

Health Reform: What Legislators Need to Know about Exchanges

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NCSL Webinar

Rick Curtis, President
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Health Insurance Exchanges

Federal Health Reform enables states to establish “American Health Benefit Exchanges” for individuals and small employers.

- **HHS Sec’y provides grants to states to develop.**
- **If state will not establish qualified Exchange, HHS Sec’y is to do so.**
 - **Can designate a non-profit entity.**
 - **To be determined before 2013.**



Key Roles of an Exchange

- Provide convenient access to consumer choice of competing qualified plans.
- “Travelocity” / “Kayak.com” of health insurance.
- “Essential health benefits” and “actuarial value” requirements outlined in federal law.
 - “Actuarial value” means how much of the cost of the essential benefits the plan pays (in %).
- Like Massachusetts Connector, specifies bronze, silver, gold and platinum benefit levels,
 - Plus low-cost catastrophic-only plan for adults <30 or individuals exempt from mandate due to cost.



Key Exchange Functions

- Arrange eligibility determinations:
 - For individual tax credits.
 - For “affordability” waiver granting access to tax credits in Exchange (where employer-offered coverage costs >9.5% of income).
 - For “affordability” exemption from individual mandate (>8.0% of income).
 - Screen and refer to Medicaid, CHIP (“one-door” eligibility)
- Certify Qualified Health Plans
Using HHS criteria (plus ____?)



Other Exchange Functions, e.g.

- Website with standardized comparative information on plans. Also toll-free hotline.
- Assign a quality rating to each exchange plan (based on criteria developed by HHS).
- Online calculator so people can determine their cost of coverage after premium credits and cost-sharing subsidies.
- Determine when employees are eligible for Exchange coverage and tax credits because employer's plan was unaffordable or inadequate.
- Inform individuals of eligibility requirements for Medicaid, CHIP, etc., and, if eligible, enroll them.
- Set up a "Navigator" program.



Who Is Served by the Exchange?

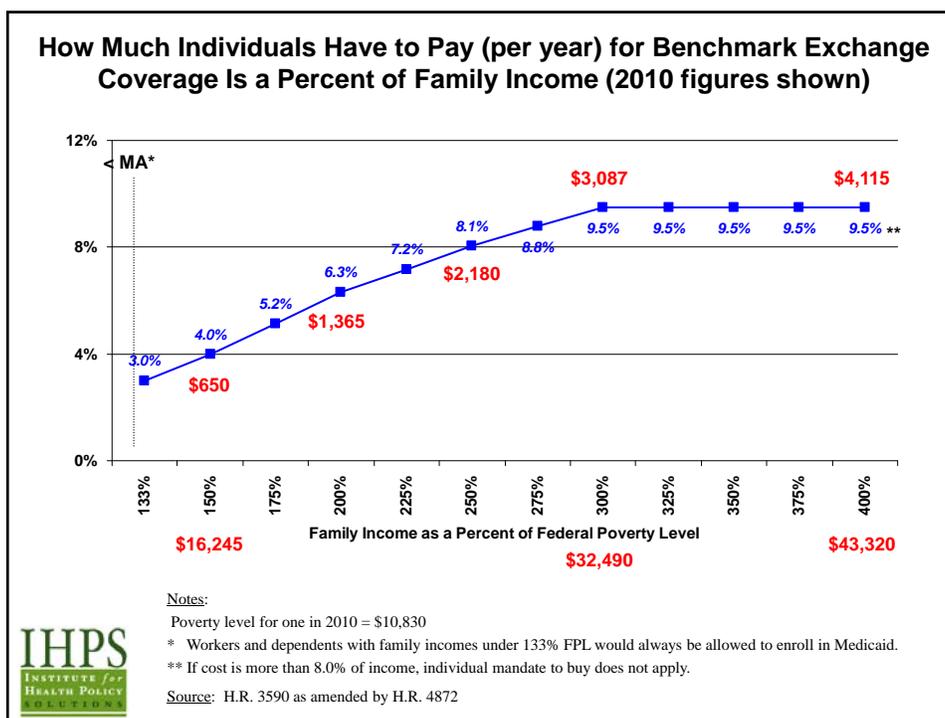
Mandatory:

- **Must** participate in Exchange to receive tax credits:
 - Individuals; small, low-wage employers.
 - Individuals are **not** eligible for tax credits (subsidies) if they are:
 - Eligible for affordable employer coverage, OR
 - Eligible for Medicare or Medicaid.

Voluntary:

- Any lawful resident who is not incarcerated may participate.
- Small employers with up to 100 EEs.
- Beginning in 2017, larger employers, at the option of the State.





Key Differences from Massachusetts Connector Model

- Mass. Connector has separate Exchanges—with different health plans—for modest-income subsidized participants <300% FPL and for non-subsidized individuals >300% FPL.
- American Health Benefit Exchanges make the same plans* available to all individuals, and
- All participants across Exchange and “outside market” are in same risk pool.
- Mass. Connector pays plans (like Medicaid).
- U.S. Treasury, not Exchanges, pays subsidies (tax credits and cost-sharing subsidies) to plans.



* Low-income persons will receive supplemental benefits (reduced cost-sharing) in addition to the “silver” plan they choose. The same “silver” plans will be offered to other Exchange participants, but without supplemental benefits.

Key Initial State Decisions

(inter-related, of course)

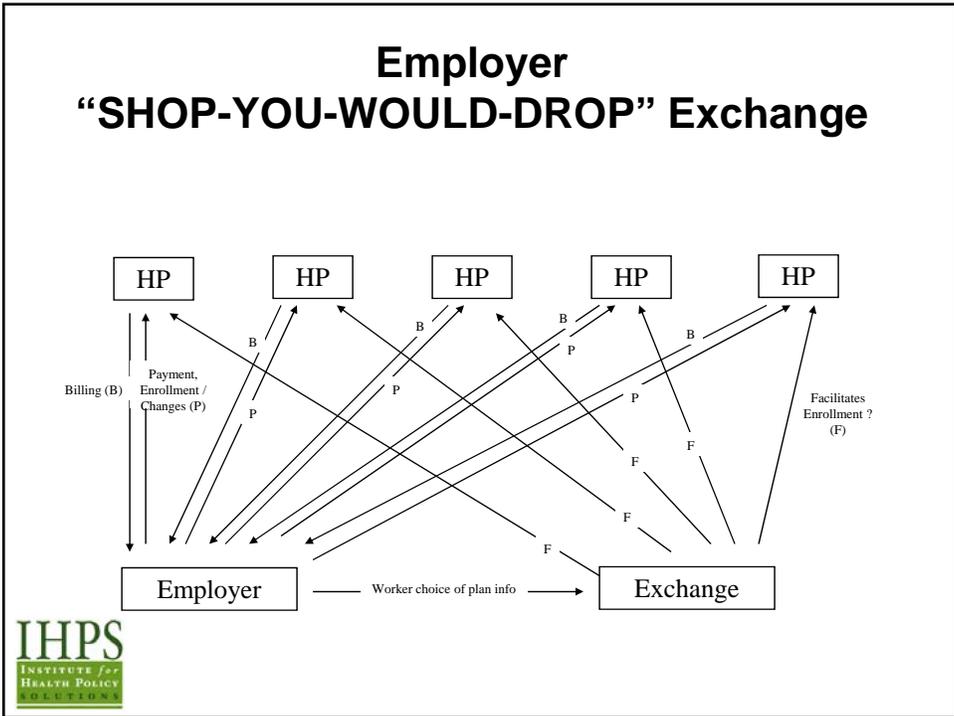
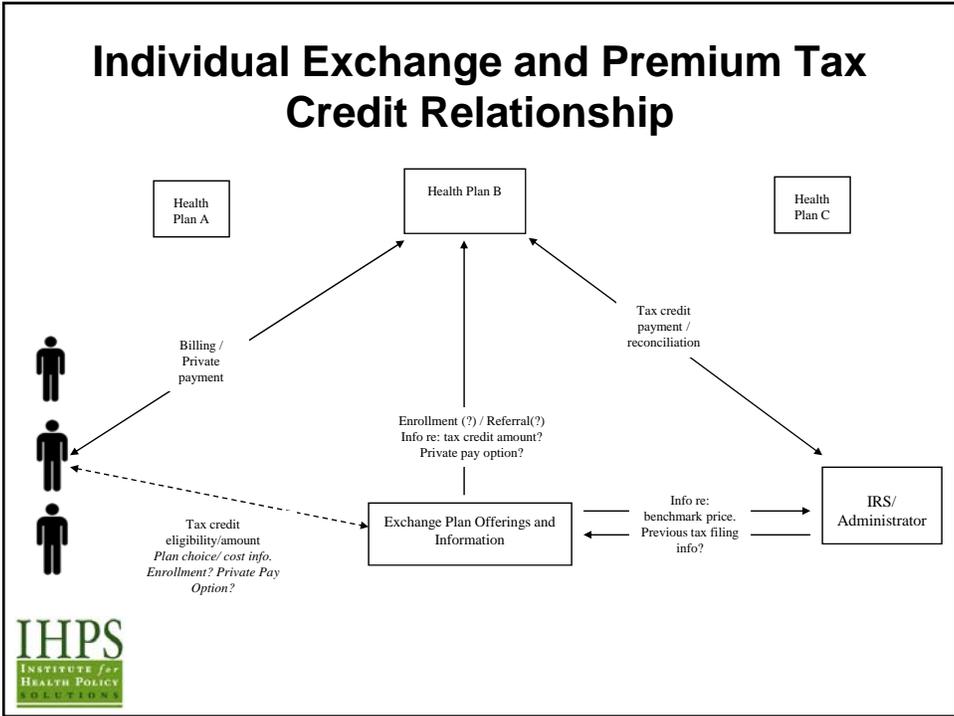
- How Many?
- Who / Where?
- What (if any) plan-selection role?
- Other issues.



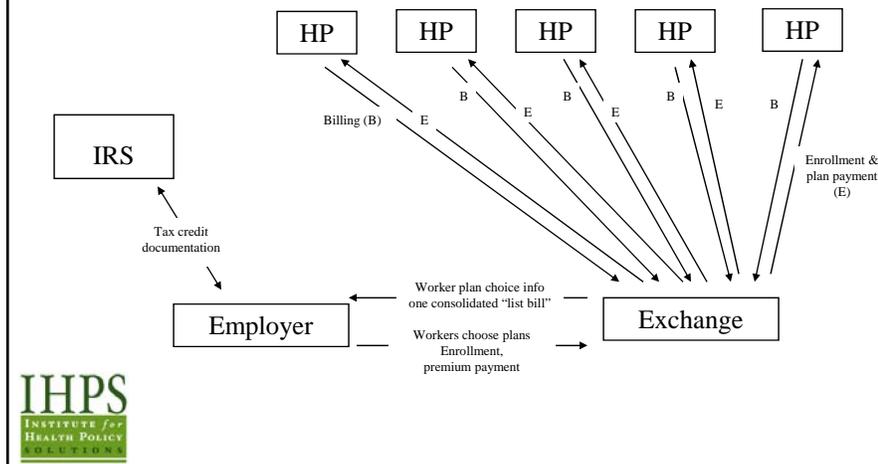
How Many?

- Individual and SHOP Employer Exchange: Same or separate?
 - State can choose to combine individual and small employer markets, or not.
 - If markets are combined, combined Exchange makes sense.
- But essential functions differ in the two markets.





Employer One-Stop SHOP Exchange



Other Issues

- **Require benefits beyond federal “essential health benefits”?**
 - If so, state pays extra subsidy costs.
- **Require greater standardization of products than the federal statute does?**
- **“Outside” market?**
 - Federal guidelines only.
 - Extend all same rules as Exchange.
 - The Exchange is the market.

Employee Eligibility Requirements for Individual Tax Credits via Individual Exchange

- Employees who are offered employer coverage are not eligible for subsidized coverage through the Exchange . . .
 - unless employer coverage costs them more than 9.5% of household income. (50+ employer fee \$3,000—does not affect employee cost.)
- BUT, if employer coverage would cost the worker between 8.0% and 9.8% (*sic*) of household income, not eligible for subsidy, but:
 - Worker can leave employer plan and enroll in Exchange plan.
 - Employer must pay to Exchange the age-adjusted amount employer would have paid toward employer coverage (for single or family coverage, as applicable).
 - Worker applies this “voucher” toward full premium of Exchange plan (not eligible for subsidies).
 - “Wyden Amendment”



Wage Levels Don't Define Family-Income-Based Subsidy Levels

Workers Holding EBI By Individual Annual Income	Total	Family Income Relative to FPL			
		<200%	200%- 299%	300%- 399%	400% +
Less than \$20,000	100.0%	55.1%	17.6%	10.6%	16.7%
\$20,000 to \$29,999	100.0%	26.5%	37.0%	15.0%	21.5%
\$30,000 to \$39,999	100.0%	7.9%	30.3%	30.4%	31.4%
\$40,000 to \$49,999	100.0%	3.1%	14.4%	30.0%	52.5%
\$50,000 or more	100.0%	0.2%	3.8%	8.8%	87.2%
All Workers w/ EBI in Own Name	100.0%	11.0%	16.1%	16.6%	56.3%



Source: Institute for Health Policy Solutions analysis of the March 2009 Current Population Survey (CPS)

Soooo . . .

- Many specifics will not be determined by DHHS and Treasury this year.
- But state could make some initial decisions:
 - E.g., who runs the Exchange(s)
- Transition measures might be considered.



What States Need to Consider to Establish a Sustainable Exchange

Amy M. Lischko
NCSL Webinar, June 2010

Lessons drawn from:

- History of exchanges (CA, NY, etc.)
- Work with states assessing feasibility and design
- Evaluations of MA Connector and Utah Exchange

History of Exchanges

- ❖ Small Group Purchasing Pools: HIPCs, AHPs, other arrangements (Arkansas, Kansas, Texas, NY)
- ❖ Target Population: Mostly small employers (size varies)
- ❖ Value Proposition: Provide more affordable health insurance by pooling small employers together, more purchasing power, employee choice, minimize administrative costs.
- ❖ Rating Rules: often different, adverse selection, participation and contribution rules for employers vary, brokers treated differently and carriers optional
- ❖ Outcome: Most purchasing pools either small in membership or closed due to poor risk, and/or broker and/or carrier resistance. AHPs can be large but cherry pick good risk.

Massachusetts Connector

- ❖ Quasi-governmental entity – separate from the state, governed by a 10-member board
- ❖ Target Populations:
 - o Premium assistance for those under 300% FPL
 - o Small employers (<50)
 - o Individual purchasers (>300%FPL)
- ❖ Value Proposition: Only market for subsidies, comparison shopping, easy on-line enrollment, for small employers: limited employee choice of plans
- ❖ Rating Rules: Same inside and out, all products offered outside, limited offerings inside
- ❖ Key Challenges:
 - o Markets exist side-by-side, carrier and broker resistance remain
 - o Most of “sales” have been of subsidized product
 - o Small business model not successful

Utah Health Exchange

- ❖ Governmental organization
Established by law in 2009, 2 staff, low start-up and operational costs.
- ❖ Target Population: Small employers although pilot for large employers just launched.
- ❖ Value Proposition: Defined contribution model for small businesses only available through exchange. Premium aggregator.
- ❖ Rating Rules : Same inside and out (recent change).
- ❖ Key Challenges:
 - o Determination of appropriate risk-adjustment
 - o Revisit law to make changes as pilot phase uncovers issues.
 - o Federal reform

Goals (for new exchanges)

- Increase transparency of insurance purchase
- Distribute insurance to individuals and small employers
- Coordinate eligibility and facilitate tax credits (subsidies)
- Increase portability
- Increase choice for employees of small (<100) employers
- Improve outreach and education
- Set standards, implement policies around health insurance
- Reduce system costs and improve quality of health care

Early Considerations for States

- Establish or not
- Level of influence on HHS regulations (early adopters)
- State (and/or private) infrastructure necessary to achieve federal and state goals
- Current capacity (state and private)
- Governmental or nonprofit entity and governance
- Number of exchanges
- Regional vs. state-level
- Determine agency involvement for each policy decision
- Determine areas where state legislation/regulations are necessary

American Health Benefit Exchange

What are some key questions?	Issues for states to consider
Which of the required exchange tasks will be conducted in-house and which will be contracted to outside vendors?	<ul style="list-style-type: none"> • Make or buy decisions are critical. Assess available public and private resource capacity • Many new vendors in this space, state will need to develop specifications carefully. • Don't recreate the wheel, avoid redundancy
How can states best implement coordinated eligibility system?	<ul style="list-style-type: none"> • Can current Medicaid (or other program's) eligibility system be easily adapted or is a complete overhaul necessary? • Does state want to consider folding in other assistance programs to create single gateway? • Where will system reside? • Will changes to other state programs be necessary or advisable?
What new consumer decision tools and interfaces are necessary to enroll new populations?	<ul style="list-style-type: none"> • Assessment of all potential users upfront and development of specific targeted interface for each population. • Infrastructure must allow for substantial growth and flexibility over time • Assess existing best practices and available technology (large employers, state employee purchasers, other public and private programs)

American Health Benefit Exchange

What are the key questions?	Issues for states to consider
Will state establish its own program for people between 133 and 200% FPL?	<ul style="list-style-type: none"> • Will it use private insurers or a Medicaid MCO? • How will state work with safety net providers in transition from DHS to private insurance?
Will states continue to mandate benefits greater than basic package determined by HHS?	<ul style="list-style-type: none"> • For subsidized individuals, state will need to calculate value of those benefits and fund with state-only • Are there sources of funding available • Equity issues with Medicaid and other programs • Are legislators open to revisit mandated benefits?
<p>Other:</p> <p>How will state make dental benefits available through the exchange?</p> <p>What quality information will be made available and how will it be displayed?</p>	<ul style="list-style-type: none"> • Assessment of all potential users upfront and development of specific targeted interface for each population. • Infrastructure must allow for substantial growth and flexibility over time • Assess existing best practices and available technology (large employers, state employee purchasers, other public and private programs)

Small Business Health Option Program (SHOP)

What are some of the key questions?	Issues for states to consider
How much choice should be offered and how will state address risk adjustment?	<ul style="list-style-type: none"> Standardization reduces complexity but also reduces choice and innovation Is there room for experimentation to determine what works?
Should individual and small group markets be merged? What are the risks/benefits?	<ul style="list-style-type: none"> Analysis of impact of merging markets can provide useful information
SHOP model will exist side by side other market, can states design a program that adds value to smaller employers?	<ul style="list-style-type: none"> Can SHOP offer better options for small businesses. How will broker fees be addressed? Can SHOP use defined contribution model and premium aggregators to add value for small employers?
Should states begin with very small employers or include all <100?	<ul style="list-style-type: none"> What do employer markets look like in state? How does rating differ among these groups? How can states best ensure success of model?

Challenges

- Duplication and redundancy of functions
 - Other state agency functions
 - Commercial functions
 - Value proposition
- Resistance from brokers, carriers and providers
- Conflicts between policy and business functions
- Establishing adaptable IT platform
- Clarity and prioritization of roles
- Improving quality and affordability
- Program integrity
- Coordination across multiple public programs, state agencies, etc.

Opportunities

- Bi-partisan support
- Innovate around product design
- Reduce administrative waste
- Increase portability
- Reach hard-to-reach (part-time workers with multiple jobs, sole proprietors, employees working for small firms)
- Assist in education and coordination of all aspects of health reform (interfaces with employers, individuals, carriers, providers)

Any Questions?

- Use the Q and A panel on your screen.
- To find the archived webinar next week, go to <http://www.ncsl.org/?tabid=20332>
- Please fill out the survey at the end of this webinar.

Thank you!



Health Reform: What Legislators Need to Know Webinar Series

State Actions So Far

Wednesday, June 9, 3PM EDT

http://ecom.ncsl.org/public/registration/mtg_reg.htm?mtg=wc060910



Additional Resources

Institute for Health Policy Solutions

<http://www.ihps.org/>

Tufts University School of Medicine

<http://www.tufts.edu/med/>

NCSL's Health Webpage

<http://www.ncsl.org/IssuesResearch/Health/tabid/160/Default.aspx>

