State Insurance Exchanges – Basic Facts

The insurance "exchange" is a portal that will facilitate comparing and purchasing health insurance for certain individuals and small businesses by offering:

- Choice of health plans
- Provide consumer assistance
- Establish rules regarding offering & pricing

In accordance with the *Patient Protection and Affordable Care Act*, each state must establish an insurance exchange, collaborate with other states (multi-state exchange) or have the federal government create the state exchange. States may choose from several governance options for the exchange; it can operate as a "state agency", be contracted to a non-profit entity; or be developed as a public-private quasi-agency. Each state's department of insurance will have regulatory oversight the health plans offered within the exchange.

Each state's insurance exchange must be fully implemented during 2013 in order to be operational for January 1, 2014. Major milestones must be reached to achieve this:

- Legislation passed creating the exchange
- Market research and IT assessment
- Governing Board convened
- Stakeholder involvement
- Exchange design & policy development
- Marketing to consumers & employers
- IT infrastructure procured and tested
- Health plans certified

Functions that the insurance exchange must perform include determining the eligibility of individuals for Medicaid or subsidies; certifying health plans as "qualified"; rating each plan offered, offering consumer assistance with a toll-free number and other resources; establishing Navigator programs; auditing and reporting functions; notifying the Treasury Dept. for different occurrences related to individuals coverage status; and several administrative functions as well.

Qualified health plans will be certified and offered through the exchange – this term has yet to be defined, but some of the requirements are as follows:

- Meet certain marketing requirements
- Ensure choice and information on providers and networks
- Obtain accreditation on clinical quality measures
- Quality improvement strategies in place
- Utilize a standard enrollment form
- Standardized plan options format
- Disclose plan performance measures

Individuals will "connect" with the exchange and their eligibility for a Medicaid program or a premium subsidy will be determined. Individuals then compare their options and select the coverage most appropriate for their situation. Individuals without insurance and without a determination of exemption will be penalized. Some individuals may choose utilizing the exchange instead of their employer-sponsored health coverage especially if they qualify for Medicaid or a premium subsidy. Some employer penalties may exist if employees are eligible for certain options.

Employers with less than 50 employees (up to 100 after 2017) may decide to purchase health coverage through the exchange to provide better choice and pricing to their employees. Larger employers (more than 50 employees) will need to assess the likelihood of offering coverage, providing vouchers for employees who qualify to enroll through the exchange or paying a penalty for not offering it.

Summarized by Cristine Vogel, Special Advisor to the Governor for Health Care Reform, State of Connecticut, October 2010