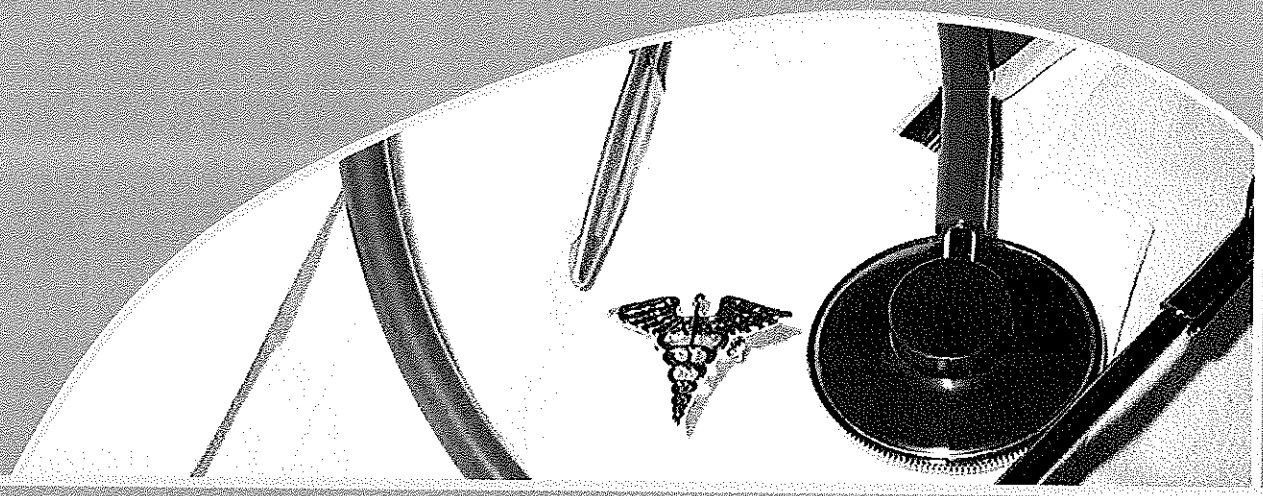
NAIC National Association of Insurance Commissioners

& The Center for Insurance Policy and Research

Health Insurance Exchanges

October 6, 2010
2:00 p.m. - 3:30 p.m. CDT



Health Insurance Exchange

- ☑ Implementation
- ☑ Timelines
- ☑ Structure
- ☑ Challenges

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Learning Outcomes

At the completion of this presentation, you will be able to:

...explain the function of an Exchange and how it will be structured.

...list implementation dates and timelines for key initiatives.

...describe the plans within the Exchange and how they will be subsidized.

...describe the role of the Navigator within the Exchanges.

...explain the risks and challenges facing the Exchanges.

...list the federal regulations required for the Exchanges.

...explain how the NAIC will support the Exchanges.

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Statutory Timelines

- Each state shall establish an American Heath Benefit Exchange by January 1, 2014.
  - Includes individual market and small group market Exchanges – these may be combined.
- The Secretary of HHS must determine by January 1, 2013 if a state will be able to operate a qualified Exchange.
  - If a state does not, the federal government will operate it.
- Not later than 1 year after date of enactment (3/23/2010) the Secretary shall award grants to states to assist in the planning and establishment of the Exchange. (no operating funds)

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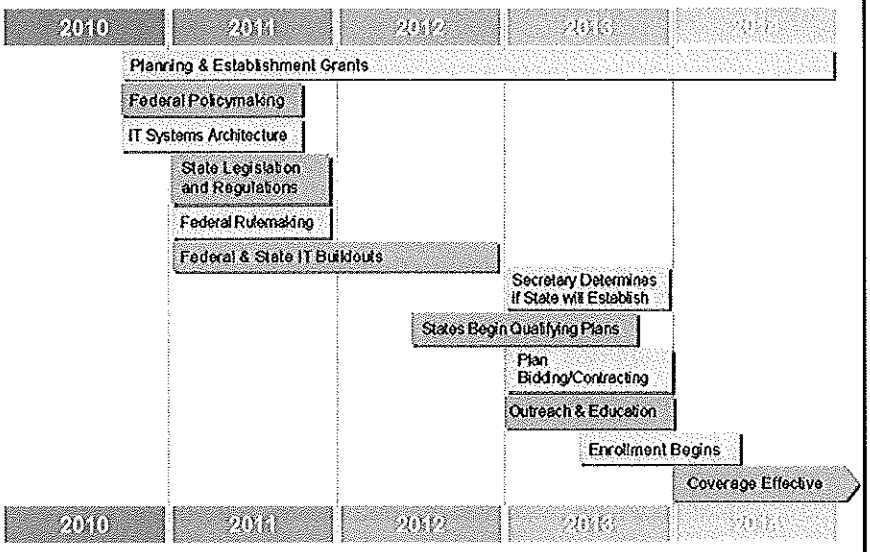
White House Suggested Timeline



Federal Exchange Grants

- **Initial Planning Grants:**
  - $1 million to 48 states + District of Columbia.
  - For research and planning:
    - Market analysis
    - Development of governance and operational framework
    - IT assessment
    - Stakeholder outreach
    - Staffing
    - Funding Requirements
- **Establishment Grants:**
  - Details to be announced in early 2011.

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Basics

- **The Exchange must be operated by a governmental agency or nonprofit entity.**
- **The Exchange may not make available non-qualified plans to individuals or employers. (dental plan OK)**
- **The Exchange must provide for:**
  - Initial open enrollment period
  - Annual open enrollment period
  - Special enrollment periods

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Exchange Structure

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- Structure & Governance
- Role of State Agencies
- Individual and SHOP Exchanges
- Regional and Subsidiary Exchanges
- Exchange Transparency

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Structure & Governance

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- State Agency:
  - Existing infrastructure
  - Accountable
  - Civil service and procurement rules could pose challenges
  - Challenges working with federal agencies
- Nonprofit Created by the State:
  - More flexibility with hiring and procurement
  - Avoids conflict of interest for regulators
  - Insulated from political concerns
  - Less accountable
  - Challenges working with state and federal agencies
- Federally Operated:
  - Less work for state government
  - Challenges working with state agencies
  - Cedes regulatory authority to federal government
  - Adverse selection

Structure & Governance
Role of State Agencies
Individual and SHOP Exchanges
Regional and Subsidiary Exchanges
Exchange Transparency

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Role of State Agencies

- Department of Insurance:
  - Licensure
  - Certification
  - Market conduct
  - Enforcement
- Medicaid:
  - Medicaid eligibility determinations and enrollment
- Governor:
  - Political leadership

Structure & Governance
Role of State Agencies
Individual and SHOP Exchanges
Regional and Subsidiary Exchanges
Exchange Transparency

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Individual & Small Group (SHOP) Exchanges

- Individual Exchange:
  - Provides subsidies.
- Small Group defined as 1-100 employees:
  - State may elect to define as 1-50 until January 1, 2016.
  - State may elect to combine non-group and small group markets.
- Employees have choice of carrier:
  - Employer may choose coverage level.
  - Employees choose from carriers offering at that level.
  - Employees individually rated.

Structure & Governance
Role of State Agencies
Individual and SHOP Exchanges
Regional and Subsidiary Exchanges
Exchange Transparency

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Regional and Subsidiary Exchanges

- Regional Exchanges:
  - States may band together to form a regional Exchange.
  - This may or may not involve pooling of risk.
- Subsidiary Exchanges:
  - States may maintain multiple subsidiary Exchanges.
  - Each must serve a distinct geographic area.

Structure & Governance
Role of State Agencies
Individual and SHOP Exchanges
Regional and Subsidiary Exchanges
Exchange Transparency

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Exchange Transparency

- An Exchange shall consult with stakeholders in carrying out its responsibilities.
- An Exchange shall publish average costs of licensing, regulatory fees, and other payment, plus admin costs of the Exchange and monies lost to waste, fraud, abuse.
- An Exchange shall submit annual report to Secretary on activities, receipts and expenditures – annual audit.
- The GAO shall study Exchange activities not later than 5 years after 2014.

Structure & Governance
Role of State Agencies
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Exchange Functions

At a minimum, an Exchange must:

- Implement procedures for certification, recertification, and decertification of health plans.
- Operate toll-free hotline.
- Maintain Internet website with standardized info.
- Assign a rating to each plan.
- Utilize standardized format for presenting options.
- Inform individuals of eligibility for Medicaid, CHIP or other applicable state or local public programs.
- Certify exemptions from individual mandate.

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Exchange Functions (continued)

- Make available a calculator to determine the actual cost of coverage after subsidies.
- Grant a certification attesting that the individual is not subject to the coverage mandate because:
  - there is no affordable option available, or
  - the individual is exempt from the mandate.
- Transfer to the Treasury a list of exempt individuals and employees eligible for tax credit.
- Provide to each employer the name of employees eligible for tax credit.
- Establish a Navigator program.

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Plans Available in Exchange

- Qualified Health Plan
  - Provides Essential Benefits and is licensed.
  - Agrees to offer at least one Silver and one Gold plan.
  - Agrees to charge same price in and out of Exchange.
- CO-OP Plans
- Multi State Plans

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Levels of Coverage

- **Bronze** — covers 60% of actuarial value of benefits.
- **Silver** — covers 70% of actuarial value of benefits.
- **Gold** — covers 80% of actuarial value of benefits.
- **Platinum** — covers 90% of actuarial value of benefits.
- **Catastrophic** — high-deductible plan for young and those exempt from individual mandate.

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Qualified Health Plan Certification

At a minimum QHPs must:

- Meet marketing requirements.
- Meet network adequacy requirements.
  - Include essential community providers in network
- Be accredited by organization recognized by Secretary.
- Implement quality improvement strategies.
- Utilize uniform enrollment form and standard format for presenting plan options.

Note: HHS and/or States could impose additional certification requirements.

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CO-OP Plans

- Federal government will foster the creation of qualified nonprofit insurers.
  - Loans for start-up costs
  - Grants for to meet solvency requirements
  - $6 billion total
- Must be governed by majority vote of members.
- Profits must be used to reduce premiums, increase benefits, or improve quality of care.
- Must be licensed by state and follow state insurance laws.

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Multi-State Plans

- U.S. Office of Personnel Management (OPM) contracts with insurers to offer at least 2 plans in each state.
- Contracting process shall be similar to FEHBP.
- Insurers must be licensed in every state.
- Benefit package must be uniform in each State.
  - States may require additional benefits.
- States may require plans to meet rating requirements.

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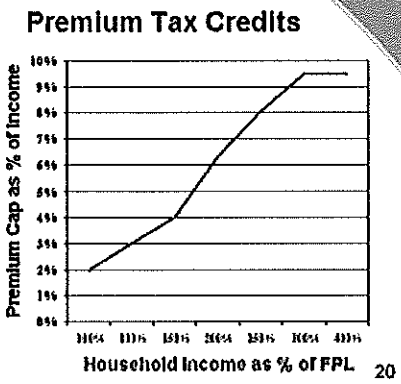
Subsidies: Premium Tax Credit

- Available from 100% - 400% FPL.
- Covers the difference between premium for the second-lowest-cost Silver plan and a percentage of income.
- Advanced to insurer.



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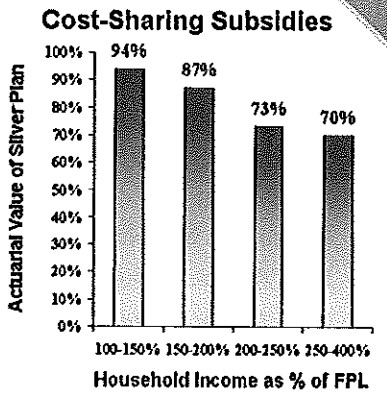
Subsidies: Reduced Cost-Sharing

- Available from 100% - 400% FPL.
- Increases actuarial value of silver plan.
- First achieved by reducing out-of-pocket limit.
- Advanced to insurer.



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Subsidies: Small Business Tax Credit

- Businesses with 25 or fewer employees.
- Average wages less than $50,000.
- Contribute at least 50% of premium.
- Phases out as size and wages of business increase.
- 2010-2013: Up to 35% of total employer contribution.
- 2014 and later: Up to 50% of contribution.

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Basic Health Plans

- States may use Basic Health Plan to cover individuals between 100% - 200% FPL.
- Funded with 95% of subsidies that would be provided for eligible population.
- Eligible population may not enroll in Exchange.
- Coverage provided through contracts with multiple private plans.
  - Premiums below benchmark Exchange plan
  - 90% AV for those below 150%
  - 80% AV for those above 150%
- States may form regional compacts.

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Plan Transparency

- Plans must submit a justification for any premium increase prior to implementation and post on website.
- Plans must disclose to the public:
  - Claims payment policies and practices
  - Periodic financial information
  - Data on enrollment and disenrollment
  - Number of claims denied
  - Rating practices
  - Cost-sharing and payments for out-of-network coverage
  - Enrollee rights under PPACA
  - Other information required by the Secretary

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Navigators

Exchanges must:

- Make grants to "Navigators."
  - Trade, industry, and professional associations
  - Fishing, ranching, and farming organizations
  - Community and consumer-focused nonprofits
  - Chambers of commerce
  - Unions
  - Licensed agents and brokers
- Conduct public education and distribute information.
- Facilitate enrollment.
- Provide referrals to consumer assistance offices.

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Navigators (continued)

- HHS to develop standards to ensure that Navigators are qualified *and licensed if appropriate*.
- Navigators may not be insurers or receive direct or indirect compensation from insurers for enrollment in a QHP.
- States should be careful to ensure that Navigators do not perform functions that would require a producer's license.

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Addressing Risk: Risk Adjustment

- Each state will operate risk adjustment for individual and small group market.
  - Plans with lower than average risk must make payments
  - Plans with higher than average risk receive payments
- Calculation of average actuarial risk based upon all enrollees in fully-insured plans in the state.
- Grandfathered plans are exempted.

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Addressing Risk: Transitional Reinsurance

- Secretary, with NAIC, to establish a mandatory reinsurance program for 2014-2016.
  - All group and individual insurers and third party administrators must contribute based upon total market share.
  - Non-grandfathered individual market plans covering high-risk individuals receive payments.
- Total contributions to be based on estimates of the NAIC.
- Program phases out over 3 years.

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Addressing Risk: Risk Corridors

- Secretary to establish risk corridors for 2014-2016.
- Qualified Health Plans in the individual and small group markets.
  - Plans whose claims exceed 103% of premiums minus administrative expenses receive payments.
  - Plans whose claims are less than 97% of premiums minus administrative expenses make payments.

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Key Decision Points

- ✓ Focus
- ✓ Governance
- ✓ Additional Functions of the Exchange
- ✓ Additional Information for Consumers
- ✓ Regulation of the Outside Market
- ✓ Mandated Benefits
- ✓ Funding of Operations
- ✓ Role of Agents

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Focus and Goals

- Transparent Marketplace (Utah Model)
  - Facilitate valid plan comparisons.
  - Simplify purchasing.
  - Administer subsidies.
- Active Purchaser (Massachusetts Model)
  - Limit Insurer participation.
  - Leverage volume in Exchange to secure lower premiums and higher quality.

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Governance

- Government Agency could be housed within:
  - Department of Insurance
  - Medicaid Agency
  - Governor's Office
- Nonprofit established by State. Board of Directors appointed by one or more state officials.

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Additional Functions

- Selective contracting
  - States may choose to restrict the number of plans allowed to participate in Exchanges.
  - Require plans to make price concessions or offer extra benefits and services.
  - Single risk pool may complicate.
- Application and enrollment
- Premium collection
  - Exchanges are not required to collect premiums from enrollees, but could do so.
  - Could be particularly important in the SHOP Exchange.

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Additional Information for Consumers

- States could require information in addition to what is required by PPACA, such as:
  - Quality information (HEDIS data)
  - All payer claims database information
  - Premium justifications
  - Comparative provider data

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Inside vs. Outside the Exchange

- Nothing in the law precludes the sale of insurance products outside of the Exchange. States must consider carefully.
- Individuals may only receive subsidies in the Exchange and grandfathered plans may not be sold in the Exchange.
- Carriers must consider all enrollees in all non-grandfathered plans to be members of the same risk pool – one for non-group, one for small group.

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Mandated Benefits

- States may require additional benefits beyond the Essential Benefits Package.
- States must reimburse all Exchange enrollees for additional cost of extra mandates.
- Open Questions:
  - Calculation of additional cost?
  - Federal enforcement?

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Funding

- Exchanges must be self-sustaining after 2014.
- Surcharge to cover administrative costs.
  - Would plans sold outside have to add surcharge to meet same premium requirement?
  - If not, people will purchase outside except to get subsidy?
  - Can states recoup surcharge outside Exchange to fund additional regulatory burden?
- Assessment on all plans.
- Assessment on providers.

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Agents and Brokers

- There will be a continued role for producers.
- Producers should present all QHPs in the Exchange.
  - Commission structure should not steer consumers to one plan or another or incent churning.
  - Commissions outside Exchange.
  - Implications for producer appointment requirements.

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Challenges: Adverse Selection

- Inside-Outside adverse selection limited by single risk pool requirement.
  - Plans not participating in Exchange could cause adverse selection by offering non-standard or minimum benefits. Risk adjustment should help.
- General adverse selection risks also apply:
  - Healthy remaining uncovered.
  - Small group market expansions. (Groups of one, or 51-100 employees)

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Other Challenges

- IT systems and interoperability:
  - Medicaid eligibility
  - Income verification
  - Legal residency status
- Other Reforms
- Public Expectations
- Politics

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Federal Regulations

The Secretary of HHS shall establish criteria for the certification of qualified health plans that includes:

- Meet marketing requirements and not discourage enrollment in plan by those with significant health needs.
- Ensure sufficient choice of providers. (no requirement to contract if provider does not accept payment rates)
- Include in network essential community providers.
- Be accredited by entity recognized by the Secretary.
- Implement quality improvement strategy in PPACA.
- Utilize uniform enrollment form in PPACA.
- Utilize the standard format for presenting plan options.
- Provide information on quality measures.

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Federal Regulations (continued)

- The Secretary shall develop a rating system to measure quality and price – also used for a Web Portal.
- The Secretary shall develop an enrollee satisfaction survey system for plans with more than 500 enrollees.
- The Secretary shall assist states in the development of Internet portal – and continue operation of a federal Web Portal.
- The Secretary shall define the Essential Health Benefits that must be in a Qualified Health Plan.

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NAIC Work

- Model Law
  - Will establish exchange and provide basis for state development efforts.
  - Encompasses minimum requirements of PPACA.
- Issue Papers.
  - Adverse Selection
  - Network Adequacy
  - Marketing
- Technical Assistance to States and HHS.
- Liaison with other Associations.
  - Consortium
  - Medicaid Directors

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Questions?

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