The Association ACA Primer: The State Exchanges

What are the state Exchanges?
Under the Affordable Care Act (ACA), every state and the District of Columbia are required to create a health insurance "Exchange". These independent health care entities would serve as, to use a common example, a Travelocity for health insurance shopping for individuals and small businesses (defined as under 50 full time employees). Individuals and businesses would be able to go online and find different private (and possibly public) insurance options that meet their needs, then receive an affordable rate because the Exchange's market is larger than if the person had been shopping for insurance individually. Individuals that go into the Exchange for insurance would enter the American Health Benefits Exchange while small employers would join the SHOP market. SHOP (Small business Health Option Program) is a marketplace where employers can find insurance offerings to provide for their employees.

Under ACA, every state must have created or be on their way to creating an Exchange for their state by 2014 (or working within a regional Exchange). States that fail to do so have two choices – work with the federal government to create a partnership Exchange or allow the federal government to create an Exchange within their state. These Exchanges must be in place and operational by 2016. A partnership Exchange would be a jointly run Exchange where the state and federal government would split the responsibilities for the Exchange; what these partnerships would look like is currently unknown.

Currently the following 19 states have elected to operate their own Exchange: California, Colorado, Connecticut, the District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Mississippi, Nevada, New Mexico, New York, Oregon, Rhode Island, Utah, Vermont, and Washington. These states have elected to run their own Exchanges for a variety of reasons. Massachusetts and Utah had created state Exchanges prior to the passage of ACA. Most of the states elected to create Exchanges for political reasons, either because their Democratic party-controlled governments supported ACA or because the Republican party-controlled legislatures were hesitant to allow a Democratic administration to create an Exchange in their state. Additionally, some states, including the District of Columbia, wanted to create Exchanges to serve their unique populations.

How would a state Exchange work?
All state Exchanges have elements in common. The states themselves will be required to perform the Exchange-building functions such as contracting with insurance companies, establishing the governing body of the Exchange, and building the necessary information technology (IT) infrastructure to run the Exchange. All Exchanges will have a SHOP option for small businesses and those SHOP plans can be expanded to employers with more than 50 employees. All Exchanges will also have Navigators, which are non-insurance entities representing a wide range of the population and can serve as information conduits to the Exchange. Associations are listed in the ACA as Navigator-eligible entities.

States can establish the Exchanges themselves in a variety of ways. Exchanges can be run from a state government agency (Kentucky, New York), created as a quasi-government agency with government employee and private sector governance (California, DC), or established as an independent nonprofit entity (Hawaii, Mississippi). How a state establishes their Exchange impacts how an association or other concerned entity interacts with the creation of an Exchange.

Another aspect of Exchange planning is how the Exchange will contract with insurance companies to provide qualified health plans (QHPs). Four states have "clearinghouse models" which require the Exchanges to contract with every insurance company that offers a plan that qualifies as a QHP. Seven other states plan to have their Exchange boards actively solicit and accept which plans their Exchange can offer. The other states have not declared their model.

What are some questions that need to be answered going forward?

1. ***How will the Exchanges publicize themselves to the eligible populations***? According to a study published in *Health Affairs*, the Massachusetts Exchange suffered through some serious gaps in information sharing. According to a survey conducted as part of the survey, 40% of respondents found Exchange information difficult to understand while 20% did not know how to select a plan in the Exchange. How Exchanges address this (and empower Navigators to help) will go a long way to defining the success of the Exchanges.

2. ***What are the health plan offerings going to look like***? Besides the basics of what all Exchanges will offer, small employers are curious to know what kinds of plans will be available in the Exchanges. If an employer's current plan is not offered through the Exchange, employers will have to decide whether to enter the Exchange or stay with their current plan. Also, if the Exchange does not offer a comparable plan, the employer will have a tough decision to make financially in human resources.

3. ***How will Navigators operate in the Exchange?*** A Navigator is an entity that represents a cross-section of the Exchange population and serves as an informational resource for participants. Associations are spelled out in the ACA as a type of Navigator. These entities are asked by the law to create an infrastructure whereby they can provide timely information on registering and operating within an Exchange. Imagine a State SAE as a Navigator for a state Exchange, serving as a resource for its members on how to receive insurance through the Exchange. How will Navigators work in the state Exchanges, and will they be required to pay for creating the websites, forms, and phone lines required to serve these populations?