



## State Health Insurance Exchanges - Highlights

May 2010

- The Exchanges are intended to group together individuals in order to reduce their costs of buying a policy and provide the insurance companies a larger group to spread their risk across, just as they do with employer group policies. The Exchanges would act like a clearinghouse to make sure the policies offered for sale meet minimum standards of coverage for basic services. The state provides oversight of plans and market regulations, provide consumer protections, review the rates charged, determine solvency, set reserve fund requirements, premium taxes, and determine rating areas. The Exchanges do not set premiums, but they would ask insurers to justify rate hikes.
- By January 2014, states are to establish two Exchanges. One is for individuals, a second Small Business Health Options Program (SHOP) for employees of small businesses to purchase of health insurance. States have the option to combine the Exchanges. Federal grants (\$30 million) are available to states to create an Exchange.
- States have flexibility in creating an Exchange. A state agency or a non-profit organization can be designated to operate the Exchange. States have the option to create an Exchange just for their state or partner with other states. There can be more than one Exchange in a state, but the Exchanges must serve different areas.
- If a state does not establish an Exchange, the Federal government will establish an Exchange in that state.
- Exchanges will likely operate as an online clearinghouse, but could operate through existing state services or any venue chosen by a state. The intent is the Exchange operate in a way that allows citizens to compare the price and features of the private insurance plans.
- The Exchanges are not intended to sell a government health insurance policy. The insurance policies purchased will be offered by private insurance companies.
- The Exchanges act as a clearing house to make sure the policies meet minimum coverage standards. The Exchanges do not set premium prices, but they may require insurers to justify rate hikes. Also, two multi-state policies (likely similar to the private insurance offered federal employees) will be offered in each state to ensure a higher level of competition.
- The law designates four levels of insurance coverage are to be offered. The higher the percent of coverage the higher the premium. Subsidies would be available to individuals and families on a graduated scale up to 400% above the federal poverty rate. The higher the income, the lower the subsidy. The policy levels are:
  - Bronze Level Policy – Provides health benefit coverage that covers 60% of the plan's benefit costs; out-of-pocket limits equal to those of a Health Savings Account (HSA) of \$5,950 for individuals; \$11,900 for families;
  - Silver Level Policy - Covers 70% of the plan's benefit costs, out-of-pocket limits matching the HSA limits;
  - Gold Level Policy - Covers 80% of the plan's benefit costs, with the HSA out-of-pocket limits;
  - Platinum Level Policy - Covers 90% of the plan's benefit costs, with the HSA out-of-pocket limits;
  - OPTION for Individuals Under Age 30 – Persons under age 30 have the option to buy catastrophic health insurance coverage with a high deductible and that includes prevention benefits and three primary care visits.
- Abortion - The state decides if it will prohibit insurance plans in their Exchange from offering coverage for abortions. Federal law prohibits any public subsidy from being used to pay for an insurance premium that covers abortions. The state would need to enact a state law to prohibit the offering of abortions through its Exchange.
- Individuals are not required to buy insurance from the Exchange, but insurance companies that offer identical plans outside the Exchange would have to charge comparable rates to what it charges for the same plan in the Exchange.
- The Exchanges will be open to:
  - uninsured individuals;
  - persons working for businesses with 100 or less employees;
  - retired persons that are not yet eligible for Medicare;
  - Beginning in 2017 states may open the SHOP Exchange to businesses with more than 100 employees.

### **Partnership or Collaboration Opportunities**

States could partner with a non-profit organization.

States could partner with other states.



## **Changes to Medicaid - Highlights**

May 2010

- The Patient Care law expands Medicaid to individuals under age 65 with incomes up to 133% of the federal poverty level (FPL). Undocumented immigrants are not eligible for Medicaid. All newly eligible adults will be guaranteed a minimum benefit package that provides the essential health benefits. To finance the coverage for the newly eligible Medicaid enrollees, states will receive 100% federal funding for 2014, 2015 and 2016; 95% federal financing in 2017, 94% federal financing in 2018, 93% federal financing in 2019, and 90% federal financing in 2020 and after. States that have already expanded eligibility to adults with incomes up to 100% FPL will receive a phased-in increase in the federal medical assistance percentage (FMAP) for non-pregnant childless adults so that by 2019 they receive the same federal funding as other states.
- States to enroll new eligible Medicaid beneficiaries by January 2014. States will continue current Medicaid and CHIP eligibility for children until 2019 and adults until the Exchange is operating in 2014. States are exempt from maintaining the requirements for non-disabled adults with incomes exceeding 133% of the federal poverty rate from January 2011 through December 31, 2013 if it certifies it has or will have a budget deficit in the next year.
- The federal law allows states to obtain a five-year waiver of some new health insurance requirements if the state certifies that it provides health coverage to all residents that is at least as comprehensive as the coverage required under an Exchange plan and that the state plan does not increase the federal budget deficit.
- Effective January 2010 the federal law increases the Medicaid drug rebate percentage for brand name drugs to 23.1% (except the rebate for clotting factors and drugs approved exclusively for pediatric use increases to 17.1%); increases the Medicaid rebate for non-innovator, multiple source drugs to 13% of average manufacturer price. Extends the drug rebate to Medicaid managed care plans.
- The federal law reduces aggregate Medicaid Disproportionate Share Hospital (DSH) allotments by \$500 million in 2014, \$600 million in 2015, \$600 million in 2016, \$1.8 billion in 2017, \$5 billion in 2018, \$5.6 billion in 2019, and \$4 billion in 2020. The HHS Secretary is required to develop a method to distribute the DSH reductions in a manner that imposes the largest reduction in DSH allotments for states with the lowest percentage of uninsured or those that do not target DSH payments, imposes smaller reductions for low-DSH states.
- In 2011 the Patient Care Act will create a new Medicaid state plan option to permit Medicaid enrollees that have at least two chronic conditions and a persistent mental health condition to designate a provider as a health home. Allows states taking the option with 90% FMAP for two years.
- Effective 2012 through 2016 the law creates new demonstration projects in Medicaid to pay bundled payments for episodes of care that include hospitalizations. Effective 2010 through 2012 to make global payments to safety net hospital systems; effective 2012 through 2016 to allow pediatric medical providers organized as accountable care organizations to share in cost-savings; and between 2011 through 2015 to provide Medicaid payments to institutions of mental disease for adult enrollees who require stabilization of an emergency condition.
- Expands the role of the Medicaid and CHIP Payment and Access Commission to include assessments of adult services (including those dually eligible for Medicare and Medicaid). \$11 million in additional funds was appropriated for FY2010.
- States will receive 100% federal financing to increase Medicaid payments for fee-for-service and managed care for primary care services provided by primary care doctors (family medicine, general internal medicine or pediatric medicine) so the payments will be equal to 100% of the Medicare payment rates for 2013 and 2014.
- Extends the "Medicaid Money Follows the Person Rebalancing Demonstration" program to September 2016 and allocate \$10 million per year for five years to continue the Aging and Disability Resource Center initiatives.
- Starting in 2010, provide states new options for offering home and community-based services through a Medicaid state plan rather than through a waiver for individuals with incomes up to 300% of the maximum SSI payment and who have a higher level of need and permit states to extend full Medicaid benefits to individual receiving home and community-based services under a state plan.
- In 2011 establishes a Community First Choice Option in Medicaid to provide community-based attendant supports and services to individuals with disabilities who require institutional care. Provide states with an improved federal matching rate of an additional 6% for reimbursable expenses in the program. The option sunsets after five years.
- Create the State Balancing Incentive Program to provide better federal matching payments to eligible states to increase the proportion of non-institutionally-based long-term care services. Some states will be eligible for FMAP increases for medical assistance expenditures for non-institutionally based long-term services and support.