. For example, in comparing plans under the silver level, consumers would view those plans that would pay an estimated 70 percent of costs for all covered benefits in that plan, making the consumer responsible for approximately 30 percent of costs. In addition, there will be an annual limit on out-of-pocket costs for individuals and families. This amount will vary according to the metal levels.

**Health insurance exchange models**

The exchanges are being established in one of three ways:

- State-based exchange where the state is responsible for creating and managing its own exchange
- State partnership exchange where the state partners with the federal government and each performs certain functions in support of the exchange’s operations, or
- Federally facilitated exchange (FFE) where the federal government will manage exchange operations in those states that have not chosen to establish their own exchange or partner with the federal government.

In a majority of states, the health insurance exchanges will either be managed by the federal government as a FFE or as a partnership between the federal and state governments. In those states, HHS and the Centers for Medicare and Medicaid Services (CMS) have been coordinating with local, state and/or regional leadership in developing the FFE and state partnership exchanges to meet the October 1, 2013 deadline.

The map on page 7 identifies the model that each state is pursuing.

Information about each state’s exchange is available on the CMS website: go.cms.gov/19oQFmS.

**Issues for psychologists to consider**

While the purpose of the health insurance exchanges (HIEs) is to benefit consumers, there are issues related to the development and implementation of HIEs that impact psychologists and other health care providers.

CMS has been reviewing applications submitted by health insurance and managed care companies seeking certification as Qualified Health Plans (QHPs), enabling those plans to be offered through the exchange. The companies must demonstrate that the plan maintains a network with a sufficient number and type of health care providers, including those providers specializing in mental health and substance abuse services, to ensure that the plan offers benefits under all ten identified essential health benefits categories.

Importantly, while the plans must ensure that there are a sufficient number of providers and types of providers to provide the essential health benefits, the ACA does not specify what providers, or how many, must actually be included in the provider network to satisfy the network adequacy criterion. So while mental health and substance abuse services are an essential health benefit category, that requirement does not necessarily mean that the provider panel must be substantially composed of psychologists.

Psychologists should find it worthwhile to educate themselves as to which plans will be offered through the exchange in their state to help them decide whether they would like to participate in any of those provider networks. With the anticipated increased number of Americans gaining access to coverage for mental health and substance abuse services in 2014, QHPs arguably will need to supplement their networks with additional providers, especially in behavioral health, to accommodate their insureds.
Likewise, it is important to understand how your state defines the scope of mental health and substance abuse services. The EHB-benchmark plan identified by your state will indicate the coverage benefits and limitations available. It is worthwhile to review that information to determine if there are any applicable coverage limitations for mental health and substance abuse services, to understand the mental health benefits that will typically be offered in your state and to ensure that those benefits comply with federal parity requirements. Additional information is available from the Centers for Medicare and Medicaid Services at go.cms.gov/16lBEk6.

Most states have been actively working with local stakeholders to design and implement health insurance exchanges. Members can check with their state psychological association to find out how the association is involved as a local stakeholder in the HIE implementation process. While much work already has been done to prepare for the January 1, 2014 deadline, the HIEs will continue to evolve in the coming plan years.

Psychologists who are currently in-network providers should consider the following issues:

- **Confirming your in-network status.** Although you may currently be an in-network provider for an insurer that has been certified as a QHP to offer coverage through the exchange, it is possible that you may not be in-network for that insurer’s exchange plans. Psychologists are encouraged to check their provider contract for an all-products clause, which would prevent providers from opting out as in-network providers for the exchange plans unless the provider chooses to terminate his/her in-network status altogether. Some insurers may be using narrow networks for their exchange plans, offering substantially smaller networks of providers and hospitals than what is offered under current commercial plans. So it is important to clarify your status with the insurance company if you are serving on any network panels.

- **Assignability provisions.** Psychologists who now contract with insurance companies as in-network providers should review their provider contract for an assignability provision. This kind of provision would allow the insurance company to assign you to another company’s network for specified reasons (for example, the company may agree to “lease” its network to another company, or if the company is acquired by or merges with another company). This provision would also mention whether the insurance company is required to notify you of this assignment and if so, what the notification requirements are.

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**HOW MEDICAID AND HEALTH INSURANCE EXCHANGES INTERACT**

Implementation of the Affordable Care Act (ACA) is expected to lead to the enrollment of tens of millions of uninsured individuals who will become newly eligible for health insurance through Medicaid and the health insurance exchanges (HIEs). The expansion of state-level Medicaid programs and the development of HIEs are meant to work together to improve access to coverage.

See the August 29, 2013 *PracticeUpdate* e-newsletter article, “Medicaid and the New Health Insurance Exchanges: Do You Know How They Interact?” from the APA Practice Organization for details. The content appears at apapracticecentral.org/update/2013/08-29/medicaid-hie.aspx. This e-newsletter article concludes a four-part series in *PracticeUpdate* about HIEs that began on April 25, 2013.

- **Provider notifications.** If you are an in-network provider, review any provider notifications that you receive either by US mail or e-mail to check for any changes to your contract.

- **Network directories.** Check to see if you are listed in the insurance company’s online provider directory and if so, whether your listing is accurate. If you had previously served on a network panel but no longer accept insurance, check to see that you are not still listed in the provider network directory. CMS expects the network directory to include contact information, location, specialty (if applicable), and any institutional affiliations for each provider in the network.

- **Cost-sharing requirements.** As an in-network provider, it will be important to be aware of any cost-sharing requirements, as mental health services are a specified category that CMS will be evaluating for discriminatory practices.

- **Complaints and appeals processes.** QHPs are required to comply with specific requirements governing internal claims and appeals and external review. Psychologists should review their provider contract and any addenda containing contract changes that may revise the appeals process. Also, it is important to note what kind of exchange will be established in your state to determine who or what agency will be responsible for addressing consumer complaints.