Health Benefit Exchange: Federal Requirements, Federal Options, and Vermont Choices
Prepared by Jennifer Carbee, Legislative Counsel, Office of Legislative Council
Updated December 14, 2012

Federal	Vermont
Establishment of an Exchange	
Requirement: Each state must establish an Exchange by January 1, 2014 or US Dept. of Health and Human Services will operate one on the state's behalf [PPACA § 1311(b)(1)]	Vermont Health Benefit Exchange to be operational by January 1, 2014 [33 V.S.A. § 1803(b)(1)(A) and Secs. 2(a)(2)(A) and 34(c)(2) of Act 48]
Option: Exchange can be either a governmental or nonprofit entity [§ 1311(d)(1)]	Exchange to be a division in the Department of Vermont Health Access [33 V.S.A. § 1803(a)(2)]
Requirement: Exchange must facilitate purchase of qualified health plans **Option:** States can have separate Exchanges for individual and small group markets or merge into one Exchange	Vermont will have one Exchange for both individuals and small businesses [33 V.S.A. chapter 18, subch. 1]
Exchange Financing	
Requirement: Exchanges must be self-sustaining by 2015 [§ 1311(d)(5)(A)]	Exchange financing plan due by January 15, 2013 [Sec. 9(a)(1) of Act 48]
Exchange Eligibility	
• **Requirement:** Starting in 2014, individuals and small employers with up to 100 employees ○ **Option:** State option to define "small employer" as 50 or fewer employees in 2014 and 2015 • **Requirement:** In 2016, individuals and small employers up to 100 employees • **Requirement:** In 2017, large employers can join, too [§§ 1304(b)(3), 1312(f)(2)(B)] •	Act 171 defines small employer as 50 employees or fewer for 2014 and 2015, then 100 or fewer in 2016
Nothing in ACA should be construed to prohibit market outside the Exchange or to require individuals to enroll in the Exchange [§ 1312(d)]	Act 171 requires all health insurance to be sold through the Exchange

Risk Pools	
Requirement: Health insurer required to consider all enrollees in the insurer's plans, whether enrolled inside or outside of Exchange, as members of a single risk pool [§ 1312(c)(1) & (2)]	Federal requirement; no state provision
Option: States may merge individual and small group markets [§ 1312(c)(3)]	Act 171 merges individual and small group market
Exchange Offerings	
Qualified health benefit plans: • Are certified by the Exchange • Provide essential health benefits package • Must be offered by licensed health insurer • Insurer must agree to offer at least a silver and a gold plan in the Exchange and to charge same premium for qualified health plan whether offered through the Exchange, through the insurer, or through an agent [§ 1301(a)] •	Act 171 requires bronze, silver, gold, and platinum plans
Requirement: All individual and small group plans offered inside and outside of the Exchange must include the essential health benefits [§ 1302(b)]; for 2014 and 2015, essential health benefits will be defined by reference to one of four benchmark plan types (Essential Health Benefits Bulletin, CCIIO, December 16, 2011)	• Act 171 requires all insurance to be sold through the Exchange • 33 V.S.A. § 1806(b)(1)(A) requires qualified health benefit plans to include the essential health benefits and any other benefits approved by the Green Mountain Care Board and required by the Secretary of Human Services by rule
Requirement: Deductible limits for small group market: $2,000 individual/$4,000 family; out-of-pocket maximums same as for high-deductible plan ($6,050 individual/ $12,100 family for 2012)[§ 1302(c)]	Subject to more restrictive deductible and cost-sharing requirements if approved by the Green Mountain Care Board and required by the Secretary of AHS by rule [33 V.S.A. § 1806(b)(2) & (3)]
Four levels of coverage: • Bronze – 60% actuarial value • Silver – 70% actuarial value • Gold – 80% actuarial value	Act 171 requires all four levels (Unclear whether federal law requires four levels)

• Platinum – 90% actuarial value	
Requirement: Exchanges must include at least two multistate plans established by federal Office of Personnel Management	Federal requirement; no related state provision
Requirement: Exchanges must include plans offered by nonprofit insurers created under CO-OP program, if any	Federal requirement; no related state provision
No related federal provision	DVHA Commissioner must make reasonable efforts to contract with at least two insurers, if at least two are interested in participating and meet requirements to offer qualified health benefit plans (Sec. 4b of Act 48)
Financial Assistance	
Federal premium tax credits available to individuals up to 400% FPL; tied to premium of second lowest cost silver plan	Act 171 allows AHS to explore providing additional state subsidies as part of Global Commitment waiver negotiation
Cost-sharing subsidies available for individuals up to 250% FPL who enroll in silver level plan	Act 171 allows AHS to explore providing additional state subsidies as part of Global Commitment waiver negotiation
Sliding scale tax credits available to certain small businesses that pay at least 50% of employees' health insurance premiums if 25 or fewer employees and average annual wages below $50,000	Federal requirement; no related state provision
Option: States can establish a Basic Health Plan for individuals between 133% and 200% FPL; state receives 95% of federal subsidies	Act 171 includes legislative intent that AHS not implement Basic Health Plan without legislative approval

Employer Responsibility Requirement	
Requirement: Employers with 50 or more full-time equivalent employees (FTEs) are subject to an annual penalty of $2,000 per employee (beyond the first 30) if they do not offer health insurance coverage and at least one employee receives subsidized coverage in the Exchange [§ 1513] **Requirement:** Employers with 50 or more FTEs who offer health insurance coverage will pay an annual penalty of $3,000 for each full-time employee who receives a premium tax credit or cost-sharing subsidy through the Exchange if the employee's required contribution for self-only coverage exceeds 9.5% of the employee's household income or if the employer's plan pays for less than 60% of covered expenses. An employer's total penalty under this provision is capped at the total number of employees (beyond the first 30) multiplied by $2,000. [§ 1513]	Federal requirements; no related state provision
Grandfathered plans	
Requirement: Most plans in effect on March 23, 2010 are grandfathered and do not have to comply with several ACA provisions unless/until the plan loses grandfathered status by, e.g., significantly increasing co-payments, coinsurance, or deductibles, or significantly decreasing employer contribution [§ 1251]	Act 171 provides for existing health insurance market provisions to apply to grandfathered plans unless/until a plan loses its grandfathered status, at which point the merged market Exchange provisions would apply
Navigators	
Requirement: Exchange must establish a navigator program to provide information and facilitate enrollment in qualified health benefit plans; health insurers cannot be navigators and navigators cannot get paid by health insurers in connection with enrolling individuals or employees in a qualified health benefit plan [§ 1311(i)]	Navigators must also provide information about and facilitate enrollment in public health benefit programs for eligible individuals [33 V.S.A. § 1807]