



Health Insurance Exchanges: An Overview

A New Marketplace for Individuals and Small Businesses

Exchanges are essentially organized insurance marketplaces which are intended to provide individuals and small business owners with a “one-stop-shop” to compare and purchase health insurance, and will use the power of a large insurance risk pool to generate competition among health plans based on quality and cost. Exchanges will also have “no wrong door” enrollment in which individuals and families apply for coverage and the exchange will determine the program they are eligible for and enroll them, whether it is Medicaid, CHIP or subsidized exchange plans. These new marketplaces must be “open for business” by January 1, 2014 and will serve as the gateway for an estimated 29 million people to access coverage by 2019.

The ACA creates two types of exchanges:

1. The American Health Benefit exchanges for individuals and
2. Small Business Health Options Program (SHOP) exchanges for small business owners.

While the new federal law sets minimum standards, it specifically delegates primary responsibility for governance and operation of the exchanges to the states.

Minimum Standards for Health Insurance Exchanges

Help consumers compare plans and enroll in coverage: The state exchanges must allow consumers and small business owners to compare and purchase insurance plans in person, through the mail, phone, or a web portal. The portal will also have comparative information about participating insurers, including covered benefits, premium rates, cost-sharing, provider networks, and financial information such as the “medical loss ratio,” or the amount plans spend to pay claims relative to overhead costs. Consumers will be able to use an electronic calculator to determine their actual cost of coverage, taking into account any premium subsidy they are eligible to receive. The exchanges are also required to maintain a toll-free consumer assistance hotline and make all information available in a culturally and linguistically appropriate manner.

Exchanges will facilitate enrollment in plans by offering *annual* open enrollment periods, and provide a standardized form that all exchange participants may use to enroll. The law also provides grants to consumer assistance programs (CAP) and requires exchanges to fund “navigators,” organizations that can help inform consumers about the availability of qualified coverage and financial assistance, and help enroll eligible individuals in the coverage that’s right for their needs.



Certify participating plans: The ACA envisions that exchanges will be more than just clearinghouses that connect consumers with health plans. Rather, exchanges may offer only “qualified” health plans (QHPs) that meet minimum requirements related to marketing and network adequacy, and offer *at least* a minimum essential health benefits (EHB) package. The comprehensiveness of coverage in each plan will be standardized into four “tiers”: bronze, silver, gold and platinum, with bronze plans being the least generous and platinum being the most generous. All participating plans must offer at least one silver and one gold option.

In addition, exchanges are responsible for ensuring that plans meet minimum certification criteria, allowing them to participate only if doing so is “in the interests of” individuals and employers in their state. The exchanges must also encourage plans to compete based on the *value* of their benefits and services, by publicizing plan ratings based on quality, price, and consumer satisfaction.

Exchanges must also “decertify” any health plans that use marketing techniques or benefit designs that discourage sicker individuals from enrolling. The law also encourages exchanges to contain premium increases, by allowing them to exclude health plans that have a history of unreasonable premium increases.

Administer subsidies and help individuals and employers meet their coverage requirements:

Exchanges will be responsible for determining who is eligible for premium and cost sharing subsidies (available to those with income up to four times the poverty level),¹ certifying individuals who are exempt from the individual mandate, and sharing that information with the Internal Revenue Service. They will also need to verify whether employees are eligible for premium subsidies through the exchange based on whether they have access to ‘affordable, adequate’ employer-sponsored coverage. Further, exchanges are required to help employers meet their requirements, by providing them with information on their employees’ enrollment in health plans through the exchange.

Coordinate with state Medicaid and CHIP programs: Many individuals and families may attempt to get coverage through their state exchange, but may be eligible for Medicaid or CHIP. In some families, children will be eligible for Medicaid or CHIP, but their parents will be eligible for premium subsidies to purchase private insurance. One of the most challenging and important aspects of the ACA is the requirement that states create a “no wrong door” policy for individuals and families seeking coverage. States must establish procedures for screening applicants no matter where they initially seek coverage (whether through an exchange,

¹ In 2012, 400 percent of the federal poverty level is \$45,000 for an individual and \$92,000 for a family of four. The poverty level is adjusted annually to reflect inflation and vary by family size.



Medicaid, CHIP, or a Basic Health Plan, if applicable in that state²) and enrolling them in the *appropriate* program, without making applicants go through additional, burdensome steps to find out which program they are eligible for.

It is also vital that state exchanges coordinate with Medicaid and CHIP programs because, as their income fluctuates, many people will move back and forth between subsidized commercial coverage in the exchanges and eligibility for public programs. The ACA makes changes intended to create a seamless eligibility and enrollment system.

- A new income standard, the *Modified Adjusted Gross Income (MAGI)*, will be used when determining eligibility for the exchange subsidies, CHIP, and most populations under Medicaid.
- States must use a single, streamlined application form developed or approved by the Department of Health and Human Services (HHS) to enroll people in exchange subsidies, Medicaid, CHIP, or a Basic Health Plan. States must also coordinate benefits for families who have some members enrolled in Medicaid and CHIP, and others that receive premium subsidies for commercial insurance.
- Exchanges and Medicaid agencies must operate linked web portals through which families can obtain information on their eligibility for the different programs and enroll in coverage. States must establish electronic interfaces that will enable the exchange of information between programs, accept an electronic signature for all programs, and use data matching to federal databases whenever possible to establish, verify, and update eligibility.

Hold health plans accountable: The ACA sets out new requirements for transparency and plan disclosure that will give consumers unprecedented access to information about benefits, cost sharing, and plans' business practices, as well as enhance regulators' ability to identify and crack down on "bad behavior." For example, plans must provide a standardized summary of benefits to consumers that uses uniform definitions of insurance and medical terms, breaks down and describes cost sharing charges, and details exceptions and limitations on coverage, all in culturally and linguistically appropriate and easily understandable language.

² States have the option of offering coverage under a "Basic Health" program to individuals and families with household income above the Medicaid eligibility threshold (133% of poverty) and under 200% of poverty. The coverage must be as comprehensive and affordable as the coverage individuals and families would have received under a qualified health plan. States would receive federal funding for 95% of what it would have cost to cover the enrollees in qualified health plans with a federal tax subsidy for premiums and cost-sharing.



Plans must also provide information to consumers on the availability of in and out of network providers. Further, plans must provide a “coverage facts label” that illustrates examples of an enrollee’s likely cost-sharing if they have an illness or condition, such as breast cancer or diabetes.

For plans to be certified to participate in the exchanges, the new law requires them to disclose information on certain business practices, such as claims payment policies and practices, financial disclosures, enrollment and disenrollment, the number of claims denied, rating practices, cost sharing and payments for out of network coverage, enrollee rights and other information required by HHS.

Improve health plan quality and value: To encourage quality improvement, plans must report to HHS and their enrollees on what programs they are implementing to improve health outcomes, reduce hospital readmissions, implement patient safety and error reduction programs, promote prevention and wellness, and reduce health disparities. HHS will post these reports on www.healthcare.gov. Further, to participate in the exchanges, plans must be accredited by an entity such as the National Committee for Quality Assurance (NCQA), which accredits health plans based on quality, performance, and patient experience. Other requirements for plans include: implementing provider payment strategies to improve quality and patient safety, requiring participating hospitals to implement patient safety systems and use discharge planning for patients, and including only those doctors and other providers who implement certain quality improvement mechanisms in their networks.

Key Choices for States

While state exchanges have to meet certain standards and perform key functions, there is considerable flexibility for states in designing and operating an exchange. For example, states may merge the individual and SHOP exchanges, partner with other states to form regional exchanges, or form multiple exchanges within their state, so long as each one serves a geographically distinct area. Alternatively, a state can elect not to run its own exchange and have HHS operate a federal exchange in the state, either on its own or in partnership with the state.

States can house the exchange in an existing or new state agency, operate it as a non-profit, and may contract with Medicaid agencies to conduct subsidy eligibility determinations. States also have the option to define eligible small employers to be those up to 50 employees for the first two years and can consider allowing large firms (more than 100 employees) into the exchange starting in 2017.

HHS has also made clear that states can also choose to operate an “active purchaser” exchange that selects or contracts with plans in the best interest of consumers or as a “clearinghouse” in which any plan that meets the minimum requirements may participate. Finally, states may offer a Basic Health Plan for those above Medicaid eligibility and below 200 percent of poverty rather than provide them with subsidies to enroll in QHPs.³

³ In 2012, 200 percent of the federal poverty level is \$22,300 for an individual and \$46,000 for a family of four.