

Health Insurance Exchange Overview

Minnesota Health Insurance Exchange Advisory Task Force

November 8, 2011



Overview

- **Existing Market Challenges**
- **What is an Exchange?**
- **Exchange Opportunities**
- **Exchange Components**
- **Key Exchange Issues**
- **Existing Exchange Structures**
- **State and Federal Status**
- **Timeline and Status**

Challenges for the Triple Aim

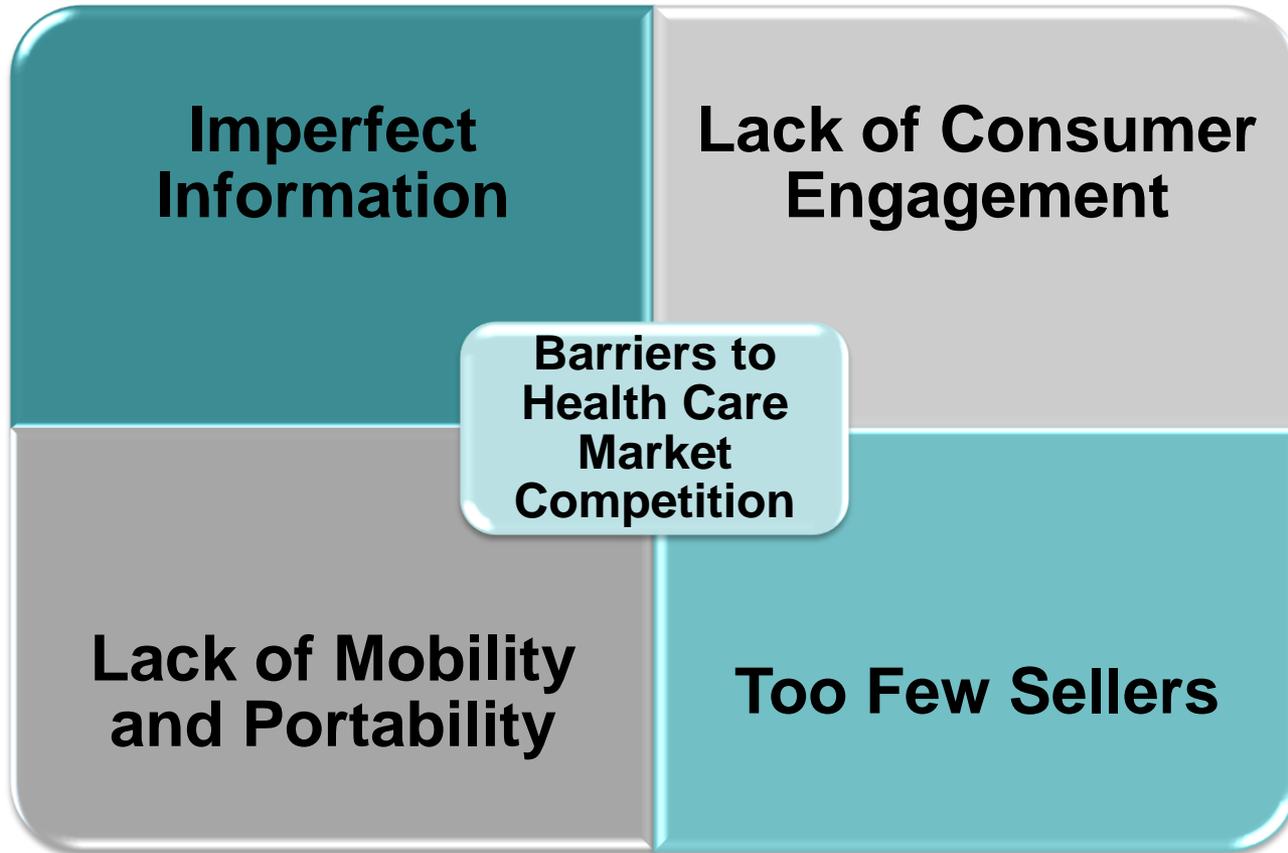
- Quality is improving but unequal
- Too little consumer engagement



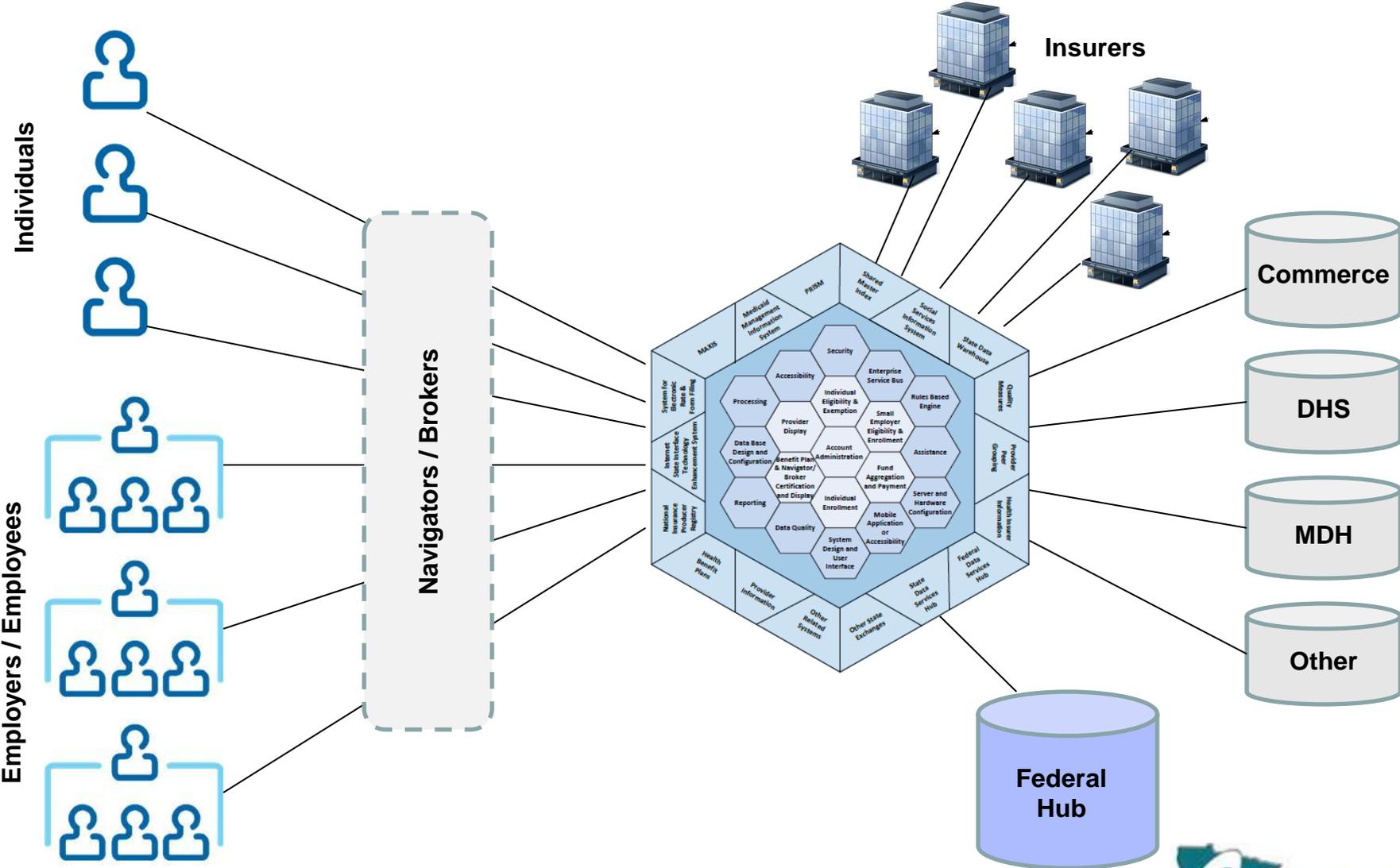
- Health care is too complex
- Lack of information to make informed decisions

- Unsustainable health care cost growth
- Growing uninsured
- Small employers dropping coverage

Challenges for Competition



What is an Exchange?



Exchange Opportunities

Advance the Triple Aim

- Potential incentives for health improvement
- Simple one-stop shop
- Streamline access to public and private coverage
- Financial assistance for individuals and small businesses
- Aggregate contributions for one health plan

Enhance Market Competition

- Transparent “apples to apples” comparison information
- Foster market competition on value and affordability
- Engage consumers in well-informed decision making
- Choice, mobility, and portability
- Reduce barriers to entry for newer and smaller insurers

Exchange Components: Functions

- Provide one-stop shop including a call center and website
- Ensure health insurance plans meet certain standards
- Provide comparative information on health benefit plans, costs, quality, and satisfaction using a standard format
- Set up open enrollment and special enrollment periods
- Facilitate “real-time” eligibility and enrollment using a uniform format
- Determine eligibility for individual and employer tax credits, Medicaid, and coverage requirement exemptions
- Communicate with employers regarding employee subsidy eligibility, cancelation of coverage, and penalty liability
- Establish a “Navigator” program
- Additional functions for small employers: Employee choice and premium aggregation

Exchange Components: Eligibility

- **Individuals:**
 - **General Individual Market**
 - **Individual Subsidies** (100-400% FPL): Through Exchange to those not eligible for “affordable” employer coverage. Subsidies limit “Silver plan” premiums to 2 - 9.5% of income and cost-sharing subsidies limit actuarial value to 94 - 70%.
 - **Medicaid Eligibility** (<133% FPL)
 - **Basic Health Plan** (133-200% FPL): State option. States may use 95% of subsidy funds to establish. Similar to MinnesotaCare.
- **Small Groups:**
 - Eligible up to 100 employees, state can limit to 50 employees until 2016
 - Sliding scale tax credits through Exchange for 2 years for up to 50% of employer premium portion for < 25 employees and < \$50,000 average wage
- **Large Groups:**
 - May be allowed to participate in 2017 at state discretion

Exchange Components: Plan Certification

- Marketing criteria
- Network adequacy requirements
- Accreditation on local clinical quality measures, patient experience, consumer access, utilization management, quality assurance, provider credentialing, complaints and appeals, and patient information systems
- Disclosure of information on claims payment policies, claims denials, data on enrollment and disenrollment, rating practices, cost-sharing for in network and out of network providers, and company financial information
- Implementation of a quality improvement strategy
- Utilization of a standard format for comparing health plan options
- Utilization of a uniform enrollment form/process
- Health plan offering of at least 1 “Silver” and 1 “Gold” plan

Exchange Components: Market Rules

- **Benefit, Rating, and Issue Rules:** Apply to all individual and small group plans inside and outside the Exchange not “grandfathered”
 - **Benefit Rules:** Must provide essential benefits and fit an actuarial level (Bronze, Silver, Gold, Platinum, or “Young Invincible”)
 - **Rating and Issue Rules:** Premium variation based on health status prohibited. Rating variation limited to tobacco use (1.5:1), age (3:1), geography (state defined), and family composition. Guarantee issue.
- **Premiums:** For the “same plans” inside and outside Exchange must be the same
- **Certification Rules:** Only apply to Exchange plans (marketing, network adequacy, etc)
- **Open Enrollment:** Appears to only apply to Exchange
- **Wellness Discounts:** 10-state demonstration project in 2014 that allows wellness discounts permitted for group plans to be applied to the individual market

Exchange Components: Risk Sharing

- **Reinsurance:** From 2014-2016 reallocates \$25 billion to individual market plans inside and outside Exchange with high risk individuals. Funded by fully and self insured plans.
- **Risk Corridors:** From 2014-2016 for individual and small group plans inside and outside the Exchange - will operate similar to Part D program.
- **Risk Adjustment:** HHS establish and operate method for risk adjustment for individual and small group plans inside and outside Exchange. States with claims databases may propose alternate mechanism.
- **Risk Pooling:** Individual market plans inside and outside Exchange are in same risk pool. Small group plans inside and outside Exchange are in same risk pool.
- **Market Merger:** States may merge their individual and small group market risk pools.

Exchanges & Adverse Selection

- **What is adverse selection?** The unequal separation of risk into different insurance arrangements
- **Why is adverse selection an issue for Exchanges?**
 - When market rules and characteristics of products offered inside vs outside a market/pool are different and lead to separation of risk. Situation can result in higher risk, higher premiums, and lower enrollment inside vs outside a market/pool that continues over time (death spiral).
 - Example: Purchasing pools enacted by many States in the 1990s (voluntary participation and different market rules and products)
- **Provisions to Mitigate Adverse Selection:** Single risk pool inside and outside Exchange, minimum benefit level, same rating rules, risk adjustment, and Exchange subsidies
- **Adverse Selection Concerns:** When different insurers and products operate inside vs outside Exchange, and when different market rules exist inside vs outside Exchange related to certification and open enrollment

Exchange Components: Operation

- **Governance:**
 - Government entity
 - Quasi public-private entity
 - Private non-profit entity established by the state
 - Federal government on behalf of a state (also federal-state partnerships)
- **Structure:**
 - Separate or combined Exchange for individuals and small groups
 - Multiple subsidiary Exchanges each serving a distinct geographic area
 - Regional Exchange including multiple states
- **Financing:**
 - HHS to fully fund states for Exchange start-up through 2014. Starting in 2015, Exchange must be self-sustaining.
 - Potential issue for Navigator funding prior to 2015

Key Exchange Issues

- **Functions:**

- Coordination/streamlining of Exchange functions with existing state functions
- Measurement and reporting of cost, quality, and satisfaction for insurers, health benefit plans, and providers
- Navigator and broker requirements and compensation
- Small group: Defined contribution and “true” portability for individuals
- Technical infrastructure
- Exchange operations

- **Eligibility:**

- Basic Health Plan or private subsidies through Exchange for 133-200% FPL – what happens to MinnesotaCare?
- Size of the small group market
- Large employer participation in 2017

Key Exchange Issues

- **Encouraging Market Competition and Value (Certification, Market Rules, Risk Sharing, and Avoiding Adverse Selection):**
 - Role: Competition within vs. against the Exchange
 - Avoiding adverse selection (certification, participation, and market rules inside and outside Exchange - regulatory simplification)
 - Use of cost, quality, and satisfaction data to incent competition and value
 - Incenting competition and improved health outcomes for high risk individuals – risk adjustment and wellness discounts
 - Risk adjustment – consideration of MN alternative methods
 - Risk sharing – reinsurance and role/transition of high risk pool
 - Merger of the individual and small group markets
- **Exchange Operation**
 - Long-term governance and unique MN options
 - Ongoing funding

Existing Exchange Structures

	Massachusetts	Utah	Private (i.e. CT, CA)
Started	2006	2009	mid 1990s
Market	public, individual, and small group	small group (testing larger groups)	small and larger groups
Governance	public/private entity	agency	private
Role	<ul style="list-style-type: none"> • negotiate terms • comparison of standard tiered plans • facilitate subsidy for those < 300% FPL 	<ul style="list-style-type: none"> • defined contribution • voluntary insurer participation • transparency of comparison info • aggregate contributions 	<ul style="list-style-type: none"> • defined contribution • contractual requirements for insurers • human resources functions and other benefits
Rating and Risk Sharing	<ul style="list-style-type: none"> • CR and GI inside and outside • merged individual and small group pools • risk adj for public 	<ul style="list-style-type: none"> • group rated • same rating rules inside and outside • risk adj inside 	<ul style="list-style-type: none"> • group rated • same general rules inside and outside
Enrollment	200,000 (160K public, < 5K sm grp)	< 3,000	75,000 – 150,000

State and Federal Status

- **State Status:**

- 49 states received planning grants
- 17 states received level 1 establishment grants
- 12 states have established Exchange through legislation (IL and ND considering legislation this week)
- 8 states have Executive Orders
- Governance thus far:
 - 2 non-profit (IN, HI)
 - 4 state agency (RI, UT, VT, WV)
 - 8 public/private entity (CA, CO, CT, MD, MA, NV, OR, WA)

- **Federal Status:**

- Federal Exchange under development with HIOS/healthcare.gov and multiple procurements
- Multiple final rules in development and additional proposed rules forthcoming

Timeline

Early to late 2011:
Planning, research, and modeling

January 1, 2013:
Prove to HHS that Exchange can be operational by January 1, 2014 or HHS will implement federal Exchange

Summer 2013:
Populate Exchange with information

January 1, 2014:
Coverage through Exchange starts

Late 2011 to 2013: Task Force, design, and development

First Half of 2013: System testing

Fall 2013: Open enrollment

Status

Planning Grant

- Economic and actuarial research and modeling
- Evaluation of technical infrastructure options and costs - IT RFP
- Initial evaluation of operations

Level 1 Grant

- Resources for design and development
- Advisory Task Force and work groups
- Marketing, communication, and outreach
- Technical infrastructure