Health Benefit Exchange and Insurance Oversight Workgroup

Additional Background Information and Future Work

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August 9, 2010

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shaping policy for a healthier state

Agenda

- More detailed description of Affordable Care Act provisions
  - Essential benefits
  - Individual responsibility and available subsidies
  - Employer responsibility
  - Health benefit exchange (HBE)
  - Insurance reform
- Future work of the Health Benefits Exchange and Insurance Oversight workgroup

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Essential Benefit Package

- HHS Secretary will recommend an essential health care benefits package that includes a comprehensive set of services: (Sec. 1302)
  - Essential benefit package must cover at least 60% actuarial costs of covered benefits
  - All qualified health plans offered through Health Benefits Exchange (HBE), small group or individual market must provide at least essential benefits
  - With exception of "grandfathered plans," insured plans offered outside the HBE must cover the essential benefits but can offer additional benefits*

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*Grandfathered plans are plans that people enrolled in as of March 23, 2010.

Essential Benefits Package

- Essential benefits must cover:
  - Hospital services; professional services; prescription drugs; rehabilitation and habilitative services; mental health and substance use disorders; and maternity care
  - In addition, plans must cover well-baby, well-child care, oral health, and vision services for children under age 21 (Sec. 1001, 1302)
  - Plans must cover preventive services recommended by Task Force on Clinical Preventive Services with no cost-sharing and all recommended immunizations (Sec. 1001, 10406)
  - Cannot include annual or lifetime limits for essential benefits (Sec. 1001, 10101)
  - Mental health parity law applies to qualified health plans (Sec. 1311(j))

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Essential Benefits Package

- Four levels of plans, all must cover essential benefits package: (Sec. 1302(d))
  - Bronze (minimum creditable coverage): must cover, on average, 60% of the costs of covered services
  - ***Silver: 70% of the benefits costs****
  - Gold: 80% of the benefit costs
  - Platinum: 90% of the benefit costs
  - Catastrophic plan (only available to people up to age 30 or if exempt from coverage mandate) (Sec. 1302(e))
- With some exceptions, existing grandfathered plans not required to meet new benefit standards (Sec. 1251, 10103 as amended Sec. 2301 of Reconciliation)

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*Subsidies tied to the second lowest cost silver plan in the HBE.

Essential Benefits Package

- States can mandate additional benefits:
  - Must pay for the cost of additional mandates for people in health benefit exchange. (Sec. 1311(d), 1401(b)(3)(D))
  - Can still require mandates for insurance outside exchange. (Sec. 1312(d)(2))

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Individual Mandate

- Citizens and legal immigrants will be required to pay penalty if they do not have qualified health insurance. (Sec. 1312(d), 1501, amended Sec. 1002 in Reconciliation)
  - Hardship waiver if health insurance is unaffordable.
  - If don't enroll, pay tax penalties.
    - Must pay the greater of: $95/person or 1% taxable income (2014); $325 or 2.0% (2015); or $695 or 2.5% (2016), increased by cost-of living adjustment.*
    - The maximum penalty is equal to the amount the individual or family would have paid for the lowest cost bronze plan (minus any allowable subsidy).
  - Required to report health insurance coverage to the IRS. (Sec. 1502)

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*Families of 3 or more will pay the greater of the percentage of income, or three times the individual penalty amount.

Individual Mandate

- Exemption/Affordability defined: (Sec. 1501(d)(2)-(4),(e))
  - Some of the exemptions include individuals who are not required to file taxes; without coverage for less than three months; and those for whom the lowest cost plan exceeds 8% of an individual's income.
- Individuals not required to change coverage under group plan or individual policy that person enrolled in as of March 23, 2010. (Sec. 1251, amended by Sec. 2301 of Reconciliation)
  - Existing plans are called "grandfathered" plans
- Individuals can enroll in qualified health plans in or outside the HBE. (Sec. 1312(a), 1312(d))

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Subsidies to Individuals

- Refundable and advanceable premium credits will be available to individuals with incomes up to 400% FPL on a sliding scale basis ($43,320/yr. for one person, $88,200 for a family of four in 2009).* (Sec. 1401, as amended Sec. 1001 of Reconciliation)
  - Subsidies based on the second lowest cost silver plan.
  - Limited to citizens and legal immigrants (including those who are barred from enrolling in Medicaid during the first 5 years in the country). (Sec. 1401(c))

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***2009 Federal Poverty Guidelines are: $10,830 for an individual, or $22,050 for a family of four**

Subsidies to Individuals

- Individuals are generally not eligible for subsidies if they have employer-based coverage, TRICARE, VA, Medicaid, or Medicare. (Sec. 1401(c)(2)(B)(C), 1501)
  - Employees are eligible for the premium credit if offered coverage by an employer that does not meet requirements for minimum essential benefits (60% actuarial value) or if the premium for employee-only coverage exceeds 9.5% of the employee's annual income. (Sec. 1401(c)(2)(C) as amended by Sec. 1001 of Reconciliation; Sec. 1501 creating 5000A of Internal Revenue Code of 1986)

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Sliding Scale Subsidies

Individual or family income	Maximum premiums (Percent of family income)	Out-of-pocket cost sharing:*	Out-of-pocket cost sharing limits**
<133% FPL	2% of income	6%	$1,983 (ind)/$3,967 (fam) (1/3rd HSA limits)
133-150% FPL	3-4%	6%	$1,983 / $3,967
150-200% FPL	4-6.3%	13%	$1,983/ $3,967
200-250% FPL	6.3-8.05%	27%	$2,975/ $5,950 (1/2 HSA limit)
250-300% FPL	8.05-9.5%	30%	$2,975/ $5,950
300-400% FPL	9.5%	30%	$3,967/ $7,934 (2/3rds HSA limit)

*Out-of-pocket cost sharing includes deductibles, coinsurance, copays.
**Out of pocket limits do not include premium costs. Annual cost sharing limited to: $5,950 per individual and $11,900 family in 2010 (HSA limits) (Sec. 1302(c), 1401, 1402, as amended by Sec. 1001 of Reconciliation)

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Employer Responsibilities

- Employers with 50 or more full-time employees required to offer insurance or pay penalty (Sec. 1201, 1513, amended Sec. 1003 Reconciliation)
  - Must offer affordable coverage to employee *and* dependents
  - But not required to pay for any part of the premium
  - However, subject to a penalty if:
    - Employer does not offer coverage that meets essential coverage requirements (premium covers 60% of the actuarial costs of the plan)
    - Employees qualify for and receive a subsidy in the health benefit exchange (because cost of premium for employee-only coverage exceeds 9.5% of the employee's income)

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Employer Responsibilities

- Potential penalties for employers with more than 50 employees (Sec. 1513, amended by Sec. 1003 Reconciliation)
  - If employer *does not offer* coverage, the employer must pay $2,000 per full-time employee, excluding first 30 employees.
  - If an employer *does offer* coverage, but at least one full-time employee qualifies for and receives a subsidy, then the employer must pay $3,000 for any full-time employee who receives a subsidy (but in no event more than $2,000 per FT employee, excluding the first 30 employees).
- Employers with 50 or fewer employees exempt from penalties. (Sec. 1513(d)(2))

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Free Choice Voucher

- Employers that offer essential coverage and pay a portion of the costs must provide a "free choice voucher" to certain employees (Sec. 10108)
  - If premium is between 8-9.8% of the employee's annual household income
  - Employee does not participate in the employer-sponsored insurance (ESI)
  - Amount of free choice voucher equal to amount employer would have paid if the individual participated in ESI
  - Employee can use the free choice voucher to purchase insurance through the Health Benefit Exchange

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Subsidies for Small Employers

- Employers with 25 or fewer employees and average annual wages of less than $50,000 can receive a tax credit. (Sec. 1421, Sec. 10105)
  - *Phase I (2010-2013):* 35% tax credit if for-profit employer provides coverage and pays at least 50% of total premium cost. (Full credit limited to employers with 10 or fewer employees and average annual wages of less than $25,000. Credit phases out for larger employers or higher average wages. Non-profit organization only eligible for 25%.)
  - *Phase II (2014-later):* Maximum of 50% tax credit for up to 2 years (with similar targeting and phase-out, non-profits eligible for up to 35% tax credit). *Subsidies only available for coverage purchased through the Health Insurance Exchange*.

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Health Benefit Exchange

- States will create American Health Benefit Exchange and Small Business Health Options (SHOP) Exchange for individuals and small businesses. (Sec. 1311, 1321)
  - To facilitate the purchase of qualified health plans
  - Limited to citizens and lawful residents who do not have access to employer-sponsored or governmental-supported health insurance and to small businesses with 100 or fewer employees (states can allow larger employers to enroll beginning 2017)* (Sec. 1312(f))
  - States will get initial grants to help establish HBEs, but must be self-sufficient beginning 2015 (Sec. 1311(a),(d)(5))
  - States can merge small group and individual markets (Effective Jan. 1, 2014; Sec. 1311(b)(2))

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*States can limit coverage into SHOP to small businesses with 50 or fewer employees until 2016.

Health Benefit Exchange

- Exchanges will:
  - Offer standardized information to help consumers choose between plans and develop rating system based on quality and cost. (Sec. 1311(d)(4)), 1311(c))
  - Offer navigators to provide information to the public about health plan choices and help them enroll. (Sec. 1311(i))
  - Determine eligibility for subsidy. If identify people eligible for Medicaid or CHIP, must enroll. (Sec. 1311(d)(4)(F), 1411, 1413)
  - Certify people who are exempt from insurance mandate and provide information to IRS. (Sec. 1311(d)(4))

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Health Benefits Exchange

- The following individuals or groups *must* obtain coverage through the HBE:
  - Individuals seeking premium and cost-sharing subsidies
  - Small businesses seeking tax credit
  - Individuals given the free choice voucher
- The following individuals or groups *may* obtain coverage through the HBE:
  - Any other qualified individual (ie, a citizen or lawfully present immigrant)
  - Small business (as defined by the state)

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Health Benefit Exchange

- States may:
  - Contract with state Medicaid agencies to determine eligibility for subsidy (Sec. 1311(f), 1413(d))
  - Allow agents or brokers to enroll people into plans and assist people in qualifying for subsidy (Sec. 1312(e))
- If states do not create qualifying HBE, then federal government will assume these responsibilities (Sec. 1321)

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Qualified Health Plans

- Qualified health plans must: (Sec. 1301, 1311, 10104)
  - Provide essential benefits package
  - Be licensed under state law
  - Offer at least one qualified health plan in silver and gold levels in the HBE
  - Agree to charge the same premium rate for each qualified health plan, whether or not offered through the HBE
  - Operate a single risk pool for the individual market (whether or not offered through the HBE), and a single risk pool for small employers
  - Be accredited, report on clinical quality measures, and implement activities to reduce health disparities (including language services)
  - Provide specific plan-related information to enrollees, in plain language

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New Insurance Plans Offered through HBE

- Secretary shall establish Consumer Operated and Oriented Plan (CO-OP) (Sec. 1322; 10104)
  - Loans and grants to foster creation of non-profit health insurance issuers to offer qualified health plans in individual and small group markets (loans must be paid back within 15 years)
  - Profits must be used to lower premiums, improve benefits or quality
  - Appropriates $6 billion to support this effort
- Multi-state or nationwide qualified health plan, at least one of which is non-profit (Sec. 10104, amending 1334)
  - Through contract with US Office of Personnel Management
- Basic Health Plan: States may establish basic health programs for individuals not eligible for Medicaid with incomes <200% FPL (Sec. 1331)

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NC Department of Insurance

- The North Carolina General Assembly gave the North Carolina Department of Insurance the authority to enforce the insurance provisions of the Patient Protection and Affordable Care Act

SECTION 24.2.(a) G.S. 58-2-40 is amended by adding a new subdivision to read:

"(10) Administer and enforce the provisions of the federal Patient Protection and Affordable Care Act (Public Law 111-148) and the provisions of the Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) to the extent that the provisions apply to persons subject to the Commissioner's jurisdiction and to the extent that the provisions are not under the exclusive jurisdiction of any federal agency."

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Sec. 24.2 of SB 897, Session Law 2010-0031

Immediate Insurance-Related Provisions

- Effective for plan years that begin after September 23, 2010:
  - Prohibits insurers from dropping coverage to people when they get sick (Sec. 1001, as amended Sec. 2301 of Reconciliation)
  - Prohibits insurers from denying coverage to children under age 19 with pre-existing conditions or imposing pre-existing condition exclusions (Sec. 1001, 1201, 10103(e))
  - Prohibits plans from imposing lifetime caps; and restricts use of annual caps (annual caps prohibited 2014) (Sec. 1001, as amended Sec. 2301 of Reconciliation)
  - Extends coverage for young people up to 26th birthday through parents coverage (Sec. 1001, as amended Sec. 2301 of Reconciliation)
  - *New* private plans must cover preventive services with no cost sharing (Sec. 1001)*

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* These provisions only apply to new group or non-group plans issued after the effective date. These provisions do not apply to grandfathered plans or ERISA plans.

Immediate Insurance-Related Provisions

- Effective for plan years that begin after September 23, 2010:
  - Enrollees can select any PCP from participating providers, can't be charged more for out-of-network emergency services, and can self-refer to an OB-GYN. (Sec. 10101)
- Appropriates to the states (effective immediately):
  - $30M (FY 2010) to states to support state health insurance consumer assistance offices to help individuals file complaints and appeals (Authorizes funds necessary in future years; Sec. 1002)
  - $250M (FY 2010-2014) to assist states in reviewing, and if appropriate under state law, approving premium increases for health insurance coverage and to make recommendations about whether insurers should be excluded from participation in Health Benefit Exchange based on unjustified rate increases (Sec. 1003)

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Immediate Provisions: Implementation Activities

- Requires insurers to spend at least 80% (individual and small group) or 85% (large group market) of premium dollars on medical services or provide rebate to enrollees (Reporting requirement 2010, rebate effective 2011; Sec. 1001, 10101)
- Appropriates $1B to the HHS Secretary to establish a Health Insurance Reform Implementation Fund (to carry out the provisions of the Patient Protection and Affordable Care Act) (Sec. 1005 of Reconciliation)
  - States will be eligible for grants to begin planning Health Benefit Exchanges. (Sec. 1311)

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Enrollment Simplification and Coordination

- States will be required to simplify enrollment and coordinate between Medicaid, CHIP, and the new Health Benefit Exchange (Sec. 2201; 1413)
  - Must conduct outreach to vulnerable populations (Sec. 2201)
  - Common application, electronic data exchange between programs, administrative data matches (Sec. 1413, 1414)

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Insurance Reform (2014)

- *Non-discrimination based on health status*: Insurers must enroll any individual or group, and cannot exclude, charge people more, or rescind policies because of preexisting conditions or use of health services (guarantee issue) (Effective 2014; Sec. 1201)
- *Rating limits in individual and small group market and exchange*: Insurers can only vary rates based on age (3:1), geographic rating area, family composition, and tobacco use (limited to 1.5:1 ratio) (Effective 2014; Sec. 1201)
- *Spreading risk across plans*: Insurers must participate in reinsurance program (CY 2014-2016), risk corridors (CY 2014-2016), and risk adjustment for individual and small group markets (Sec. 1341-1343)

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Insurance Reform

- Insurers are prohibited from:
  - Including annual or lifetime limits for essential benefits. (Sec. 1001, 10101)
  - Imposing a waiting period of more than 90 days. (Effective Jan, 1, 2014; Sec. 1201)

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Structure of the Health Benefit Exchange

- Workgroup will consider:
  - Whether the state should establish an exchange or leave it to the federal government (Sec. 1321(b))
  - Which entity will operate the exchange (state or non-profit) (Sec. 1311(d))
  - Whether to create one or two exchanges (for individual and small group) (Sec. 1311(b)(2))
  - What size employer to allow into the exchange (states can decide to limit small employer groups to <50 until Jan. 2016) (Sec. 1304(b)(3))
  - Whether to have one statewide exchange or regional exchanges within a state (Sec. 1311(f)(1)(2)))
  - Whether to participate in a regional exchange across state lines (Sec. 1311 (f))

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HBE Requirements

- In creating the HBE, the state must ensure the HBE will:
  - Certify qualified health plans and enroll co-op and federally approved multi-state plans (Secs. 1301, 10104, 1311, 1321, 1322, 1334)
  - Operate a toll-free hotline for consumers and employers, rate qualified health plans, present plan options in a standard format (Sec. 1311)
  - Determine eligibility for the subsidies and exemption from mandate, and report this information to Secretary and IRS (Secs. 1411, 1401(f)(3), 1001, 1004, 1412, 10105)
  - Credit the free choice voucher paid on behalf of a qualified employees and consider information from employers contesting imposition of penalties (Secs. 10108(d)(2), 1411(f)(2))

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Role of Patient Navigators and Agents

- Health Benefit Exchange must contract with qualified patient navigators. Navigators must: (Sec. 1311(i))
  - Have relationship with employers, employees, consumers
  - Conduct public education activities, distribute fair and impartial information, facilitate enrollment in qualified health plans, provide referrals to the consumer assistance or health information ombuds program, and provide information in culturally and linguistically appropriate manner
- Role of agents (Sec. 1311(i), 10104(h) 1312(e), (10104(i)(2))
  - Can serve as navigators
  - States may allow agents to enroll individuals and small employers into plans offered through HBE, and to assist individuals in applying for subsidies

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Consolidated Enrollment Process

- States must create a process to coordinate and streamline enrollment for the health benefit exchange, Medicaid and CHIP (Sec. 1413)
  - New federal HIT standards to facilitate enrollment of individuals in federal and state health and human service programs (Sec. 1561; potential grant opportunity for the state (1561(d))
  - Must use modified adjusted gross income in determining eligibility for Medicaid, CHIP, and eligibility for premium tax credit/cost sharing subsidy (Sec. 1004 of Reconciliation, Sec. 2001)
  - Will be able to obtain income information from IRS to determine eligibility for Medicaid, CHIP or premium tax credit/cost sharing subsidy (Sec. 1414)

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Consumer Assistance or Ombuds Program

- States eligible for awards to support offices of health insurance consumer assistance or ombuds programs
  - State must designate an independent office of health insurance consumer assistance or ombudsman that receives and responds to inquiries and complaints
  - Office shall assist with filing complaints and appeals, collect track and quantify problems and questions, educate consumers on rights and responsibilities, assist consumers with enrollment in health plans, and resolve problems obtaining premium tax credits (Sec. 2793 of the Public Health Service Act; Sec. 1002)

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Insurance Law Changes

- States must:
  - Establish a medical reimbursement data center (Secs. 2794 of 1003, 10101)
  - Establish rating areas (Sec. 2701(a)(2))
  - Adopt federal reinsurance laws and establish a nonprofit reinsurance entity (Sec. 1341, 10104(r)(1))
  - Assess a charge on health plans and insurers based on health risk (Sec. 1343)

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Insurance Law Changes

- States have the option to:
  - Establish higher medical loss ratios than 80%/85% (Sec. 2718(b))
  - Determine whether to enter into health care choice compact to offer qualified health plans across state lines (Sec. 1333)
  - Decide whether to continue to mandate coverage of certain benefits in the HBE (ie, mandated benefits) (Sec. 1311(d)(2)(3))*

*If state offers mandated benefits in the HBE, it must pay for the costs of the benefits. Mandated benefits can continue to be offered in plans outside the exchange.

State Option to Create Basic Health Plan

- States can create basic health plan (Sec. 1331)
  - For people between 133-200% FPL without access to affordable employer sponsored insurance
  - Must offer essential benefits, and ensure enrollees not charged more than would have paid to purchase silver plan
  - Cost sharing can not exceed 10% for people with incomes <150% FPL, or 20% for those with incomes between 150-200% FPL
  - States can contract with one or more plans to provide benefits
  - States will receive 95% of what federal government would have paid in premium and cost sharing subsidies

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Waiver for State Innovation

- States can apply for waiver of certain provisions of the ACA, including requirements for qualified health plans, essential health benefits, and affordable choice (Sec. 1332)
- To be approved for the waiver:
  - States must engage in a process of public notice and comment
  - States must ensure the waiver provides coverage at least as comprehensive as essential benefits offered through exchange, that costs are at least as affordable, and that the waiver will cover at least a comparable number of people

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Useful Resources

- Senate Bill: Patient Protection and Affordable Care Act (HR 3590 signed into law March 23, 2010)
  http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h3590enr.txt.pdf
- Health Care and Education Reconciliation Act of 2010 (HR 4872 signed into law March 30, 2010)
  http://frwebgate.access.gpo.gov/cgi-bin/getdoc.cgi?dbname=111_cong_bills&docid=f:h4872eh.txt.pdf
- Kaiser Family Foundation
  http://www.kff.org/healthreform/upload/8061.pdf
- Congressional Budget Office
  http://www.cbo.gov/ftpdocs/113xx/doc11379/Manager'sAmendmenttoReconciliationProposal.pdf
  http://www.cbo.gov/ftpdocs/114xx/doc11490/LewisLtr_HR3590.pdf
  http://www.cbo.gov/ftpdocs/114xx/doc11493/Additional_Information_PPACA_Discretionary.pdf

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