Individual Health Insurance Exchanges

A health insurance exchange is an online, telephone, and in-person marketplace for buying and selling of health insurance plans. The ACA provides that each state must have an individual exchange as well as a Small Business Health Options Program (SHOP) exchange; the two exchanges can be merged together, at each state's discretion.

Exchange Functions

ACA health insurance exchanges perform the following functions:

- Certify health plans within the exchange, and assign ratings based on quality and price.
- Operate a website to allow consumers to compare plans, determine eligibility, and enroll in coverage.
- Operate a toll-free hotline for consumer support, provide "Navigators" for consumer assistance, and conduct outreach and education to consumers.
- Determine eligibility to enroll in insurance plans, Medicaid, and the Children's Health Insurance Program (CHIP), and receive tax credits.
- Facilitate enrollment in plans.

Health Plans on the Exchange

All health care plans offered within the ACA exchanges must:

- Cover 10 Essential Health Benefits (see below for list)
- Provide guaranteed issue (i.e., take all comers, and cannot drop coverage)
- Charge the same price regardless of any pre-existing conditions, health status, or gender
- Charge older customers no more than 3x times the price for young customers
- Have no annual or lifetime limits on benefits
- Provide four levels of coverage: platinum, gold, silver, and bronze, which will cover on average 90%, 80%, 70%, and 60% of health care costs, respectively.

Existing state regulations will continue to be in effect. In addition, states may choose to improve standards over these ACA minimum requirements.

Exchange Subsidies

Individuals and families with incomes up to 400% of the Federal Poverty Line will be eligible for Federal subsidies to purchase health insurance coverage on the exchanges. Those with incomes at less than 250% of the poverty level will also be eligible for subsidies to reduce out-of-pocket payments.

For more information on the individual subsidies and penalties, visit CWA's Fact Sheet on ACA Subsidies and Penalties. For more information about health insurance exchange subsidies that may be available in your area, visit www.healthcare.gov.

Prepared by the CWA Research Department ▪ October 2013

Insurance Plan Rates on Exchanges

There are four levels of coverage for plans on the exchanges (bronze, silver, gold, and platinum), and premium rates will vary depending on the coverage level. Premium rates also vary by insurer, geographic region within the state, age of individuals, and (possibly) whether or not the individual is a smoker.

To compare individual plan rates in your state, visit www.healthcare.gov.

Qualified Health Plans (QHPs)

All ACA exchange plans must be certified "Qualified Health Plans" and provide the following:

- **Accreditation:** QHP issuers must be accredited, based on clinical quality measures and patient experience ratings.
- **Essential Health Benefits:** All plans must provide ten "essential health benefits"
    - ambulatory patient services;
    - emergency services;
    - hospitalization;
    - maternity and newborn care;
    - mental health and substance use disorder services;
    - prescription drugs;
    - rehabilitative services and devices;
    - laboratory services;
    - preventive and wellness services and chronic disease management;
    - pediatric services.
- **Network Adequacy:** Exchanges must ensure that a plan network "offers a sufficient choice of providers for enrollees." Considerable discretion is granted to states here.
- **Essential Community Providers:** Plans must include in network a "sufficient" number of providers that serve the low-income and medically-underserved.
- **Marketing Practices:** Plans must not engage in "unfair and deceptive" marketing practices to discourage sicker people. Enforcement is left to the state.
- **Quality:** Plans must implement and report on quality improvement strategies, disclose information on health care quality, and implement enrollee satisfaction surveys.
- **Rate Justifications:** Plans must submit justification for any rate increase prior to implementing. Exchange must consider these justifications in determining recertification.
- **Transparency:** Plans must provide detailed information on financial status, claims practices, and performance measures that go beyond what most states currently require.
- **Standardization:** Plans must use a uniform enrollment form and standardized format to summarize benefits.

State Variation in Exchanges

Under the ACA, all states must have a health insurance exchange in place. Individual states can opt to run their own exchange, or engage in a partnership with the federal government. In those states that choose not to run their exchanges, the federal government will run the exchange. Those states initially in a federally facilitated or partnership exchange may choose to run their own exchange in subsequent years.

16 states and the District of Columbia will run their own state-based exchange in 2014, 7 are planning for a partnership exchange, and 27 have defaulted to a federally facilitated exchange. For more information, see State Decisions For Creating Health Insurance Exchanges.

The ACA mandates certain minimum regulations, but provides states significant flexibility in the design of their exchanges. For example:

- States can require exchange to contract with all qualified health plans, or to selectively contract based on choice, quality, value, etc.
- States can establish QHP criteria beyond that defined in ACA, but are not required to.
- States are not required to eliminate the individual marketplace outside of the exchange.
- Exchanges must be self-financed, but states are given flexibility in financing. For example, they may assess fees on providers, use state funds, or find other public/private sources.

Also, all exchanges must abide by existing state laws and regulations. States in their discretion may choose to increase rules over the ACA minimum requirements. For more information on states' exchange designs, see State Decisions For Creating Health Insurance Exchanges.

Assistance in Choosing a Health Plan

The ACA provides for three different types of customer assistance roles: Navigators, non-Navigator assistance personnel, and Certified Application Advisors (CACs). All are required to complete comprehensive training.

Navigators

Navigators have a vital role in helping consumers prepare electronic and paper applications to establish eligibility and enroll in coverage through the Marketplace. This includes helping consumers find out if they qualify for insurance affordability programs (including a premium tax credit, cost sharing reductions, Medicaid and CHIP), and if they're eligible, to get enrolled. Navigators also provide outreach and education to consumers to raise awareness about the Marketplace, and refer consumers to ombudsmen and other consumer assistance programs when necessary. They are funded through state and federal grant programs.

Non-Navigator Assistance Personnel (in-person assistance personnel)

Non-Navigator assistance personnel generally perform the same functions as Navigators, but do not exist in Federally Facilitated Exchanges. Non-Navigator assistance personnel are be optional for states to set up before the Navigator program is fully functional. Non-Navigator assistance

personnel can be funded through state grants or contracts; exchange establishment grant funding can be used.

Certified Application Counselors (CACs)

Certify application counselors perform many of the same functions as Navigators and non-Navigator assistance personnel, including educating consumers and helping them complete an application for coverage. Organizations who want to become CACs might include community health centers or other health care providers, hospitals, or social service agencies. In states that already have their own certification programs, staff at consumer non-profit organizations may also be certified as CACs. CACs do not receive new federal grant money, but federal funding through other grant programs or Medicaid may be available.

For more information, see Assistance Roles to Help Consumers Apply & Enroll in Health Coverage Through the Marketplace