

# Health Insurance Exchanges



**Layna S. Cook**

Baker, Donelson, Bearman, Caldwell & Berkowitz, PC

450 Laurel Street, 20th Floor

Baton Rouge, LA 70801

225.381.7000

E-mail: [lcCook@bakerdonelson.com](mailto:lcCook@bakerdonelson.com)

[www.bakerdonelson.com](http://www.bakerdonelson.com)

## What We Will Cover

- What is provided for in the Patient Protection and Affordable Care Act relative to the Exchanges.
- Projections on Exchange populations and available subsidies.
- States' responses to legislation relative to the Exchanges.
- Current models in place.
- The future for Louisiana's Exchange.

## The Purpose of an Exchange

- To promote transparency in health insurance
- Increase competition
- Increase portability of coverage
- Facilitate ease of enrollment in health insurance plans

## Timeline of Events

<b>October 2010</b>	HHS awards first round of planning and establishment grants to states
<b>2011 – 2012</b>	States authorize exchange through legislation
<b>January 2013</b>	HHS determines if state is willing and able to open exchange by January, 2014
<b>July 2013</b>	Exchange soft launch
<b>January 2014</b>	State exchange must be fully operational
<b>January 2015</b>	Exchange must be self-sustaining
<b>2016</b>	Small group must be expanded to groups up to 100 EEs
<b>2017</b>	State <i>may</i> open exchange to large groups (>100 EEs)

## The Exchanges

- States required to establish American Health Benefit (AHB) Exchange and Small Business Health Options Program (SHOP) Exchange.
- States are permitted to merge AHB and SHOP into one Exchange.
- States permitted to form more than one Exchange, if that Exchange serves a specified geographical area.
- The law allows for multi-state Exchanges.

## Requirements of Exchanges

- Must be operated by a State-established governmental agency or nonprofit entity (*i.e.* not an insurance company or broker)
- Required to publish average costs of licensing, regulatory fees as well as administrative costs
- Must make qualified health plans (QHP) available to individuals and small businesses and barred from including non-qualified plans

## Functions of the Exchanges

- Implement procedures for certification, recertification and decertification of health plans as QHP.
- Provide a telephone hotline to respond to requests for assistance.
- Provide an Internet portal for enrollees to obtain comparative plan information.
- Assign a rating of plan premiums and quality.
- Utilize a standardized format for presenting benefit options.
- Inform individuals of eligibility requirements for Medicaid, CHIP or any applicable state or local public program and enroll such individual if he or she is eligible.

## Functions of the Exchanges

- Establish an electronic calculator to determine cost of coverage.
- Grant a certification attesting that an individual is exempt from the individual mandate to have insurance because no affordable QHP is available and notify the Treasury Secretary.
- Provide each employer name of employee who ceases coverage in a QHP during the year.
- Require QHPs to submit justification for any premium increase prior to implementation of increase.

## Qualified Health Plan

- QHP is defined as a plan that:
  - Is certified by the Exchange through which it is offered that it meets the Act's certification criteria
  - Provides the Essential Health Benefits
  - Is offered by an insurer that is:
    - Licensed and in good standing in each state in which it offers coverage
    - Agrees to offer at least one QHP in the silver and gold levels in each Exchange
    - Complies with the regulations promulgated by the Secretary

## Essential Health Benefits

- Each QHP must offer a core set of “essential health benefits” set by HHS.
- The scope of essential health benefits must equal the scope of benefits provided under a typical employer plan.
- If a State mandates additional benefits, it must provide payment to the enrollee, or to the plan on the individual’s behalf, for the incremental premium cost attributable to the extra mandated benefit.
- No impact on state benefit mandates outside Exchange.

## Benefit Categories

- **Bronze Plan:** provides essential health benefits and pays for 60% of the costs of the plan with the HSA out-of-pocket limits
- **Silver Plan:** provides essential health benefits and pays for 70% of the costs of the plan with the HSA out-of-pocket limits
- **Gold Plan:** provides the essential health benefits and pays for 80% of the costs of the plan with the HSA out-of-pocket limits
- **Platinum Plan:** provides the essential health benefits and pays for 90% of the costs of the plan with the HSA out-of-pocket limits
- **Catastrophic Plan:** available to those up to age 30 or to those who are exempt from the mandate to purchase coverage

## Consumer Operated and Oriented Plans

- Loans and grants available to create non-profit, member-run health insurance companies known as Consumer Operated and Oriented Plans (CO-OPs).
- To be eligible to receive federal funds, an organization wanting to set up a CO-OP must meet the following requirements:
  - not be an existing health insurer or sponsored by a state or local government
  - its activities must only consist of the providing and managing health benefit plans in each state in which it is licensed
  - control of the organization must be subject to a majority vote of its members
  - must operate with a strong consumer focus
  - all profits must be used to lower premiums, improve benefits, or improve the quality of health care delivered to its members

## Deductibles for QHP

- Employer small group plans in Exchange may not have deductibles >\$2,000 for individual coverage and >\$4,000 for family coverage.
- These may be increased by employer contributions under flexible spending plans.
- The cap rises by a percentage formula for years after 2014 and is then rounded up to the nearest \$50 increment.

## Eligible Small Groups

- A small employer with an ERISA group health plan can participate in the Exchange if all full-time employees are eligible for coverage.
- “Small group” means an employer that in the previous year averaged 1 or more employees but not more than 100.
  - Until 2016, a State can substitute 50 for 100.
- A small employer in the Exchange will continue to be treated as small until it leaves the Exchange, even if it becomes larger.

## Eligible Individuals

- Any person qualifies for individual Exchange QHP coverage if he or she lives in the State, is not incarcerated (except for those awaiting disposition of charges), and does not otherwise have credible coverage
- Refundable premium assistance credit only available to individuals purchasing through the Exchange
- Individuals purchasing through Exchange may be eligible for cost sharing reduction

## Eligible Large Groups

- Large groups may not participate in state Exchanges until 2017.
- Starting in 2017, a State may permit insurers to provide coverage for large employers through the Exchange.

## Projections on Exchange Populations

- The Congressional Budget Office has estimated that approximately 24 million people will purchase coverage through the AHB Exchanges by 2019.
- An additional 5 million are expected to receive health insurance through the Exchanges because they work for an employer that allows all of their workers to choose among health insurance plans offered from the Exchange.

## Projected Enrollees – Year 2019

- Approximately 16 million individuals who would otherwise be uninsured.
- Three and a half million individuals who lose their employer-based insurance.
- One and a half million individuals who previously had employment-based coverage but whose financial contribution for the coverage exceeds 9.5% of their total family income.
- One million individuals who would otherwise purchase health insurance in the non-group market.
- Two million adults above 138% FPL who lose their Medicaid coverage.

## Availability of Subsidies

- CBO estimates that about 81% of individuals purchasing their own coverage through the Exchanges in 2019 will receive subsidies.
- Subsidies are only available on coverage bought through the Exchanges.
- The subsidies are federally funded and available to citizens and legal US residents with incomes below 400% FPL.
- To qualify enrollees cannot be eligible for any other source of minimum essential coverage (such as Medicaid or Medicare) and cannot have an affordable offer of insurance from their employer.

## Availability of Subsidies

- The amount of the subsidy decreases with increasing income, both as a specified amount and as a proportion of income.
- Individuals and households with incomes below 138% FPL are expected to enter into the expanding Medicaid program.
- Households earning less than 250% FPL will receive subsidies for the cost-sharing component of their health insurance packages.
- Enrollees with incomes greater than 400% FPL are not eligible for subsidies.

## Tax Credits

- The amount of the tax credit that a person can receive is based on the premium for the second lowest cost silver plan in the Exchange in area where the person is eligible to purchase coverage.
- The amount of the tax credit varies with income such that the premium that the premium a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income (adjusted for family size).

<b>Income Level</b>	<b>Premium as a Percent of Income</b>
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

## Employer Penalties

- Employers with at least 50 full-time *equivalent* employees will face penalties, beginning in 2014, if one or more of their full-time employees obtains a premium credit through an Exchange.
- An individual may be eligible for a premium credit either because the employer does not offer coverage or the employer offers coverage that is either not “affordable” or does not provide “minimum value.”

## Employer Penalties

- Only a large employer may be subject to penalties.
- A “large employer” is an employer with more than 50 full-time *equivalent* employees during the preceding calendar year.
- “Full-time employees” are those working 30 or more hours per week.<sup>3</sup> The number of full-time employees excludes those full-time seasonal employees who work for less than 120 days during the year.
- The hours worked by part-time employees (i.e., those working less than 30 hours per week) are included in the calculation of a large employer, on a monthly basis, by taking their total number of monthly hours worked divided by 120.
- *Example* - A firm has 20 part-time employees who all work 24 hours per week (96 hours per month).  
 $20 \text{ employees} \times 96 \text{ hours} / 120 = 1920 / 120 = 16 \text{ full-time equivalents.}$

## Employer Penalties

- Employers will *not* be treated as meeting the employer requirements if at least one full-time employee obtains a premium credit in an Exchange plan because the employee's required contribution exceeds 9.5% of the employee's household income or if the plan offered by the employer pays for less than 60% of covered expenses.
- In 2014, the *monthly* penalty assessed to the employer for each full-time employee who receives a premium credit will be 1/12 of \$3,000 for any applicable month.
- However, the total penalty for an employer would be limited to the *total* number of the firm's full-time employees minus 30, multiplied by 1/12 of \$2,000 for any applicable month.
- After 2014, the penalty amounts will be indexed by a premium adjustment percentage for the calendar year.

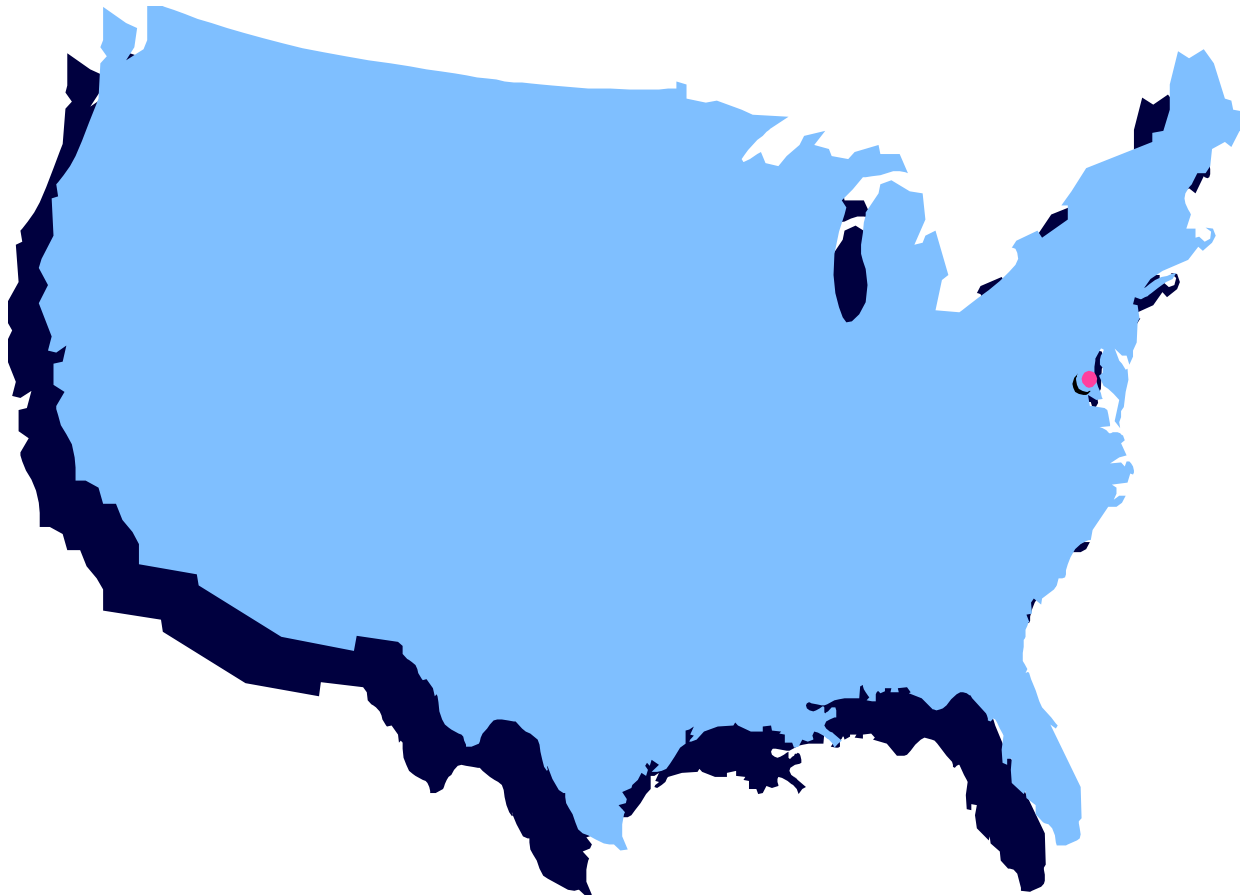
## Free Choice Vouchers

- An employer who offers minimum essential coverage and pays any portion of the premium must provide free choice vouchers to each qualified employee.
- A “qualified employee” is defined as an employee whose required contribution to the employer plan, for self-only coverage, is greater than 8% and less than 9.8% of the employee’s household income for the taxable year, whose household income is not greater than 400% of the FPL for the relevant family size, and who does not participate in the plan offered by the employer.
- Beginning after 2014, the 8% and 9.8% would be indexed by the rate of premium growth over the rate of income growth.

## Free Choice Vouchers

- The voucher will be equal to the monthly amount that the employer would have contributed toward the plan for which the employer pays the largest portion of plan costs, for either self or, if elected by the employee, family coverage.
- An Exchange will credit the amount of a voucher to the monthly premium of an Exchange plan in which the qualified employee is enrolled, and the employer will pay the Exchange the credited amount.
- If the amount of the voucher exceeds the premium, the excess will be paid to the employee.
- An individual receiving a free choice voucher will not be eligible for the Exchange premium credits or cost-sharing subsidies.
- No penalty will be imposed on an employer with respect to any employee who is provided with a voucher.

## States' Responses to the Exchanges



## Premium Review Grants

- On September 30, 2010, HHS announced \$49 million dollars in grants to help 48 States and the District of Columbia plan for the establishment of the health insurance Exchanges.
- The grants of up to \$1 million were to provide States with resources to conduct the research and planning needed to build their health insurance marketplace and determine how their Exchanges will be operated and governed.

## Premium Review Grants

- Forty-six states received grants.
- At least five states have returned their grants, including Louisiana.

## Early Innovator Grants

- On February 16, 2011, the U.S. Department of Health and Human Services (HHS) announced the award of seven cooperative agreements to help a group of “Early Innovator” states design and implement the Information Technology (IT) infrastructure needed to operate the Exchanges.
- The grants to these seven states totaled approximately \$241 million dollars.
- Using these funds, the Early Innovator states are to develop Exchange IT models that can be adopted and tailored by other states.

## Kansas

- Award Amount: \$31,537,465
- Kansas is extending the new Kansas Medicaid/CHIP eligibility system (K-MED) and integrating K-MED with the Kansas Health Insurance Exchange.
- Kansas is in preliminary discussions with Missouri to partner on their Exchange.
- Depending on the interest of other states and potential arrangements with strategic business partners, Kansas may explore the possibility of creating a “cloud” solution for other states to have their own instance of one or more of these healthcare applications.

## Maryland

- Award Amount: \$6,227,454
- Maryland proposes to build off a prototype it has already developed that models the point of access for the Exchange, integration with Maryland legacy systems and the federal portal systems, and Maryland's consumption of planned federal web services (e.g. verification and rules).
- The technology foundation used by Maryland in its Healthy Maryland initiative is currently being used by several other states. This “point” solution will extend the existing Healthy Maryland platform, which was recently implemented.

## Massachusetts

- Award Amount: \$35,591,333
- This is a multi-state consortia proposal led by the University of Massachusetts Medical School and will include individuals and small businesses in Connecticut, Maine, Massachusetts, Rhode Island, and Vermont.
- The plan is to create and build a flexible Exchange information technology framework in Massachusetts and share those products with other New England states.
- The proposal hopes to learn from the Massachusetts Exchange implementation and gain efficiencies so it can accelerate Exchange development for participating New England states.

## New York

- Award Amount: \$27,431,432
- New York proposes to build off its eMedNY Medicaid Management Information System (MMIS) system to build products for the Exchange.
- The eMedNY Medicaid Management Information System (MMIS) processes payments for approximately one of every three health care dollars paid in the state. It is also the primary source of Medicaid data used for financial reporting, program analysis, auditing, and quality measurement.
- The Department plans to use MMIS' assets as the basis for designing and developing an Exchange to serve all New York State health insurance consumers.

## Oklahoma

- Award Amount: \$54,582,269
- Oklahoma proposed to extend its current technical architecture of Medicaid Management Information System (MMIS) and several other systems to implement the Oklahoma Health Infrastructure and Exchange initiative.
- It would leverage tools such as the web-based real time claims processing provider service portal created in 2003 by the Oklahoma Health Care Authority.
- Oklahoma has announced that it will not accept its grant and has determined not to create an Exchange.

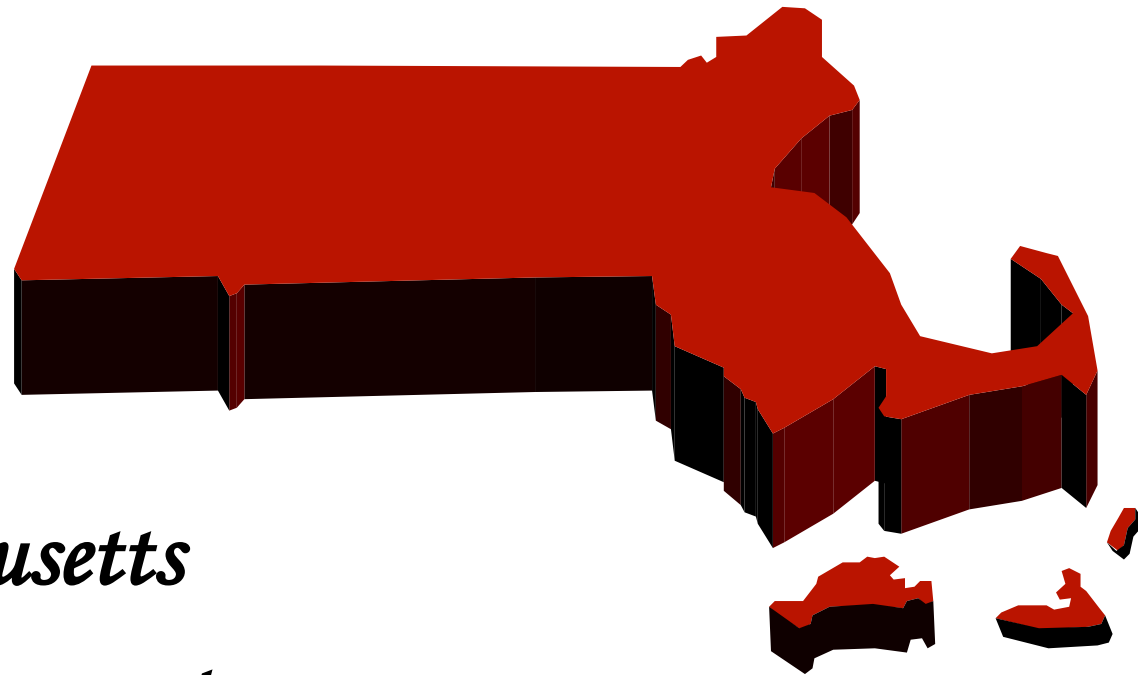
## Oregon

- Award Amount: \$48,096,307
- Oregon is using commercially available, off-the-shelf software to create the Exchange.
- Oregon intends on creating a modular, reusable IT solution that will provide the Exchange's customers with seamless access to information, financial assistance and easy health insurance enrollment, with no gaps in coverage or assistance cliffs for anyone up to 400% of the federal poverty level.

## Wisconsin

- Award Amount: \$37,757,266
- Wisconsin's proposal envisions a single, intuitive portal through which residents can access subsidized and non-subsidized health care and other state-based programs (e.g. Medicaid, CHIP, child care).
- The Exchange will integrate across health and human services programs to promote efficiency and lower overall administrative cost.

## The Forerunners



*Massachusetts  
Health Connector*

## Massachusetts Health Connector

- Implemented in 2006 as part of Massachusetts' health care reform.
- An independent quasi-governmental exchange made to purchase affordable insurance by small businesses and individuals without employer-sponsored coverage.
- It facilitates purchase of insurance by individuals and groups by providing exchange for purchase of plans, collecting payments, and dispersing them to insurers.
- It defines minimum coverage insurers can provide.
- It provides certification for those that are exempt from mandated coverage.

## The Forerunners

# Utah Health Exchange



## Utah Health Exchange

- The Exchange assists small groups offering defined contribution coverage.
- It does not have a subsidized program comparable to Massachusetts'.
- It has a limited operating budget - \$750,000 annually with just two full-time staff plus contractors.

# Louisiana's Exchange



## Louisiana's Exchange

- Louisiana was provided a research grant of \$998,416.00.
- On March 23, 2011, the Secretary of the Louisiana Department of Health and Hospitals, Bruce Greenstein, announced that Louisiana would not implement a state-run exchange.
- On March 24, 2011, Secretary Greenstein returned the premium review grant provided by HHS.

## Federally Run Exchanges

- If HHS determines by January 1, 2013 that a State has not elected to operate an Exchange or that it will not have the Exchange operational by January 1, 2014, the Secretary shall operate an Exchange, either directly or through agreement with a non-profit entity.

# QUESTIONS