

The Affordable Care Act includes two basic types of federal requirements for Exchanges, most of which are found in Section 1311. These include:

- 1) minimum functions Exchanges must undertake directly or, in some cases, by contract; and
- 2) oversight responsibilities the Exchanges must exercise in certifying and monitoring the performance of Qualified Health Plans (hereafter referred to as “plans”), as defined in Section 1301. Plans participating in the Exchanges must also comply with State insurance laws and federal requirements in the Public Health Service Act.

In defining the authority and duties of an Exchange, States in authorizing legislation or other governing documents should incorporate, by reference or explicit provisions, the federally-required Exchange functions and oversight responsibilities.

### States have a range of options for how the Exchange operates



#### Open Marketplace

Exchange operates as a clearinghouse that is open to all qualified insurers and relies on market forces to generate product offerings.

#### Active Purchaser

Exchange operates as large employers often do in using market leverage and the tools of managed competition to negotiate product offerings with insurers

### Within these ranges, Exchanges statutorily must provide the following functions and perform the following oversight:

- Certification, recertification and decertification of plans
- Operation of a toll-free hotline
- Maintenance of a website for providing information on plans to current and prospective enrollees
- Assignment of a price and quality rating to plans
- Presentation of plan benefit options in a standardized format
- Provision of information on Medicaid and CHIP eligibility and determination of eligibility for individuals in these programs
- Provision of an electronic calculator to determine the actual cost of coverage taking into account eligibility for premium tax credits and cost sharing reductions
- Certification of individuals exempt from the individual responsibility requirement
- Provision of information on certain individuals identified in Section 1311 (d)(4)(I) to the Treasury Department and to employers
- Establishment of a Navigator program that provides grants to entities assisting consumers as described in Section 1311(i)
- Presentation of enrollee satisfaction survey results under Section 1311(c)(4)
- Provision for open enrollment periods under Section 1311(c)(6)
- Consultation with stakeholders, including tribes, under Section 1311(d)(6)
- Publication of data on the Exchange’s administrative costs under Section 1311(d)(7)

Certify that plans meet regulatory standards as defined by the Secretary in five areas in order to be certified as qualified health plans

- Marketing
- Network adequacy
- Accreditation for performance measures
- Quality improvement and reporting
- Uniform enrollment procedures

Additional areas where Exchanges must ensure plan compliance with regulatory standards established by the Secretary include:

- Information on the availability of in-network and out-of-network providers as identified in Section 1311(c)(1)(B) and (C), including provider directories and availability of essential community providers
- Consideration of plan patterns and practices with respect to past premium increases and submission of plan justifications for current premium increases under Section 1311(e)(2)
- Public disclosure of plan data identified in Section 1311(e)(3)(A), including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing for out of network coverage, and other information identified by the Secretary
- Timely information for consumers requesting their amount of cost sharing for specific services from specified providers as described in Section 1311(e)(3)(C)
- Information for participants in group health plans as described in Section 1311(e)(3)(D)
- Information on plan quality improvement activities as specified in Section 1311(g)