

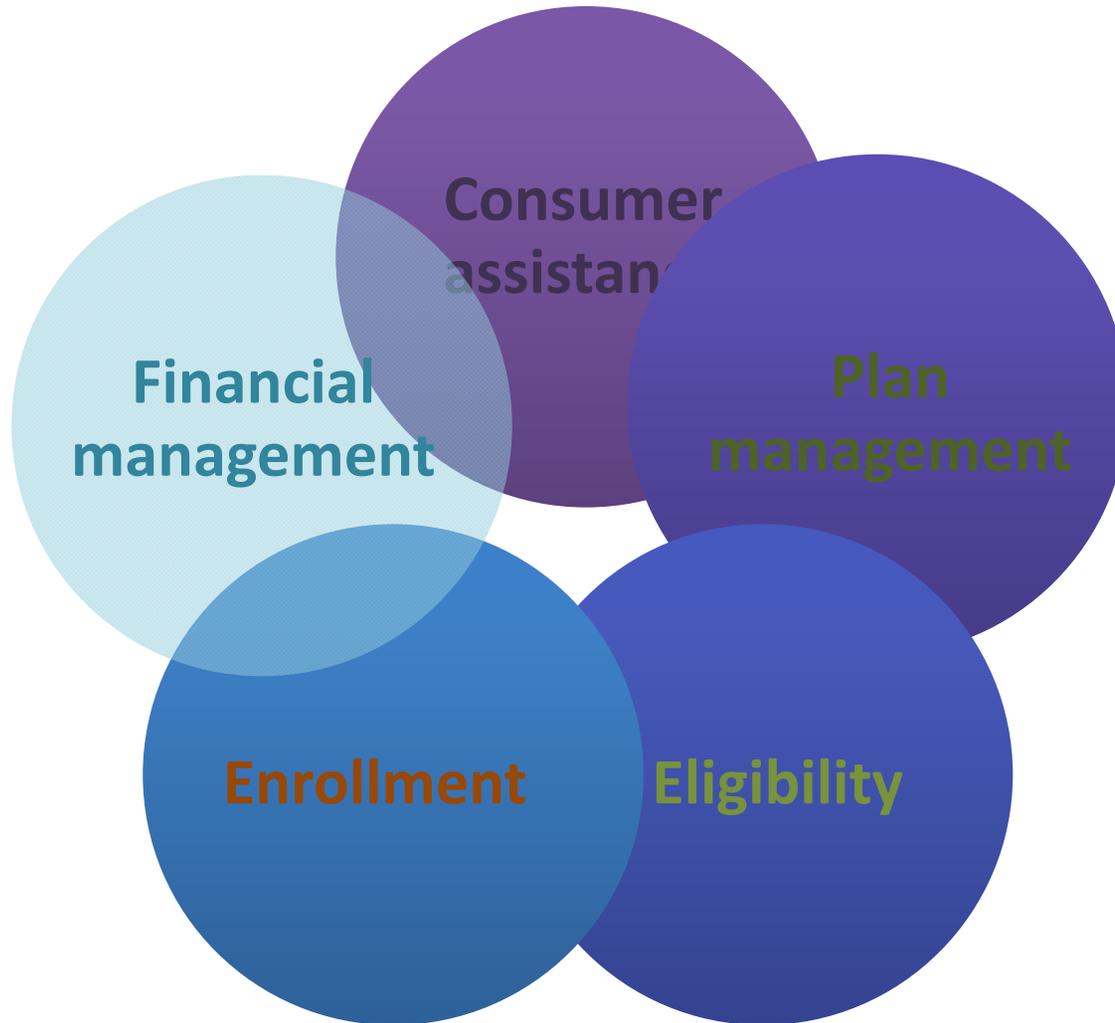
Health Insurance Exchanges

Exchange Advisory Board
December 13, 2012

What are Exchanges?

- The Affordable Care Act (ACA) requires that **each state** have an exchange.
- Exchanges will function as **new marketplaces** where individuals and small businesses can **purchase health insurance** and, depending on income, individuals can **qualify for premium tax credits** and cost sharing subsidies.
- Individuals may also use the exchange to **enroll in Medicaid**.
- States may establish their own exchanges; the U.S. Department of Health and Human Services (HHS) **will operate exchanges** in states that elect not to do so.
- In addition to the exchange for the individual market, each state must have an exchange for the small group market, known as a **Small Business Health Options (SHOP) exchange**; a state may combine the exchanges.
- Exchanges must be operational by **January 1, 2014**, and self-sustaining by January 1, 2015.

Exchange Functions



Core Exchange Functions

Consumer Assistance:

- Consumer support with respect to eligibility and enrollment
- Education and outreach
- Management of “Navigators”
- Call center operations
- Website management

Plan Management:

- Plan selection approach (e.g., “active purchaser” or “facilitator”)
- Collection and analysis of plan rate and benefit package information
- Issuer monitoring and oversight
- Ongoing issuer account management
- Issuer outreach and training
- Data collection and analysis for quality

Core Exchange Functions (con't)

Eligibility:

- Accept applications
- Verify applicant information
- Determine eligibility for enrollment in a Qualified Health Plan (QHP) and for insurance affordability programs
- Connect Medicaid eligible applicants to Medicaid
- Conduct redeterminations and appeals

Enrollment:

- Enrollment of consumers into qualified health plans
- Transactions with QHPs and transmission of information necessary to initiate advance payments of the premium tax credit and cost-sharing reductions

Financial Management:

- User fees
- Financial integrity
- Support of risk adjustment, reinsurance, and risk corridor programs

Exchange Models

- **State Based Exchange:** A Health Benefits Exchange established and operated at the state level
 - Deadline for states to choose this model for 2014: 12/14/12
- **Federally Facilitated Exchange (FFE):** A Health Benefits Exchange established and operated by the Federal Government. Some state roles may still remain.
 - Default option for states that do not choose a model
- **Partnership Exchange:** An **FFE** with certain functions (plan management and / or consumer assistance) operated by the state
 - Deadline for states to choose this model for 2014: 2/15/13

*States can transition between models for 2015
(or subsequent years)*

Three Types of Federal-State Partnerships

Option 1: Plan Management

- Goal is to let States help tailor health plan choices
- Plan management functions include:
 - » Plan selection
 - » QHP certification, including: licensure and good standing, EHB, meaningful difference review, etc.
 - » Collection and analysis of plan rate and benefit package information
 - » Ongoing issuer account management
 - » Plan monitoring, oversight, data collection and analysis for quality
- HHS would coordinate with states to provide plan oversight to resolve consumer complaints and issues with enrollment.

Option 2: Consumer Assistance

- Goal is to take advantage of State's experience to support a seamless consumer experience
- Consumer assistance functions that a State would operate:
 - » In-person assistance
 - » Navigator management
 - » Outreach and education
- Consumer assistance functions that HHS would operate:
 - » Call center operations
 - » Website management
 - » Written correspondence with consumers to support eligibility and enrollment

Option 3: Plan Management and Consumer Assistance – combines all state functions listed above

- HHS will perform all other exchange functions (eligibility, enrollment, and financial management).

Requirements for Products Offered on The Exchange

Include essential health benefits (EHB)

Adhere to deductible and out-of-pocket maximum limits

Provide 60% actuarial value minimum

Comply with “metal levels” – benefit tiers with specified actuarial values (60% 70% 80% 90%)

Be certified by the exchange through which the plan is offered (certification requirements to be determined)

Essential Health Benefits

The ACA requires coverage of services in the following 10 general categories:

1. Ambulatory patient services
2. Emergency services
3. Hospitalization
4. Maternity and newborn care
5. Mental health and substance abuse disorder services, including behavioral health treatment
6. Prescription drugs
7. Rehabilitative and habilitative services and devices
8. Laboratory services
9. Preventative and wellness services and chronic disease management
10. Pediatric services, including oral and vision care

Who May Use Exchanges and Why?

- Individuals

to **satisfy the individual mandate** to purchase minimum essential coverage in order to avoid penalties; individuals can only **access subsidies** when they purchase coverage through the exchange

- Small businesses w/ fewer than 50 employees

those eligible for a temporary two year **tax credit** to offset part of the employer premium contribution; those attracted to the **functionality** of the SHOP exchange

- Members of Congress and their staff

required under the law

Individuals

In 2014 uninsured Americans not covered under a government plan will either:

- Secure coverage through their **employer** if available; or
- If unavailable or “unaffordable” buy an **individual market plan** through either:
 - The individual market **exchange** – purchaser may be eligible for subsidy
 - The **private** (off-exchange) **market**; or
- Go **uninsured** (*will pay penalty unless qualified for an individual exemption*)

Small Groups

Employers who have 50 or fewer employees will have at least three health insurance options in 2014:

- Offer a **fully insured** plan through either:
 - A **SHOP** exchange
 - The private (off-exchange) **small group market**
- Offer a **self-funded** plan, if allowed by state law, where essential health benefits and metal level requirements don't apply
- **Stop offering coverage**; let employees buy through the individual market

Large groups

Employers who have 51 or more employees will have at least three health insurance options in 2014:

- Offer health insurance – either fully insured or self-insured – that meets the minimum coverage definition (no essential health benefit or metal level requirements) and is affordable
- Offer some level of coverage that does not meet minimum requirements and pay the employer penalty
- Stop offering coverage, let employees buy through the individual market and pay the employer penalty

Decision Regarding Medicaid Expansion Will Also Impact Exchanges

- As a result of the U.S. Supreme Court's June 2012 decision on the ACA, states can choose whether or not to expand Medicaid eligibility in 2014 to all those at or below 138% FPL
- States will have to weigh several factors in their decisions:

Cost

- The federal government will cover 100% of the expansion cost until 2017 and phase down to 90% by 2020

Gaps in Coverage

- In states that chose not to expand, individuals with income levels less than 100% FPL who don't meet current Medicaid eligibility requirements will not be eligible for Medicaid or exchange subsidies, leaving a subset of individuals below 100% FPL that may not have access to coverage

Impact on Exchanges

- States that don't expand Medicaid will have to grapple with concerns about individuals moving between exchange coverage and uninsured status

Exchange Timeline

