

STATE HEALTH INSURANCE EXCHANGES *FREQUENTLY ASKED QUESTIONS*

What are state health insurance exchanges?

One of the ways the Affordable Care Act (ACA) aims to expand access to insurance coverage is the creation of state-based health insurance exchanges. A health insurance exchange, also known as a health insurance marketplace, is essentially an online shop for individuals and small businesses (up to 100 employees) to compare and purchase private health plans. The exchanges will also help consumers determine if they are eligible for programs such as the Children's Health Insurance Program (CHIP) or tax credits for private insurance.

Are states required to create exchanges?

All states are required to have exchanges through which consumers can purchase health insurance. States can choose to create their own exchange (state-based exchange); partner with the federal Department of Health and Human Services (HHS) to operate an exchange (state partnership exchange); or opt to have the federal government set-up and operate the exchange (federally-facilitated exchange). The majority of states (26) have elected to have federally-facilitated exchanges, while 16 states and DC will operate their own exchanges. Eight states have chosen to partner with the federal government in the state partnership exchange.

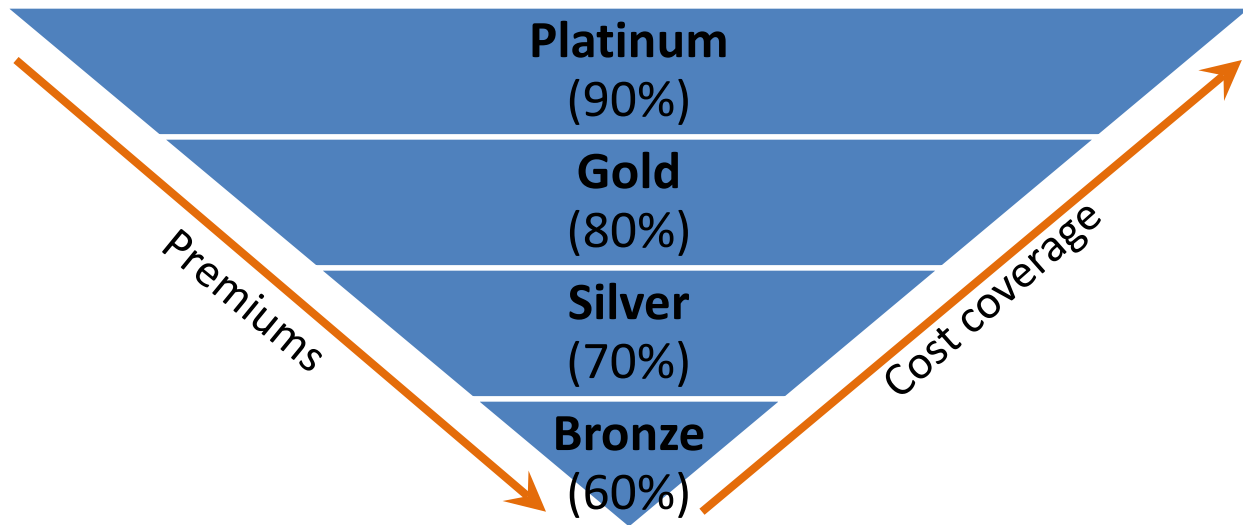
Federally-Facilitated Exchange	State-Based Exchange	State Partnership Exchange
Alabama, Alaska, Arizona, Florida, Georgia, Indiana, Kansas, Louisiana, Maine, Mississippi, Montana, Missouri, Nebraska, New Jersey, North Carolina, North Dakota, Ohio, Oklahoma, Pennsylvania, South Carolina, South Dakota, Tennessee, Texas, Virginia, Wisconsin, Wyoming	California, Colorado, Connecticut, District of Columbia, Hawaii, Idaho, Kentucky, Maryland, Massachusetts, Minnesota, Nevada, New Mexico, New York, Oregon, Rhode Island, Vermont, Washington	Arkansas, Delaware, Illinois, Iowa, Michigan, New Hampshire, Utah, West Virginia

When will exchanges begin operating?

Open enrollment begins October 1, 2013 and the exchanges are required by law to be operational by January 1, 2014.

What choices will the consumer have for health plans sold through the exchanges?

Consumers will be able to choose between multiple health insurance plans when shopping through an exchange. The exchanges are required to rank the health plans from bronze to platinum to indicate what level of coverage the plan offers. The chart below shows the percentage of health care costs coverage by each level plan.



What benefits will the health plans purchased through the exchanges offer?

All health plans offered through the exchanges (for both individual and small groups) will offer a comprehensive package of items and services called “essential health benefits”. Essential health benefits must include items and services within at least the following 10 categories:

- ambulatory patient services
- emergency services
- hospitalization
- maternity and newborn care
- **mental health and substance use disorder services, including behavioral health treatment**
- prescription drugs
- rehabilitative and habilitative services and devices
- laboratory services
- preventive and wellness services and chronic disease management
- pediatric services, including oral and vision care

Insurance companies that wish to participate in an exchange must cover these benefits in order to be certified and participate in the exchanges, and all Medicaid state plans must cover these services by 2014. However, flexibility has been left to states in defining and implementing their essential health benefits package within the 10 required categories, including the choice of a “benchmark” health care plan from which to model their comprehensive package of benefits. The Department of Health and Human Services recommended that states choose to model their benefits package on one of four existing health plans:

- the Federal Employee Health Benefit Plan;
- the state employee health benefit plan;
- the health benefit plan of the three largest small businesses in the state; or
- the health benefit plan from the largest Health Maintenance Organization (HMO) in the state.

All essential health benefits must also comply with the Mental Health Parity and Addiction Equity Act of 2008. For more information about essential health benefits, read [AACAP Comments on Essential Health Benefits](#), submitted to the Department of Health and Human Services.

How do I find out what's happening in my state?

States have great latitude in designing and implementing their health insurance exchanges, allowing states to decide on structure (new or existing public agency, non-profit entity), governance (Exchange Board, advisory committee, existing health agency), inclusion of state mandated health benefits (such as treatment for autism spectrum disorder), and other key elements. Consequently, no two state exchanges will look the same or follow the same processes.

To help you identify what is happening in your state, including the current status of implementation and points of contact, see AACAP's [Toolkit on State Health Insurance Exchanges](#).

The Kaiser Family Foundation is tracking the development of exchanges in each state. To view a profile of your state, [click here](#).

How can I get involved in the development of my state's exchange?

Every state forming their own exchange is required to solicit input from stakeholders on the development and implementation of their exchange. However, *how* this feedback is solicited varies greatly from state to state, with some states forming governing boards and other having broader stakeholder groups. The degree of physician and provider involvement is also quite varied. Many states have strong conflict of interest requirements to serve on their governing boards, precluding practicing physicians from participating, while others require the board to have physician representation.

To learn more about how physicians are involved in your state, contact your state medical society and ask how they are participating in the stakeholder process. Offer to be a resource to them as they engage with policymakers about the exchange to ensure they consider the interests of children with mental illness and psychiatrists.

To solicit public feedback from consumers, providers, and businesses, many states continue to hold statewide forums to hear, form listservs, and release documents for public comment. To find out if your state is soliciting public feedback, check AACAP's chart of state insurance exchange information for your state's exchange website (if available).

How can I become a network provider in the health plans sold through the exchanges in my state?

The process to participate in the health plans sold through the exchanges will not differ from the process you follow to participate in other health insurance plans. Go to your state's exchange website for more information on becoming a network provider.

How can my patients get help purchasing health insurance through the exchange?

All exchanges are required to establish a “navigator program” to help individuals and small employers with the application and enrollment process. Navigators will also conduct public education activities to raise awareness about the exchange and provide referrals to other consumer assistance resources. Information about the navigator program in each state can be found on the exchange website.

Additionally, exchanges will certify existing organizations, such as community health centers, as certified application counselors (CACs) to ensure that they are qualified to help people apply for Medicaid, CHIP, and plans sold through the exchange.