Update on the Uninsured

HBE Federally Mandated & State Optional Provisions

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NCIOM North Carolina Institute of Medicine
shaping policy for a healthier state

Agenda

- New data on the uninsured
- Operation of a Health Benefit Exchange
- Discussion questions

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- **New data on the uninsured**
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- Discussion Questions

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Data on the NC Uninsured

- Focus on non-elderly population below age 65
  - Medicare nearly universal in 65 and older population
- Most statistics come from Current Population Survey Annual Social and Economic Supplement (U.S. Census)
  - Approximately 4000 North Carolinians asked about coverage in prior year
- Most recent data released September 16, 2010
  - Includes data from March 2010 survey, which asks questions about insurance coverage in 2009

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Potential HBE Eligibles: Uninsured (0-64 years old)

- Approximately 20% of the non-elderly (0-64) were uninsured in 2008-2009 (~1.6 million people)
  - Family income (as percent FPG):
    - ~727,000 (45% of uninsured) have incomes <133% FPG—***most eligible for public coverage***
      ~723,000 (45%) have incomes 133-400% FPG—***some will be eligible for subsidies through the HBE***
      ~157,000 (10%) have incomes >400% FPG
  - Citizenship
    - ~ 1.33 million (83% of uninsured) are citizens
      ~ 277,000 (17%) are non-citizens (*Note: many non-citizens are in the United States legally and eligible for coverage in the HBE*)

Source: Holmes M. Analysis of the Current Population Survey, 2009 and 2010 Annual Social Economic Supplement (reflecting insurance coverage in 2008-2009)

Potential HBE Eligibles: Uninsured (0-64 years old)

- Age:
  - ~ 282,000 (18% of the uninsured) are children between the ages of 0-18
    ~ 485,000 (30%) are young adults between the ages of 19-29 (*Note: these individuals would be eligible for catastrophic coverage in the HBE)*
    ~ 449,000 (28%) are people between the ages of 30-44
    ~ 229,000 (14%) are people between the ages of 45-54
    ~ 162,000 (10%) are people between the ages of 55-64

Source: Holmes M, Yorkery B. Analysis of the Current Population Survey, 2009 and 2010 Annual Social Economic Supplement (reflecting insurance coverage in 2008-2009)

Potential HBE Eligibles: Uninsured *Adults* (19-64 years old)

- Approximately 23% of the non-elderly adults (19-64) were uninsured in 2008-2009 (~1.3 million people)
  - Family income (as percent FPG):
    - ~579,000 (44% of uninsured) have incomes <133% FPG—***many will be eligible for public coverage***
      ~607,000 (46%) have incomes 133-400% FPG—***some will be eligible for subsidies in the HBE, if they do not have access to affordable employer-based coverage***
      ~139,000 (11%) have incomes >400% FPG

Source: Holmes M, Yorkery B. Analysis of the Current Population Survey, 2009 and 2010 Annual Social Economic Supplement (reflecting insurance coverage in 2008-2009)

Potential HBE Eligibles: Uninsured *Adults* (19-64 years old)

- Approximately 23% of the non-elderly adults (19-64) were uninsured in 2008-2009 (~1.3 million people)
  - Employment status of individual adult
    - ~ 333,000 (25% of uninsured) were not in the labor force
    - ~ 211,000 (16%) were unemployed
    - ~ 247,000 (19%) were working part-time
    - ~ **534,000 (40%) were working full-time**
  - Of the 534,000 full-time, uninsured workers:
    - ~276,000 (52% of uninsured, full-time workers ages 19-64) work for firms with <25 employees *(some may gain coverage through HBE)*
    - ~70,000 (13%) work for firms with 25-99 employees *(some-HBE)*
    - ~166,000 (31%) work for larger employers (100+ employees)

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Source: Holmes M, Yorkery B. Analysis of the Current Population Survey, 2009 and 2010 Annual Social Economic Supplement (reflecting insurance coverage in 2008-2009)

Potential HBE Eligibles: Uninsured *Adults* (19-64 years old)

- 295,000 of the 534,000 full-time workers have incomes between 133-400% FPG. These individuals may be eligible for subsidies in the HBE if they do not have access to affordable employer-sponsored insurance. Of these:
  - ~157,000 (53% of uninsured, full-time workers ages 19-64 with incomes between 133-400%) work for firms with <25 employees
  - ~39,000 (13%) work for firms with 25-99 employees
  - ~95,000 (32%) work for larger employers (100+ employees)

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Source: Holmes M, Yorkery B. Analysis of the Current Population Survey, 2009 and 2010 Annual Social Economic Supplement (reflecting insurance coverage in 2008-2009)

Potential HBE Eligibles: *Uninsured Children* (<19 years old)

- Approximately 12% of the children (0-18) were *uninsured* in 2008-2009 (~282,000 million people)
  - Family income
    - ~ 214,000 (76% of uninsured children) were in families with incomes <200% FPG—***most eligible for public coverage***
    - ~ 50,000 (18%) were in families with incomes between 200-400% FPG—***some will be eligible for subsidies in HBE***
    - ~ 18,000 (6%) were in families with incomes >400% FPG

Source: Holmes M, Yorkery B. Analysis of the Current Population Survey, 2009 and 2010 Annual Social Economic Supplement (reflecting insurance coverage in 2008-2009)

Potential HBE Eligibles: Small Group Coverage (2008-2009, MEPS)

	Less than 50 employees	50-99 Ees	<100 Ees
Number of private sector establishments (Table II.A.1)	139,286	6,161	145,447
Number of private sector employees (Table II.B.1)	908,267	208,328	1,116,595
Number of private sector employees enrolled in health insurance through their job	284,055	113,497	397,552
Number of private sector employees working for small firms who are NOT enrolled in health insurance through their job	624,212	94,831	719,043

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Source: Schiro S. Analysis of the Medical Expenditure Survey Data. Agency for Healthcare Research and Quality. 2008-2009.

Potential HBE Eligibles: Background Data on Small Group Coverage (2008-2009, MEPS)

	Less than 50 employees	50-99 Ees	<100 Ees
Percent of private sector employees in establishments that offer health insurance (Table II.B.2)	55.5%	80.1%	60.1%
Percent of private sector employees eligible for health insurance in establishments that offer health insurance (Table II.b.2.a)	77.4%	84.6%	79.2%
Percent of private sector employees eligible for health insurance that are enrolled in health insurance in establishments that offer (Table II.B.2.a.1)	72.8%	80.4%	74.8%
Percent of private sector employees that are enrolled in health insurance at establishments that offer health insurance (Table II.B.2.b)	56.3%	68.1%	59.2%

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Source: Schiro S. Analysis of the Medical Expenditure Survey Data. Agency for Healthcare Research and Quality. 2008-2009.

Agenda

- New data on the uninsured
- **Operation of a Health Benefit Exchange**
  - **Federally mandated provisions**
  - Provisions where the state has flexibility in the design and operation of the HBE
- Discussion Questions

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Health Benefit Exchange (HBE) Requirements

- Exchanges must:
  - Implement procedures for the certification, recertification, and decertification of qualified health plans and enroll co-op and federally approved multi-state plans (Secs. 1301, 10104, 1311 (d)(4)(A), 1321, 1322, 1334)
  - Provide for the operation of a toll-free telephone hotline to respond to requests for assistance (Sec. 1311(d)(4)(B))
  - Assign a quality rating to each qualified health plan offered through the HBE (Sec. 1311(d)(4)(D))
  - Maintain an internet website that uses standardized comparative information on plan options that includes costs and quality rating (Secs. 1311 (c), 1311(d)(4)(C), 1311(d)(4)(E))

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Health Benefit Exchange (HBE) Requirements

- Exchanges must:
  - Determine eligibility for the premium subsidy and cost sharing reductions (Secs. 1411, 1401(f)(3), 1412, 10105; as amended by1001, 1004 of Reconciliation)
  - Inform people about eligibility for Medicaid and CHIP, and if eligible, enroll the individuals into these programs (Secs. 1311(d)(4)(F), 1411, 1413)
  - Establish and make available an electronic calculator to determine the costs of coverage after applicable premium tax credits and cost sharing reduction (Sec. 1311(d)(4)(G))
  - Certify individuals who are exempt from the mandate (Sec. 1311(d)(4)(H))
  - Provide information to the Secretary of DHHS about anyone who is eligible for the premium tax credit or cost-sharing reductions, and the level of coverage (Sec. 1401(f)(3), as amended by 1004(c) of Reconciliation)

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Health Benefit Exchange (HBE) Requirements

- Exchanges must:
  - Provide the Secretary of the Treasury information about anyone who is exempt; anyone who is receiving a subsidy who works for an employer required to offer insurance; and information about individuals who change employers and who cease coverage under a qualified health plan (Sec. 1311(d)(4)(I))
  - Provide information to employers of any employee who ceases coverage under a qualified health plan (Sec. 1311(d)(4)(J))
  - Establish a navigator program to provide information to the public about health plan choices and help them enroll (Sec. 1311(d)(4)(K), 1311 (i))

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HBE Requirements

- Exchanges must:
  - Consult with stakeholders relevant to carrying out required activities (Sec. 1311(d)(6))
  - Publish average costs of licensing, regulatory fees and other payments to the HBE, and administrative costs (Sec. 1311(d)(7)
  - Report on all activities, receipts and expenditures annually to the Secretary of DHHS (Sec. 1313)
  - Credit the free choice voucher paid on behalf of qualified employees and consider information from employers contesting imposition of penalties (Secs. 10108(d)(2), 1411(f)(2))

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HBE Requirements

- Exchange must be self-sufficient beginning January 1, 2015. Exchange can charge assessments or user fees to participating health insurance issuers or otherwise generate funding (Sec. 1311(d)(5)(A))
- If states do not create qualifying HBE, then federal government will assume these responsibilities (Sec. 1321)

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Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
  - Meet marketing requirements
  - Ensure sufficient choice of providers and provide information about in-network and out-of-network providers
  - Include essential community providers in the network
  - Be accredited on clinical quality measures and implement a quality improvement strategy
  - Utilize a uniform enrollment form
  - Provide standardized health plan information
  - Report pediatric quality reporting measures
  - Submit a justification for any premium rate increase prior to the increase

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Qualified Health Plans

- To be certified, a 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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Qualified Health Plans

- To be certified, a qualified health plans must: (Sec. 1301, 1311, 10104)
  - Provide specific plan-related information to enrollees, in plain language, including information on finances, enrollment and disenrollment, denied claims, out-of-network costs, claims payment policies and practices.
  - Provide timely information about the amount of cost-sharing (deductibles, copayments and coinsurance), and make this information available through the Internet

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State Flexibility (If State Operates HBE)

- States can:
  - Determine governance structure of the HBE: state, quasi state, or nonprofit (Sec. 1311(d))
  - Choose whether to create two HBEs, or merge non-group and small group HBE (Sec. 1311(b)(2))
  - Determine the size of small employers allowed to purchase health insurance in the exchange
    - Initially states can decide to limit small employer groups to <50 until Jan. 2016, after which states must offer coverage to businesses with <100 employees (Sec. 1304(b)(3))
    - In 2017, states can decide whether to open the HBE to businesses with more than 100 employees (Sec. 1312(f))

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State Flexibility (If State Operates HBE)

- States can:
  - Determine whether to have one statewide exchange or substate regional exchanges within a state (Sec. 1311(f)(1)(2))
  - Decide whether to participate in an interstate regional exchange (Sec. 1311 (f))
  - Identify and establish contractual or grant arrangements with partner organizations, including patient navigators, and any other contractor needed to carry out responsibilities of the HBE (Sec. 1311(i), 1311(f))
  - Allow agents or brokers to enroll people into plans and assist people in qualifying for subsidy (Sec. 1312(e)) (Note: this is likely separate from the navigator function).

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State Flexibility (If State Operates HBE)

- HBE may certify qualified health plan if health plan meets the requirements for certification and, the HBE determines making the plan available through the HBE is in the interests of qualified individuals and employers in the state (Sec. 1311(e))
  - Implies that HBE (and/or states if operating the HBE) has discretion to limit number of plans
- HBEs may help facilitate enrollment for small employers by administering premium transactions
  - This would include monthly premium billing, collection, changes in coverage status, notices for delinquent payments, renewal notices, etc.

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Premium Flow for Small Business

- HBEs can play different roles:
  - If the HBE acts solely as an information source about different health plans, then small business offering a choice of health plans to employees might need to submit separate monthly premium checks to multiple insurers.
  - If the HBE helps to administer the premium billing, collection and remittance to the insurers, the small business can pay one check for all employees to HBE. HBE distributes to insurers.

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- New data on the uninsured
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- **Discussion Questions**
  - **Should the state operate an HBE or leave it to the federal government?**
  - **If state, what is the appropriate administrative structure? Governance structure?**

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Federal vs. State Exchange

Pros of State Operated HBE	Pros Fed
• State maintains regulatory authority over large share of commercial market •Mitigate risk selection that can result from different rating and underwriting rules for insurance sold in and outside of HBE •Greater coordination of benefits and eligibility rules b/t HBE, Medicaid, CHIP •Ability to promote state health reform strategies and priorities through HBE (including payment reform, support for medical homes) •More control over number and types of plans offered through HBE •If federal government operates HBE, carriers may be subject to two sets of rules and reporting requirements for policies sold in HBE (federal oversight), and those sold outside (state oversight)	•Challenge of creating a new program •Requirement that HBE be self-sustaining by 2015 •Tension between keeping administrative fees low and satisfying demands for high quality customer service

Source: Carey B. Health Insurance Exchanges: Key Issues for State Implementation. State Coverage Initiatives. Sept. 2010.

Group Discussion

Pros of State Operated HBE	Pros Fed

Source: Carey B. Health Insurance Exchanges: Key Issues for State Implementation. State Coverage Initiatives. Sept. 2010.

Group Discussion

Administration/Governance

- HBE can operate through existing state agency, quasi-state organization, or nonprofit
  - Massachusetts Connector: Independent public entity.
    - 10 member board: 4 designated public officers, 3 appointed by Governor, 3 appointed by Attorney General
  - Utah Health Exchange: State agency (office of Consumer Health Services, Governor's Office of Economic Opportunity)
  - California Exchange: Independent agency
    - 5 member board: 1 appointed by Secretary of Health and Human Services, 2 appointed by Governor, 1 appointed by Senate Committee on Rules, 1 appointed by Speaker of the Assembly

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Source: Jost T. Health Insurance Exchanges and Affordable Care Act. Eight Difficult Issues. Commonwealth Fund. Sept. 2010.

Administration

- If *state agency*, choices could include: Department of Insurance (DOI); Division of Medical Assistance (DMA); State Health Plan (SHP); or Governor's Office.
  - Potential issues:
    - DOI: May pose a conflict both being an administrator, and a regulator
    - DMA: Extensive experience with public programs, less experience with commercial insurance
    - SHP: Individual and small group market different than large group
    - Governor's office (or other agencies): not set up to administer premium subsidies or operate insurance program

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Source: Carey B. Health Insurance Exchanges: Key Issues for State Implementation. State Coverage Initiatives. Sept. 2010.

Administration (cont'd)

- If *quasi-state*, need to determine:
  - Whether state procurement rules apply, conflict of interest and public disclosure, whether staff subject to civil services rules and state compensation levels
  - Who makes board appointments?
- If *non-profit*, need to decide:
  - Whether non-profit organization has the legal authority to carry out all of the "public" regulatory requirements of the ACA
  - How to ensure coordination between HBE and Medicaid, DOI
  - How to ensure public accountability
  - Who makes board appointments?

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Source: Carey B. Health Insurance Exchanges: Key Issues for State Implementation. State Coverage Initiatives. Sept. 2010.

Administration: Pros & Cons

State Executive Agency	Quasi State	Non Profit
Pros: •Direct link to state administration, and easier to coordinate with other state agencies *Cons:* •Decision-making and operations become politicized •Difficulty to be nimble in hiring, contracting	*Pros:* •Exemption from state personnel and procurement laws •More independence from existing state agencies (less chance of politicization) *Cons:* •Difficult to coordinate health purchasing strategies and initiatives with other state agencies	*Pros:* •Flexibility in decisions making and less opportunity to become politicized *Cons:* •Isolation from state policy maker and key state agency staff •Decreased public accountability

Source: NAIC. American Health Benefit Exchange Model Act. Sept. 27, 2010

Group Discussion

State Executive Agency	Quasi State	Non Profit
Pros:	*Pros:*	*Pros:*
Cons:	*Cons:*	*Cons:*

Source: NAIC. American Health Benefit Exchange Model Act. Sept. 27, 2010

Group Discussion

Governance Structure: Board Roles and Responsibilities

- Board structure
  - Can be an executive agency (if state agency)
  - If non-profit or quasi-governmental organization, would need independent board
    - How would board members be selected?
- Board roles and responsibilities
  - Policy making
  - Approving contracts
  - Setting carrier selection criteria
  - Overseeing HBE staff

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Source: Carey B. Health Insurance Exchanges: Key Issues for State Implementation. State Coverage Initiatives. Sept. 2010.

Board Selection Options

- Can have designated stakeholder "slots"
  - Could include board slots for key state agencies that would also be involved in regulatory oversight or administration of health coverage (ie, Medicaid, DOI)
  - Stakeholder groups including consumers, small business
- Could require specific "competencies"
  - For example: health economists, actuaries, or experts in health policy
- Board appointments should avoid real or potential conflicts of interests

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Source: Jost T. Health Insurance Exchanges and Affordable Care Act. Eight Difficult Issues. Commonwealth Fund. Sept. 2010.

Board Selection Discussion

Next Steps

- What information is needed for next meeting?