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# Health Care Reform: Exchanges 101

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## Today's Agenda

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- Overview of Exchange Provisions in ACA
  - American Health Benefit Exchange
  - Small Business Health Option Program (SHOP)
  - Key functions of Exchange
- Comparison of ACA Exchange to other models
- What will it take to create an Exchange?
  - Early Considerations
  - How will the Exchange interact with other aspects of reform?
  - Future policy questions
- Opportunities and Challenges

## By 2014 we will have

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A new world with respect to health insurance:

- Welfare and Health Insurance completely delinked
- Near universal coverage
- Single portal for eligibility and access
- Greater transparency of costs and quality of plans
- More equitable insurance rules
- Greater choices of plans for many individuals and businesses
- Greater affordability of insurance via subsidy and cost-sharing credits and tax credits

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## What is an exchange?

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- A “break-through” concept!!
- One-stop portal for health insurance eligibility and purchase
- A place where low-income individuals and businesses attain subsidies and tax credits
- A website for comparing the cost and quality of health plans
- A new marketplace for insurance purchase that can increase competition among plans
- A pooling mechanism for more broadly distributing risk across a greater number of insured lives
- An entity for educating and informing the public (employers, individuals) about ACA and health insurance

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## What does the ACA require of states?

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- States must establish American Health Benefit Exchange (AHBE) and Small Business Health Options Program (SHOP) by 1/1/2014
- Exchanges may be administered by a Governmental Agency or a non-profit entity
- Exchanges may be organized at a multi-State, State, or a regional level
- States must decide on the structure of their Exchange(s) by 1/1/2013
- HHS Secretary will decide whether significant progress has been made by 1/1/2013

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## What does the ACA require of states?

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- Grants are available to states for planning the AHBE and technical assistance for SHOP
- State Exchanges must be financially self-sustaining by 2015
- Must consult with relevant stakeholders in establishing Exchange
- If a state does not establish an Exchange, HHS will establish one for them
- In 2017 states may apply for waiver of many Exchange (and overall reform) features

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## Goals of the Exchange

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- Increase transparency of insurance coverage
- Standardize and simplify insurance purchase
- Increase competition among insurance plans
- Increase portability and choice
- Improve outreach and education
- Reduce costs and improve quality of health care

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## Key Functions of the Exchange

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- Determine and Coordinate Eligibility
- Create standardized benefit categories of health insurance plans
- Offer multistate plans
- Certify Qualified Health Plans
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- Assign quality ratings
- Reward Quality
- Set up a "Navigator" program

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## Determine and Coordinate Eligibility

- For individual premium credits
- For employer tax credits
- For “affordability” waiver granting access to Exchange (where employer-offered coverage >9.5% of income)
- For employer voucher (where employer offer is between 8-9.8% income or AV < 60%)
- For “affordability” exemption from individual mandate (>9.5% of income)
- For Medicaid and CHIP

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## Who can access the Exchange?

### Mandatory:

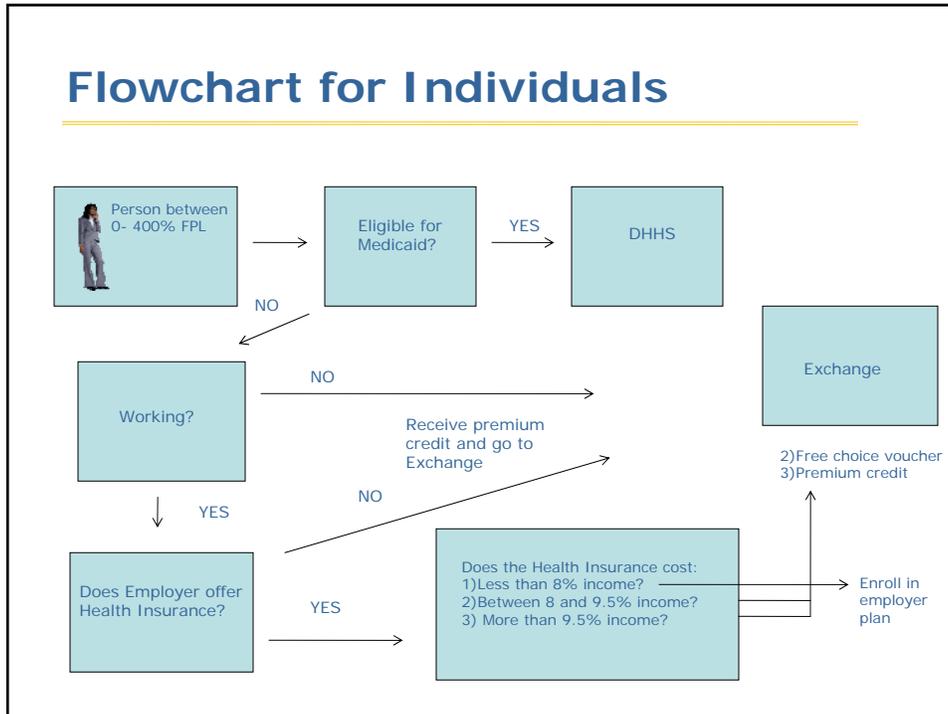
- Must participate in Exchange to receive premium or tax credits:
  - Individuals
  - Small, low-wage employers

### Voluntary:

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

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## Flowchart for Individuals



## Premium Credits and Cost-Sharing Subsidies

- Premium Credits are set on a sliding scale such that the premium contributions are limited to the following percentages of income for specified income levels:
  - Up to 133% FPL: 2% of income
  - 133-150% FPL: 3 – 4% of income
  - 150-200% FPL: 4 – 6.3% of income
  - 200-250% FPL: 6.3 – 8.05% of income
  - 250-300% FPL: 8.05 – 9.5% of income
  - 300-400% FPL: 9.5% of income
- Cost-Sharing subsidies reduce the cost-sharing amounts and annual cost-sharing limits, increasing the actuarial value of the basic benefit plan to the following percentages:
  - 100-150% FPL: 94% of the benefit costs will be covered
  - 150-200% FPL: 87% of the benefit costs will be covered
  - 200-250% FPL: 73% of the benefit costs will be covered
  - 250-400% FPL: 70% of the benefit costs will be covered

## Cost of HI by Income Category

FPL	% Income for HI	Annual Income	Annual Cost of HI
133%	3.00%	\$13,579	\$407
150%	4.00%	\$15,315	\$613
175%	5.15%	\$17,868	\$920
200%	6.30%	\$20,420	\$1,286
225%	7.18%	\$22,973	\$1,649
250%	8.05%	\$25,525	\$2,055
275%	8.78%	\$28,078	\$2,465
300%	9.50%	\$30,630	\$2,910
325%	9.50%	\$33,183	\$3,152
350%	9.50%	\$35,735	\$3,395
375%	9.50%	\$38,288	\$3,637
400%	9.50%	\$40,840	\$3,880

Notes: Poverty level for one in 2010 = \$10,830. Workers and dependents with family incomes under 133% FPL are enrolled in Medicaid. Above subsidized range, if cost is more than 9.5% of income, individual mandate to buy does not apply.

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## Who Can Receive Employer Tax Credits?

- From 2010-2013, employers with 25 or fewer FTE low-income ( avg < \$50,000) employees receive tax credit up to 35% of their contribution
- From 2014 on, employers can receive tax credits up to 50% of their contribution but must purchase via exchange
- Credit is only available to an employer for a 2 year period
- Employers with 10 or fewer with average wages of \$25,000 receive full credit
- Must contribute at least 50% of the premium cost of the qualified health plan

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## Create Standardized Benefit Categories

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- Four benefit categories must provide essential health benefits (defined by the HHS)
- Platinum (90% of the benefit costs must be covered by the plan)
- Gold (80%)
- Silver (70%)
- Bronze (60%)
- Out-of-pocket limits:
  - 100% - 200%: \$1,983 individual/\$3,967 family
  - 200% - 300%: \$2,975 individual/\$5,950 family
  - 300% - 400%: \$3,987 individual/\$7,973 family
  - > 400% FPL : \$5,959 individual/\$11,900 family (Federal HSA limits)
- Catastrophic (< age 30 or exempt from mandate and only available in the individual market)

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## What are Essential Health Benefits?

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- Regulations will specify further:
  - Ambulatory and Emergency Services
  - Hospitalization
  - Maternity & newborn care
  - Mental health & substance abuse
  - Rx
  - Rehabilitation and devices
  - Lab
  - Preventive and wellness
  - Pediatric (oral and vision)

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## Offer Two Multistate Plans

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- Two multistate plans
  - Overseen by the U.S. Office of Personnel Management (OPM)
  - Available through Exchanges only
  - One must be non-profit
  - Beginning in 2014
  - Only offered to individuals and small groups (to 100)

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## Certify Qualified Health Plans (1 of 2)

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- Certify Qualified Health Plans using HHS criteria including:
  - Provide Essential Benefits package
  - Offered by issuer in good standing
  - Must offer at least one gold and one silver plan
  - Use same premium inside and outside of exchange
  - Comply with other requirements of HHS and exchange
  - State may prohibit qualified plans from offering abortion coverage

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## Certify Qualified Health Plans (2 of 2)

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- Regulations will specify further, plans must:
  - Meet marketing requirements
  - Ensure provider network adequacy
  - Include essential community providers
  - Be accredited by recognized entity
  - Use market-based strategies for Quality Improvement
  - Utilize uniform enrollment form - (NAIC)
  - Use standard format for presenting options
  - Submit justification for premium increases

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## Reward Quality

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- Reward quality through market-based incentives
- HHS secretary will develop guidelines
- Provide for increased reimbursement or other incentives for improving health outcomes or patient safety, prevent hospital readmissions, implement wellness and health promotion activities by:
  - Effective case management
  - Quality reporting
  - Care coordination
  - Chronic disease management
  - Use of medical home model
  - Patient education
  - Evidence-based medicine

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## The Navigator Program

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- When: By 1/1/2014
  - Who: trade, community organization, unions, chambers of commerce, licensed producers, other
  - What: public education, facilitate enrollment in plans, referrals to ombudsman
  - How: Funding (grants?) will be made from operational funds (no federal funding)
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## Comparison of ACA Exchange to Earlier Models

Earlier Models	ACA
Rating rules different inside entity vs. out	Rating rules the same
Different plans for subsidized vs. non-subsidized	Same plans for all
Entity pays plans	US Treasury pays plans
Mostly small business	Small business and individuals
No individual mandate	Individual mandate
Limited Medicaid eligibility integration	Single eligibility portal
Little to no risk adjustment	Risk adjustment

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## Comparison of ACA Exchange to Dirigo

ACA	Dirigo
Determines and coordinates eligibility	Determines and coordinates eligibility
Create four benefit categories	Establishes benefit designs for insurance product
Certify Qualified Health Plans	Certifies qualified health plan to serve as carrier for DirigoChoice
Maintain call center and enroll Individuals and businesses	Maintains call center and enrolls individuals and businesses
Establish website with standardized comparative information and online calculator	Maintains online subsidy calculator
Assign Quality ratings	Quality Forum laid groundwork for Quality ratings
Reward quality through market based incentives	
Navigator program	
Risk-adjustment and risk corridors	
Financial reporting to Secretary	Provides financial reporting to Board and Legislature and will report to HHS on high-risk pool
Subsidies to 400%	Subsidies to 300%
Eligibility determined on Modified Adjusted Gross Income	Eligibility determined on Adjusted Gross Income and assets
Treasury pays plans	Pays plans- current relationship with IRS for administration of HCTC for joint payment/subsidy.
Single eligibility portal	Coordinates DirigoChoice / MaineCare enrollment with DHHS

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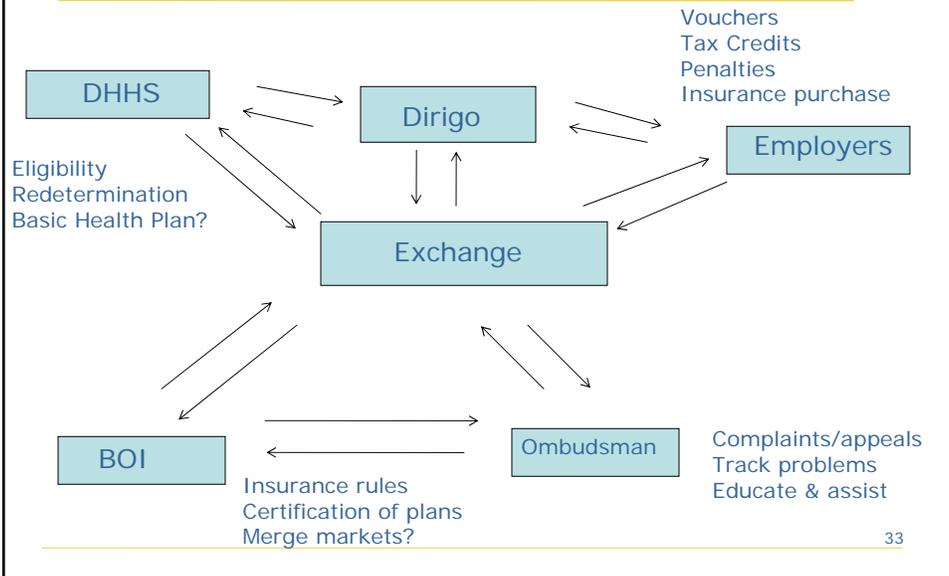
## Early Considerations Regarding Exchanges

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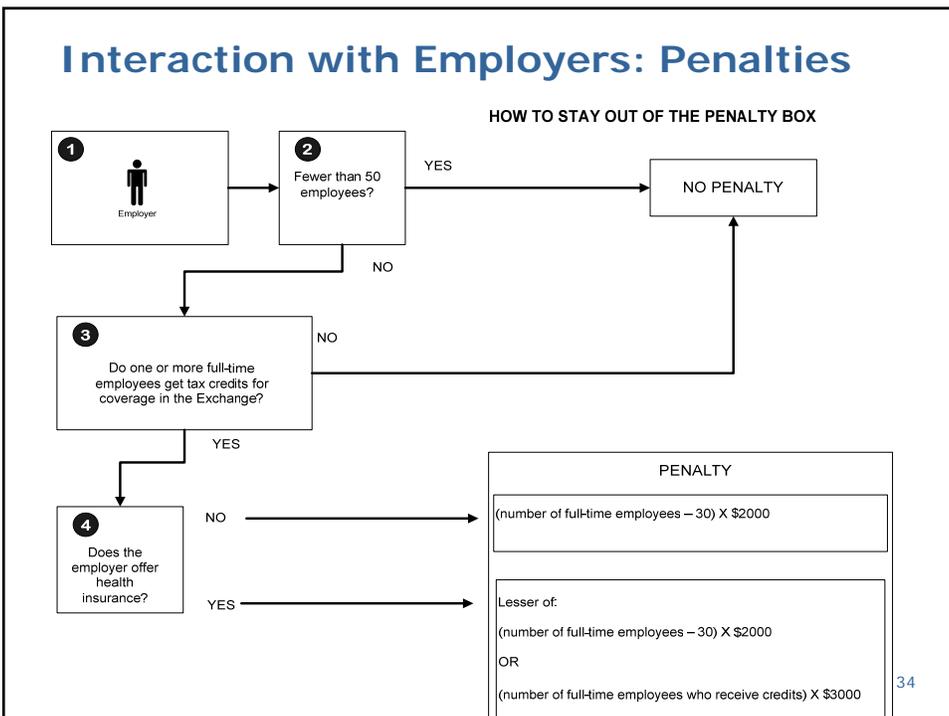
- Prioritize State goals for Exchange
- Establish a State run, regional, multi-state Exchange or allow Federal Government to create
- One or more exchanges
- Determine exchange location and governance structure
- Determine level of influence on HHS regulations
- Evaluate existing State (and/or private) infrastructure
- Assess resource needs for forthcoming planning funds

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## Interaction with other aspects of Reform



## Interaction with Employers: Penalties



## Future Policy Questions Regarding Exchanges

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- Individuals with income between 133 - 200%FPL, exchange or Basic Health Program
- Allow employers with > 100 employees to purchase through exchange
- Merge individual and small group markets
- Require additional criteria for plans to meet to offer in exchange or all products
- Types of plans offered in exchange
- Waiver from some or all of exchange requirements in 2017

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## Opportunities

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- 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)
- Address quality, cost-containment and payment reform

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## Challenges

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- Establishing adaptable IT platform
- 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
- New complex interactions with other state agencies and federal government

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## Timeline for Exchange Implementation

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