

The Creation of American Health Benefit Exchanges

The Affordable Care Act (ACA) will greatly increase the availability of health insurance and broadly impact the delivery of health care in America. This Fact Sheet provides an overview of the law's provisions related to American Health Benefit Exchanges.

Close to 17 million¹ nonelderly individuals were covered by individual, or nongroup, health insurance in 2009. And some 68² percent of small employers (with 3 to 199 employees) offered health coverage to their workers in 2010. For both groups, finding adequate, affordable health coverage can be a challenge. To help individuals and small businesses find and enroll in appropriate private or public coverage options, the ACA calls for the creation of American Health Benefit Exchanges.

Under the ACA, residents of every state must have access to an exchange by January 2014—when insurers will no longer be able to turn people down for coverage and the individuals will be responsible for having health coverage. Exchanges will provide—

- A new option for people to more easily find and compare coverage that will satisfy their responsibility to have coverage, and
- A place where those who are eligible get subsidies to help with the cost of private coverage or can be enrolled in public coverage programs.

Access to the exchange is limited to qualified employers and individuals and to citizens or lawfully present immigrants.

Both the federal and state governments have roles under the law related to exchanges, which are described below,

along with the functions of the exchange itself.

Choice to Participate

Consumers Get a New Option for Finding and Getting Coverage

Participation in the exchange is voluntary. Eligible individuals may purchase qualified health plans either through the exchange, or through the market outside the exchange. However, consumers eligible for subsidies to help with premiums and cost sharing for their private coverage can access the subsidies only if they buy through the exchange.

Eligible employers also may choose to offer their employees qualified health plans either through the exchange or the market outside the exchange. At first, only employers with fewer than 100 employees will be able to participate. Until 2016, states have the option of limiting access to the exchange to groups with up to 50 employees. Starting in 2017, states may allow employers with more than 100 employees to participate.

For consumers wanting to get coverage, the decision to shop through the exchange may depend on a number of factors:

- The attractiveness of the plans offered;
- The cost of the plans; and
- Whether they are eligible for subsidies or public coverage.

The Creation of American Health Benefit Exchanges

Some plans may be available only in the exchange. For example, the Office of Personnel Management, which arranges the health benefit choices for federal employees and members of Congress, is charged with arranging for two multistate plans to be offered through the exchange in each state. And states have the option of providing coverage to the Medicaid expansion population up to 200 percent of poverty through the exchange.

As noted earlier, the exchange is a doorway to public coverage, as well as private coverage and subsidies for private coverage. A person applying for coverage through the exchange who is found to be eligible for coverage under a public program will be enrolled in the program. For those who aren't sure whether they qualify for assistance, the exchange offers a single point to access the coverage system and find assistance for which they may be eligible.

States Decide Whether to Create an Exchange for Their Residents

States also have a choice; they can decide whether or not to create an exchange. If a state chooses not to establish an exchange, the secretary of the U.S. Department of Health and Human Services (HHS) must do so. If a state chooses to establish an exchange, it must establish one for the individual market and one for the small group market (the Small Business Health Options Program [SHOP]), as well as meet the requirements of the exchange, no later than January 2014. (See exchange requirements below.) States also have the option to merge the individual and SHOP exchanges, provided there are adequate resources to assist individuals and small employers.

Financial and technical assistance is available for states. In September 2010, HHS awarded planning grants to 48 states and the District of Columbia. Additional resources are available to states through 2014 to help with

expenses associated with planning and establishing exchanges. HHS is making grants available on a rolling basis. As of January 1, 2015, exchanges are to be self-sustaining. States can receive technical assistance to facilitate the participation of qualified small businesses in SHOP exchanges.

Secretary's Responsibilities

Under the ACA, the federal government sets standards for a range of activities that exchanges will carry out. The law requires that all plans offered through the exchange must cover essential benefits, which must be equal to the scope of benefits in a typical employer plan.³

The secretary of HHS is responsible for establishing the certification criteria of qualified health plans in the exchange. (See table 1 for plan criteria.) The secretary must also develop a rating system on the basis of relative quality and price for qualified health plans and an enrollee satisfaction survey system to evaluate the level of satisfaction with qualified plans.

The secretary is also responsible for operating, maintaining, and updating the Internet portal that will assist qualified individuals and employers in the purchase of health plans. This Internet portal, www.healthcare.gov, became available in July 2010 and is evolving over time. Finally, the secretary will determine open enrollment periods for the exchange.

Exchange Requirements

An exchange may be a government agency or a nonprofit entity. It is allowed to offer only qualified health plans, but may also offer stand-alone dental benefits. A state may require an exchange to offer qualified health plans with benefits beyond the essential health benefits. If it does, the state must assume the cost of the additional benefits and make payments for

The Creation of American Health Benefit Exchanges

them directly to the enrolled individual or qualified health plan.

Exchange Functions

Under the law, an exchange has functions ranging from offering qualified health plans to providing a range of information on those plans, to getting people to the public coverage or private subsidies for which they are eligible, to providing exemptions from the requirement to have coverage to those qualifying. Specifically, an exchange is charged with the following responsibilities:

- Implement procedures to certify, recertify, and decertify qualified health plans based on standards established by the secretary.
- Provide a toll-free telephone hotline to respond to requests for assistance.
- Maintain a Web site where consumers can find standardized comparative information on qualified health plans.
- Assign to qualified health plans offered a rating based on quality and price in accordance with the criteria developed by the secretary.
- Present health benefit plan options offered in a standardized format.
- Inform people of eligibility requirements for Medicaid, the Children’s Health Insurance Program, or any applicable state or local public program, and enroll them if they are eligible.
- Offer an electronic calculator for people to determine the actual cost of coverage after the application of any premium tax credit or cost-sharing reduction.
- Certify any individuals exempt⁴ from the coverage requirement.
- Provide to the secretary of the Treasury a list of individuals issued an exemption certification, and those who notified the exchange that they have changed employers or ceased coverage under a qualified health plan during a plan year.
- Provide to each employer the name of each employee who ceases

Table 1
Criteria to Certify Health Plans as Qualified Health Plans

- | |
|--|
| <p>A. Meet marketing requirements and not employ marketing practices or benefit designs that discourage the enrollment of individuals with significant health needs.</p> <p>B. Ensure a sufficient choice of providers and provide information to current and prospective enrollees on the availability of providers in and out of network.</p> <p>C. Include within health insurance plan networks the essential community providers, where available, that serve predominately low-income, medically underserved individuals.</p> <p>D. Be accredited with respect to local performance on clinical quality measures such as the Healthcare Effectiveness Data and Information Set, patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey, as well as consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, network adequacy and access, and patient information programs.</p> <p>E. Implement a quality improvement strategy. (See “Rewarding Quality in the Exchange,” below.)</p> <p>F. Utilize a uniform enrollment form that takes into account the criteria that the National Association of Insurance Commissioners develops and submits to the secretary.</p> <p>G. Utilize a standard format for presenting health benefit plan options.</p> <p>H. Provide information to enrollees, prospective enrollees, and each exchange on any quality measures for health plan performance.</p> <p>I. Present pediatric quality reporting measures to the secretary at least annually.</p> |
|--|

The Creation of American Health Benefit Exchanges

coverage under a qualified health plan during a plan year.

- Establish a navigator program (see below).

Funding

Beginning January 1, 2015, an exchange must be self-sustaining. Exchanges are allowed to charge assessments or user fees to participating health insurance issuers or otherwise generate funding to support their operations. Funds may be used only for administrative and operational expenses.

Consultation

An exchange must consult with relevant stakeholders, including educated health care consumers enrolled in qualified health plans, individuals and entities experienced in facilitating enrollment in qualified health plans, small businesses and self-employed representatives, state Medicaid offices, and advocates for enrolling hard-to-reach populations.

Publication of Exchange Costs

To educate consumers and be transparent and accountable, an exchange must publish on a Web site its average costs of licensing, regulatory fees, and other required payments, as well as the administrative costs and monies lost to waste, fraud, and abuse.

Health Plan Certification by Exchanges

An exchange may certify a health plan as qualified if the plan meets the certification requirements set by the secretary and is in the interests of qualified individuals and employers in the state in which it operates. An exchange may not exclude fee-for-service health plans by imposing premium price controls or exclude plans that provide treatments necessary to prevent patients' deaths, even if the exchange determines that these treatments are inappropriate or too costly.

Premium Considerations

Health plans seeking certification are required to submit a justification before implementing any increase.

Coverage Transparency

Health plans seeking certification are required to submit and make available to the public accurate and timely disclosure of the following:

- Claims payment policies and practices
- Periodic financial disclosures
- Data on enrollment, disenrollment, number of denied claims, and rating practices
- Information on cost sharing and payments for out-of-network coverage
- Information on enrollee and participant rights
- Other information determined appropriate by the secretary

This information must be submitted in language that is concise, well organized, and readily understood and used.

Cost-sharing Transparency

Health plans seeking certification are required to provide individuals, in a timely manner, upon their request, the amount of cost sharing under their plan or coverage of a specific item or service they are responsible for paying.

State Exchange Flexibility

An exchange may operate in more than one state if each state permits such operation and the secretary approves the plan to operate a regional or interstate exchange.

A state may establish one or more subsidiary exchanges if each exchange serves a geographically distinct area and the area served is as at least as large as a rating area.

The Creation of American Health Benefit Exchanges

A state may also authorize an exchange to enter into an agreement with an eligible entity to carry out one or more responsibilities of the exchange.

Rewarding Quality in the Exchange

To reward quality, a new payment structure will provide increased reimbursement or other incentives to implement activities that—

- Improve health outcomes through quality reporting, effective case management, care coordination, chronic disease management, and medication and care compliance initiatives, including through the use of the medical home model, for treatment or services
- Prevent hospital readmissions through a comprehensive program, including patient-centered education and counseling, and comprehensive discharge planning and postdischarge reinforcement
- Improve patient safety and reduce medical errors through the appropriate use of best clinical practices, evidence-based medicine, and health information technology
- Promote health and wellness
- Reduce disparities in health and health care, including through the use of language services, community outreach, and cultural competency trainings

An exchange will be required to periodically report the activities conducted by qualified health plans relating to the quality strategy above. The secretary will consult with health care quality experts and stakeholders to develop guidelines.

Quality Improvement in the Exchange

To enhance patient safety, beginning January 1, 2015, a qualified health plan

may contract with a hospital that has more than 50 beds only if the hospital has a patient safety evaluation system and implements a mechanism to ensure that each patient receives a comprehensive program for hospital discharge. Likewise, a qualified health plan may contract with providers only if they implement the quality improvement mechanisms the secretary required. The secretary may establish reasonable exceptions to these requirements and may adjust, by regulation, the number of beds.

Function of Navigator Program

As noted earlier, an exchange has to establish a navigator program to educate consumers, raise awareness, and provide fair and impartial information that is culturally and linguistically appropriate about the exchange, qualified health plans, and the availability of premium tax credits and cost-sharing reductions. The program also aims to facilitate enrollment in qualified health plans and provide referrals to any applicable office of health insurance consumer assistance, ombudsman, or other appropriate state agency or agencies for enrollees with grievances, complaints, or questions regarding health plans, coverage, or a determination under plan or coverage.

Grants will be awarded to eligible entities, which may include trade, industry, and professional associations; chambers of commerce; unions; resource partners of the Small Business Administration; or other licensed insurance agents and brokers. An eligible entity must demonstrate an existing or readily established relationship with those qualified to enroll in a qualified health plan, including employers, employees, consumers, and self-employed individuals.

The Secretary will establish standards to ensure that any private or public entity selected is qualified and licensed, if appropriate, to engage in navigator

activities and to avoid conflicts of interest. Under such standards, a navigator must not be a health insurance issuer or receive any consideration directly or indirectly from any health insurance issuer in connection with the health plan enrollment of any qualified individual or employer. The secretary must also develop standards to ensure that information made available by navigators is fair, accurate, and impartial.

Exchange Financial Integrity

To maintain financial integrity, each exchange must keep an accurate accounting of all activities, receipts, and expenditures, and submit an annual report to the secretary. Each exchange will be subject to an annual audit. If the secretary determines that an exchange or state has engaged in serious misconduct, failing to comply with or carry out the requirements, the secretary may rescind payments by an amount not to exceed 1 percent per year until corrective actions are taken. The secretary will also implement measures or procedures to reduce fraud and abuse. The Government Accountability Office will provide oversight. No later than 2019, the comptroller general will conduct a study of exchange activities and enrollees in qualified health exchange plans.

Summary

This Fact Sheet provides a basic overview of American Health Benefit Exchanges. A host of issues and choices will be considered and decided by the secretary, states, and newly created exchanges between now and the beginning of 2014, the deadline for exchanges being available to residents across the country. Not only must a variety of standards be set by federal agencies, but organizational structures and infrastructure and outreach must be in place and ready to assist people with finding qualified health coverage that meets their needs, linking them with appropriate public programs and subsidies,

and meeting their individual responsibility to have health coverage when the requirement takes effect in 2014.

Work related to articulating essential benefits is under way at the federal level, and regulations addressing various issues related to exchange standards will be forthcoming at intervals throughout 2011 and beyond. Meanwhile, states are assessing their options and making decisions about whether to establish their own exchanges, how to structure them, and how to operationalize exchange functions. State legislatures and governors are taking legislative and other action necessary to support their decisions.

¹ U.S. Census Bureau, Current Population Survey, ASEC Supplement, Health Insurance Coverage Status and Type of Coverage by Selected Characteristics, 2009, http://www.census.gov/hhes/www/cpstables/032010/health/h01_001.htm and Public Policy Institute analysis.

² <http://ehbs.kff.org/?page=charts&id=1&sn=3&ch=1515>

³ For further discussion, see AARP Fact Sheet FS 194, “Health Reform Changes Insurance Rules,” <http://assets.aarp.org/rgcenter/ppi/health-care/fs194-health.pdf>.

⁴ Individuals are exempt if they cannot be covered by any affordable qualified health plan available through the exchange or through their employer, or if they meet the requirements for any other such exemption from the individual responsibility requirement or penalty.

Fact Sheet 215, March, 2011

Written by Gerry Smolka and Shelly-Ann Sinclair
AARP Public Policy Institute,
601 E Street, NW, Washington, DC 20049
www.aarp.org/ppi
202-434-3910, ppi@aarp.org
© 2011, AARP.
Reprinting with permission only.