Health Care Reform: Exchanges 101

Amy Lischko, Tufts University School of Medicine
July 2010

Today’s Agenda

• 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

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

What is an exchange?

- 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
What does the ACA require of states?

- 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

What does the ACA require of states?

- 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
Goals of the Exchange

• 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

Key Functions of the Exchange

• Determine and Coordinate Eligibility
  • Create standardized benefit categories of health insurance plans
  • Offer multistate plans
  • Certify Qualified Health Plans
  • Maintain a call center for customer service and establish procedures for enrolling individuals and businesses
  • Establish website
  • Assign quality ratings
  • Reward Quality
  • Set up a “Navigator” program
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

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
Flowchart for Individuals

- **Person between 0–400% FPL**
  - Eligible for Medicaid? 
    - YES: DHHS
    - NO: Working?
      - YES: Receive premium credit and go to Exchange
      - NO:
        - NO: Receive premium credit and go to Exchange
        - YES: Does Employer offer Health Insurance?
          - YES: Does the Health Insurance cost:
            1. Less than 8% income?
            2. Between 8 and 9.5% income?
            3. More than 9.5% income?
              - YES: Enroll in employer plan
              - NO: 2) Free choice voucher 3) Premium credit

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
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.

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

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
Key Functions of the Exchange

• Determine and Coordinate Eligibility
  • Create standardized benefit categories of health insurance plans
  • Offer multistate plans
  • Certify Qualified Health Plans
  • Maintain a call center for customer service and establish procedures for enrolling individuals and businesses
  • Establish website
  • Assign quality ratings
  • Reward Quality
  • Set up a “Navigator” program

Create Standardized Benefit Categories

• 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)
What are Essential Health Benefits?

• 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)

Key Functions of the Exchange

• Determine and Coordinate Eligibility
• Create standardized benefit categories of health insurance plans
  • Offer multistate plans
  • Certify Qualified Health Plans
• Maintain a call center for customer service and establish procedures for enrolling individuals and businesses
• Establish website
• Assign quality ratings
• Reward Quality
• Set up a “Navigator” program
Offer Two Multistate Plans

- 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)

Key Functions of the Exchange

- Determine and Coordinate Eligibility
- Create standardized benefit categories of health insurance plans
- Offer multistate plans
- Certify Qualified Health Plans
  - Maintain a call center for customer service and establish procedures for enrolling individuals and businesses
- Establish website
- Assign quality ratings
- Reward Quality
- Set up a “Navigator” program
Certify Qualified Health Plans (1 of 2)

- 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

Certify Qualified Health Plans (2 of 2)

- 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
Key Functions of the Exchange

- Determine and Coordinate Eligibility
- Create standardized benefit categories of health insurance plans
- Offer multistate plans
- Certify Qualified Health Plans
  - Maintain a call center for customer service and establish procedures for enrolling individuals and businesses
  - Establish website
  - Assign quality ratings
- Reward Quality
- Set up a “Navigator” program
Reward Quality

- 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

Key Functions of the Exchange

- Determine and Coordinate Eligibility
- Create standardized benefit categories of health insurance plans
- Offer multistate plans
- Certify Qualified Health Plans
- Maintain a call center for customer service and establish procedures for enrolling individuals and businesses
- Establish website
- Assign quality ratings
- Reward Quality
  - Set up a “Navigator” program
The Navigator Program

- **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)

Today’s Agenda

- 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
### Comparison of ACA Exchange to Earlier Models

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

### Comparison of ACA Exchange to Dirigo

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

• 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

Early Considerations Regarding Exchanges

• 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
Interaction with other aspects of Reform

- **DHHS**
  - Eligibility
  - Redetermination
  - Basic Health Plan?

- **Dirigo**

- **Employers**
  - Vouchers
  - Tax Credits
  - Penalties
  - Insurance purchase

- **Exchange**
  - Insurance rules
  - Certification of plans
  - Merge markets?

- **BOI**

- **Ombudsman**
  - Complaints/appeals
  - Track problems
  - Educate & assist

---

Interaction with Employers: Penalties

**HOW TO STAY OUT OF THE PENALTY BOX**

1. Employee
   - Fewer than 50 employees?
     - YES → NO PENALTY
     - NO → 2

2. Do one or more fulltime employees get tax credits for coverage in the Exchange?
   - YES → 3

3. Does the employer offer health insurance?
   - YES → PENALTY
     - Number of fulltime employees – 30 X $2000
   - NO → PENALTY
     - Lesser of:
       - Number of fulltime employees – 30 X $2000
       - $0
     - Number of fulltime employees who receive credits X $2000
Future Policy Questions Regarding Exchanges

- 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

Today’s Agenda

- Overview of Exchange Provisions in ACA
  - American Health Benefit Exchange
  - Small Business Health Option Program (SHOP)
  - Key functions of Exchange
- Comparison of Exchange to earlier 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
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)
• Address quality, cost-containment and payment reform

Challenges

• 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
Timeline for Exchange Implementation

- Exchanges launched
- Employer requirements/assessments
- Premium & cost sharing subsidies
- Insurance reforms

2010 - 2013
- System improvement initiatives
- Insurance reforms

2016
- Option for multi-state compacts