WHAT IS AN EXCHANGE?

Think of an exchange as an online marketplace. It's a website where shoppers can research all their options and then buy health insurance.

The Affordable Care Act requires every state to offer an exchange to its residents. States have a few options:

- A state can choose to create and run its own exchange.
- If a state decides not to run its own exchange, residents of that state can shop on an exchange that will be run by the federal government.
- Or a state can partner with the federal government. In a partnership model, the state and federal government share responsibility for operating that state's exchange.

No matter what each state decides to do, an Exchange will be available to residents in every state.

Why are exchanges expected to be so popular? There are a few reasons:

- The Affordable Care Act no longer allows insurers to deny coverage or charge people more based on their health status or pre-existing conditions. So, many people who were unable to buy coverage in the past will now start shopping for a health plan.
- Starting in 2014, individuals are required to buy health insurance or face penalties. This is called the "individual mandate." Although the penalty for not buying coverage is initially low, it will grow over time. As the penalty goes up, so will participation on exchanges.
- The Affordable Care Act will provide tax credits and subsidies for individuals who qualify, to help make insurance more affordable, when they shop on a public exchange.

Many individuals who shop on exchanges will be new to health insurance. To help make shopping easier, health plans on a public exchange will be labeled platinum, gold, silver or bronze. The metallic level helps shoppers understand the level of coverage a plan offers – how much they will need to pay and what the plan pays.

Platinum plans will have the lowest out of pocket cost for members but the monthly premiums will generally be higher. Bronze plans, on the other hand, will have the highest out of pocket costs for members, but will typically feature lower monthly premiums.

All plans on an exchange have to offer some core benefits – called "essential health benefits" - like preventive and wellness services, prescription drugs, and coverage for hospital stays. Public exchanges are designed to help shoppers choose a plan that fits their needs and their budget.

The intent of this analysis is to provide general information regarding the provisions of current health care reform legislation and regulation. It does not necessarily fully address all your organization's specific issues. It should not be construed as, nor is it intended to provide, legal advice. Your organization's general counsel or an attorney who specializes in this practice area should address questions regarding specific issues.

FREQUENTLY ASKED QUESTIONS?

1. **What are exchanges?**

   Exchanges are online marketplaces where consumers can go to shop for health insurance. On these sites, consumers can compare the plans available to them and then purchase online.

2. **Who creates and maintains the exchanges?**

   - Each state has the option to create and operate its own exchange.
   - If the state opts not to offer an exchange, a federal exchange will be available.
   - Outside of the government, private exchanges may also exist.

3. **Who can shop on an exchange?**

   Starting on October 1, 2013, the federal and state-based exchanges, for those states that choose to participate, will be available for small employers and individuals shopping for health insurance.

4. **Do exchanges help address the cost of health insurance?**

   For individuals who meet certain criteria, two new elements can help make health insurance affordable for them:

   - Subsidies
   - Tax credits

5. **What kind of plans will be available on an exchange?**

   To participate on an exchange, health plans will need to meet specific criteria. While some of these are still being defined, here are the basics:

   - Essential health benefits
   - Network requirements
   - Qualified health plan
   - Coverage levels

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EXCHANGE GLOSSARY

1. **Cost-sharing subsidies**
   For individuals and families with household incomes at or below 250 percent of the federal poverty level, the ACA limits the amount they have to spend of their own money ("out of pocket") on their health care, when they enroll in a silver level plan through an exchange.

   In 2012, 250 percent of the federal poverty level is approximately $28,000 for an individual and $58,000 for a family of four.

2. **Coverage levels**
   Both on and off exchange, health insurance plans for individuals and small group markets will now be assigned a metallic level. The level is based on the how much of the total health care cost the plan pays, versus what the member will pay out-of-pocket.

Metallic plan name	Percentage of costs covered by plan
Bronze	60%
Silver	70%
Gold	80%
Platinum	90%

3. **Essential health benefits**
   The ACA requires that the following services are included in any benefits package sold on or off exchange to individuals and small group employees. These include:

   - Ambulatory services
   - Emergency services
   - Hospitalization
   - Rehabilitative/habilitative services
   - Laboratory services
   - Preventive/wellness services
   - Maternity/newborn care
   - Mental/behavioral health
   - Prescription drugs
   - Chronic disease management
   - Pediatric services

4. **Network requirements**
   Qualified health plans must have networks that meet certain requirements, including the size of the network and how it is created. The network also needs to include essential community providers, who typically provide care to patients with low incomes.

5. **Tax credits**
Individuals and families with household incomes between 100 and 400 percent of the federal poverty level are eligible for a tax credit when they enroll through an Exchange.

In 2012, 400 percent of the federal poverty level is approximately $44,000 for an individual and $92,000 for a family of four.

6. **Qualified health plan**
The ACA requires that all health plans offered through an Exchange meet certain requirements. These include:

- Being certified by the state exchange for criteria such as the size of the network, how the plan is marketed, and the how the plan helps improve the member's health.
- Providing a minimum essential health benefits package
- Following established limits on cost-sharing (like deductibles, copayments and out of pocket maximums)
- Offering at least one silver and one gold plan
- Charging the same premium both on and off exchange

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