# Affordable Care Act: Healthcare Exchange



HOUSE & SENATE HEALTH & INSURANCE COMMITTEES
MARCH 2, 2011

# Agenda

- Update: Health Care Reform Issues
- Senate Bill 461
- Healthcare Exchange

# Since April 2010

- Interagency working group & subgroups:
  - FSSA, IDOI, ISDH, SPD
- Nationalhealthcare.in.gov webpage.
- Financial analysis:
  - Focused on Medicaid expansion.
  - $2.6-3.1B through 2020.
- Stakeholder input:
  - Meetings.
  - Web-based questionnaires.

# Since April 2010

- Grants:
  - Rate Review Grant.
  - Exchange Grant.
  - Aged & Disabled Resource Center (ADRC) Grants.
  - Maternal, Infant and Early Childhood Home Visiting Program Grant.
  - Strengthening Public Health Infrastructure for Improved Health Outcomes Grant.
- Other Initiatives:
  - Rules on new insurance regulations 9/10.
  - Correct Coding Initiative (CCI).
  - Provider enrollment.
  - Healthy Indiana Plan (HIP) state plan amendment (SPA).

# SB461 - Dependent Age 26

- Upon request of the policyholder or certificate holder, Indiana Code § 27-8-5-28 provides that a policy of accident and sickness insurance may not be issued, delivered, amended, or renewed unless the policy provides for coverage of a child under 24 years.
- In order to comply with ACA, the age limit is raised to 26 years.

# SB461- Preexisting Condition Exclusions for Enrollees Under Age 19

- Enrollee under age 19 cannot be denied benefits or enrollment based on a preexisting condition.
  - Except individual grandfathered plans, which must enroll a dependent under age 19 upon the request of the insured, but may continue to waive coverage for preexisting conditions for a period of time consistent with Indiana law.
  - Not a requirement that carriers offer child-only coverage.

# SB461 - Prohibiting Rescission of Coverage

- Rescission: Treating insurance contract as if it never existed.
  - Provide 30 day notice to each participant who would be affected before coverage may be rescinded.
- Rescission is only permitted if an individual committed fraud or made an intentional misrepresentation of a material fact.

# SB461 - External Review

- Provides for an individual to seek an external review if he or she has sought and subsequently has been denied coverage.
- Requires Independent Review Organizations (IROs) conducting external reviews to keep records not less than three (3) years.
- Extends the amount of time a complainant has to file for an external review from 45 days to 120 days.
  - IDOI is concurrently seeking a waiver from HHS because its external review statutes are in substantial compliance with federal requirements.

# SB461 - HIP Changes

- Effective January 1, 2014:
  - Use HIP as the Medicaid ACA expansion vehicle instead of the traditional Medicaid program.
  - Gives Secretary the authority to make benefit modifications to align with ACA requirements. ACA could increase benefit costs 10-15% depending on final CMS rules.
  - Eligibility alignment to reduce of duplication of federal program.

# SB461– HIP Changes

- Effective immediately:
  - Amend code to require individuals to make a minimum contribution of not less than $100 annually.
  - State POWER account savings not substantial, but could drive down premium costs.
  - Allow nonprofit organizations to contribute no more than 75% of the individual's required payment.
  - Health plans may contribute if related to health improvement.

# HIP Results

- Currently 21%, or 8,900 HIP members are not required to make POWER account contributions.
- Last year, Milliman studied 6 months of HIP enrollment data and indicated a significant decrease in non-emergent utilization of the ER by those making POWER account contributions.
  - Contributors: 9% decrease in ER use in 3 months.
  - Contributors: 15% decrease in ER use after 6 months.
  - Non-contributors: Initial 5% decline in 3 months and no additional decline thereafter.
- Mathematica Study:
  - Ratio of physician visits to non-emergent ER use is higher for contributors than non-contributors.
- No evidence that POWER account contributions dissuade members from seeking care.

# POWER Accounts: Average Monthly Contributions

**Average POWER Account Contributions**

| FPL | Monthly 2008 | Monthly 2009 | Monthly 2010 | Average Annual Contribution (2008 – 2010) |
|---|---|---|---|---|
| <=100% | $12.49 | $13.14 | $14.29 | $159.65 |
| 101% - 125% | $33.43 | $34.30 | $36.02 | $414.98 |
| 126% - 150% | $51.11 | $52.53 | $55.04 | $634.72 |
| >150% | $69.49 | $71.12 | $70.86 | $845.89 |

# POWER Accounts: Number Who Were Disenrolled for Failure to Pay the Monthly Contribution

| FPL Level | Number Who Failed to Pay Subsequent Payment |
|---|---|
| Total | 1,835 (3%) |
| <22% FPL | 81 |
| 23 to 51% FPL | 249 |
| 51 to 101% FPL | 755 |
| 101 to 151% FPL | 549 |
| > 151% FPL | 201 |

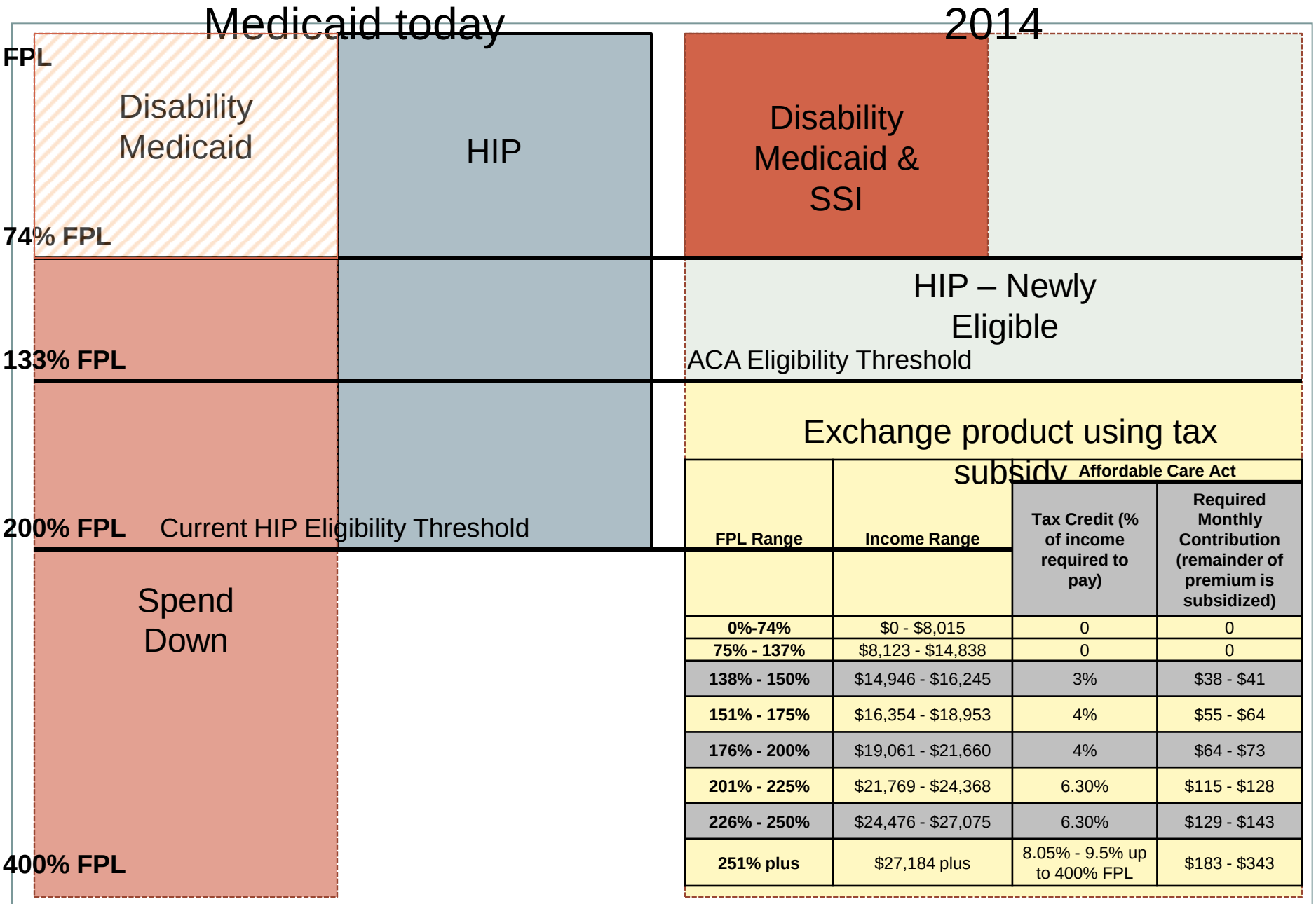
N = 61,797 HIP members as of December 2009

*Information from HIP CMS Annual Report – year 2 (2008 – 2009 combined)

# SB461– Medicaid Disability Changes

- 209b vs. 1634.
- Spend Down Program - Medicaid Advisory Committee (MAC) recommendation.

| Current Medicaid | 2014 |
|---|---|
| < 74% FPL<br>23,000 SSI individuals not on Medicaid | <74% FPL<br>All individuals below 133% become eligible for Medicaid, including 23,000 SSI recipients not on Medicaid today |
| 74% FPL – 133% disabled individuals are on Spend Down | 74-133% receive full Medicaid benefits |
| > 133% FPL- Spend Down | > 133% FPL tax credits to purchase a product on the Exchange |




| FPL Range | Income Range | Affordable Care Act: Tax Credit (% of income required to pay) | Affordable Care Act: Required Monthly Contribution (remainder of premium is subsidized) |
|---|---|---|---|
| 0%-74% | $0 - $8,015 | 0 | 0 |
| 75% - 137% | $8,123 - $14,838 | 0 | 0 |
| 138% - 150% | $14,946 - $16,245 | 3% | $38 - $41 |
| 151% - 175% | $16,354 - $18,953 | 4% | $55 - $64 |
| 176% - 200% | $19,061 - $21,660 | 4% | $64 - $73 |
| 201% - 225% | $21,769 - $24,368 | 6.30% | $115 - $128 |
| 226% - 250% | $24,476 - $27,075 | 6.30% | $129 - $143 |
| 251% plus | $27,184 plus | 8.05% - 9.5% up to 400% FPL | $183 - $343 |

# Medicaid Disability - Fiscal Impact

| Cost Projections Without Enhanced Match | |
|---|---|
| 10-Year Costs | Change to 1634 |
| Cost of ACA to State – Less than 133% FPL | $811M |
| MRT Savings | ($3M) |
| Current Spend Down - over 133% FPL | ($141M) |
| Net | $667M |

| Cost Projections With Enhanced Match | |
|---|---|
| 10-Year Costs | Change to 1634 |
| Cost of ACA to State – Less than 133% FPL | $86M |
| MRT Savings | ($3M) |
| Current Spend Down - over 133% FPL | ($141M) |
| Net | ($58M) |

# Exchange Functions

***Expedia*** **for health insurance; tool with which individuals or small employers can find, compare and enroll in health insurance.**

- Certify, recertify and decertification of plans.
- Assign quality ratings to plan, per HHS guidelines.
- Website & Call Center.
- Single application for Medicaid and tax subsidy eligibility.
- Seamless interface with Exchange and Medicaid and other State subsidy programs.
- Administer federal tax credits.
- Free Choice Vouchers for employers/employees.
- Exchange for individuals & small business Exchange (SHOP).
- Notification and appeals of employer liability.
- Education and outreach; assistance to help customers purchase health insurance.
- Cost calculator.
- Risk adjustment for plans.
- Provide income data to the IRS, and citizenship or immigration status to SSA & Homeland Security.
- Determine eligibility for tax credits & cost-sharing reductions.
- Adjudication of eligibility determinations and appeals.
- Waiver of individual mandate.

**Exchange Models:**

- Active purchaser.
- Clearinghouse.
- Comparative data on cost.

# Available Health Plans on the Exchange

Essential Benefits to be Designed by Federal Government.

- Bronze:
  - The plan pays 60 percent of the full actuarial value of benefits; the individual is at risk for 40 percent of the costs.
- Silver:
  - The plan pays 70 percent of the full actuarial value of benefits; the individual is at risk for 30 percent of the costs.
- Gold:
  - The plan pays 80 percent of the full actuarial value of benefits; the individual is at risk for 20 percent of the costs.
- Platinum:
  - The plan pays 90 percent of the full actuarial value of benefits; the individual is at risk for 10 percent of the costs.

# ACA & Healthcare Exchanges

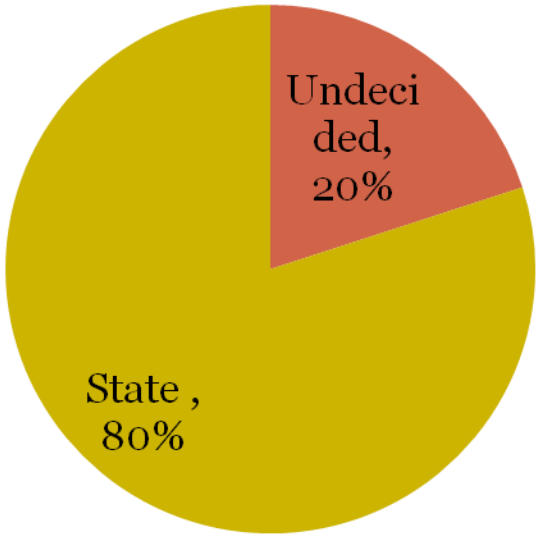
- Only place to purchase insurance with tax subsidies.
- Options:
  - State or Federally operated.
  - State or regional/multi-state Exchange.
  - State agency, not-for-profit or quasi-governmental.
- Funded through 2015 by feds; after that must be self-sustaining.
- Timeline:
  - Feds will determine readiness by 1/1/2013.
  - Federal Exchange for states that have not made progress.

# Potential Users of an Exchange

- Report prepared by the State Health Access Data Assistance Center (SHADAC) at the University of Minnesota.
- SHADAC's estimate of potential users of an Exchange.
- Individuals.
- Businesses.
- Large employers that may drop insurance.

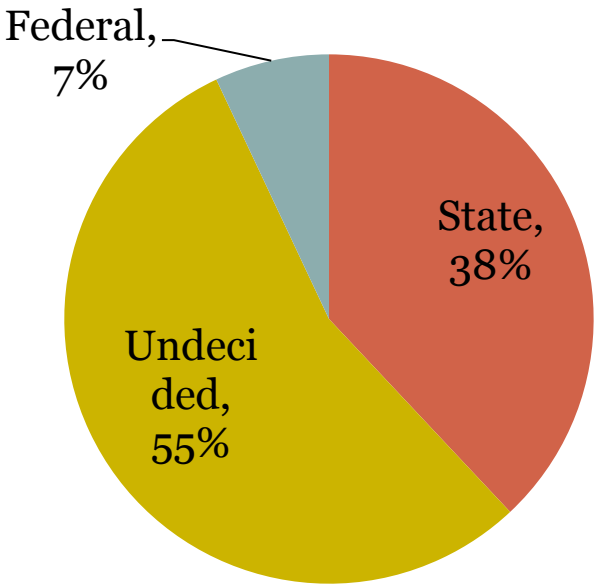
# Exchange: State v. Federal

The September questionnaire asked respondents to identify who should operate the Exchange.




Above: Insurers

Below: Businesses



# Exchange Structure

- Executive Order was issued by Governor Daniels on January 14, 2011.
- Conditionally establishes a not-for-profit entity to operate an Indiana-based Exchange.
- Leverages current agencies (IDOI and FSSA) without creating new agencies.
- Board of Directors to be appointed in 2013 after federal approval of Exchange.
- Board composition:
  - State agencies.
  - General Assembly.
  - Standing committees (consumer, providers, actuarial, etc.).

# Status of Activities

- IT gap analysis.
- Questionnaire of Exchange design questions/options.
- Actuarial analysis of options.
- Stakeholder input.
- IT plan to support Exchange.
- Financing plan.
- Legislative needs.
- Operational plan.

# Concerns & Risks

- Exchange:
  - Large impact on Hoosiers
  - Lack of federal guidance.
  - Lack of a federal Exchange model for comparison purposes.
  - Deadlines & readiness.
  - Operating costs in 2015 & beyond.