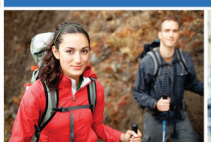
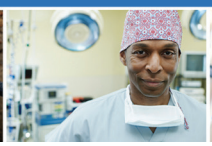
States Implement Health Reform

November 2010

American Health Benefit Exchanges

Overview

The 2010 Affordable Care Act (the act) requires that, by January 1, 2014, states have a fully functional American Health Benefit Exchange that facilitates insurance purchasing through qualified health plans and a Small Business Health Options Program. States may establish and operate one or more exchanges, join with another state or states to do so, or defer to the federal government to establish and operate the exchanges in the state.

Federal Provisions

For most states, health benefit exchanges are new entities that will function as a marketplace for health insurance purchasers by providing choices to consumers who are shopping for health coverage. Exchanges will offer a variety of qualified health plans and will provide information and educational services to help consumers understand their options for coverage.

Exchanges will offer "qualified health plans" based on requirements related to marketing, choice of providers, plan networks, essential benefits and other features. States will license issuers of qualified health plans to provide coverage through the exchanges.

Exchanges will initially target those who purchase coverage on their own and small businesses with up to 100 employees. In the future, exchanges may be expanded to larger employers. The Congressional Budget Office estimates that approximately 30 million people will be covered through an exchange by 2019, most of whom will be eligible for a subsidy available through the exchange.[1]

The act lists broad categories of services that must be included, called "essential health benefits," and requires the secretary of the Department of Health and Human Services (DHHS) to define additional essential health benefits. In November 2010 the first in a series of guidances was released by DHHS. Additional guidance will be released over the next three years as required under Section 1311 (b) of the act.

Exchanges will offer insurance plans with different levels—bronze, silver, gold and platinum—depending upon the services the consumer prefers and cost sharing determined by the actuarial value of the coverage compared to the actuarial value of the "essential health benefits." Health insurers must offer silver and gold plans in the exchange.

Subsidies

To help ease the financial burden of the requirement for insurance coverage in 2014, the act provides federal subsidies for people with incomes between 133 percent and 400 percent of federal poverty guidelines in the form of a premium credit. Those who have employer-sponsored coverage are not eligible for the exchange and/or subsidies, with exceptions related to the actuarial value of the employer health plan and the employee contribution. If an employer health plan does not have an actuarial value of at least 60 percent or if an employee's share of the employer premium exceeds 9.5 percent of the employee's income, then the individual can enroll in the exchange and qualifies for subsidies.

Tax credits also will subsidize small businesses with fewer than 25 employees. Eligible individuals must meet certain criteria, such as being a U.S. citizen or legal immigrant. Premium credits will be based on a sliding scale related to income, ranging from 3 percent of income for people with incomes at 133 percent up to 9.5 percent for those with incomes between 300 percent and 400 percent of the federal poverty guideline. Cost-sharing subsidies also are available to limit out-of-pocket expenses and allow people to enroll in health plans with higher actuarial value.

The **actuarial value** of a health insurance policy is the percentage of the total covered expenses that the plan would, on average, cover. A plan with a 70 percent actuarial value means that consumers would on average pay 30 percent of the cost of health care expenses through features such as deductibles and coinsurance.
Source: Kaiser Family Foundation, http://healthreform.kff.org/SubsidyCalculator/Faq.aspx.

Interoperability with Health and Human Services Programs

State exchanges also must screen enrollees for eligibility in health and human services programs, such as Medicaid, which will require transfer of data for verification and screening. The data must be compatible between the exchange and public programs such as Medicaid.

States will need to evaluate their existing information technology systems to determine if an upgrade or replacement

is required. Legislators may need to address the cost of these system changes for both the purchase of new technology and the personnel to meet requirements and operate the systems.

State Roles in Implementation

Establishing an exchange will require a great deal of planning. Most states already have started the process of examining and analyzing the feasibility of an exchange. The following key issues are among those that states will want to consider.

- Should the state establish an exchange? Does it have the capacity to establish, operate and sustain an exchange? What are the pros and cons of allowing the federal government to set up the exchange?
- What legislation or regulations are needed to create, implement and administer the exchange?
- How will the exchange be governed and administered, by a government agency or a nonprofit organization?
- Who will pay for it?
- What data are needed to make policy decisions regarding the exchange, and who will collect it?
- How will the state make the exchange "interoperable" with the Medicaid program?

State Experiences

In 2006, Massachusetts passed health reform legislation that created the Commonwealth Health Insurance Connector Authority. The Connector is an independent, quasi-government agency that helps small businesses and people who purchase insurance on their own. The Connector serves many functions and manages two health insurance programs: Commonwealth Care, which subsidizes insurance purchases for adults who do not have employer-sponsored insurance; and Commonwealth Choice, which offers commercial insurance plans for those who are not eligible for Care, and for small employers. The Connector offers levels of coverage designated as bronze, silver and gold, based on the actuarial value. The Connector facilitates enrollment, regulates the plans offered in the Connector, conducts outreach programs, and helps make administrative policy decisions related to the state's broad-based health reform law. Since the 2006 health reform legislation, 360,000 people have been newly insured in the state, which now has the lowest uninsured rate in the nation.

Utah laws passed in 2008 and 2009 led to development and implementation of a statewide health insurance exchange. Since fall 2009, the Utah Health Exchange allowed employees of small employers, on a pilot basis, to compare, select and enroll in commercial health insurance through an entirely online, Internet-based process. The exchange was opened to all small employers in fall 2010 and to large employers on a pilot basis. The exchange includes 146 plans (both required and optional), that rely mainly on partnering with the private sector. It allows employers to determine their contribution levels (a defined contribution arrangement) and allows employees to aggregate contributions from several employers, including those of other household members. Utah currently is developing a blueprint for how the exchange will operate under new federal requirements.

California was the first state to enact legislation designed to set up an exchange in response to the requirements of the act to date, although specific federal requirements will be forthcoming. Like the Massachusetts exchange, California's will be governed by an independent board responsible for setting up and determining which plans can participate.

Funding

On Sept. 20, 2010, DHHS released $49 million in planning grants to 48 states and the District of Columbia. Grants will be renewed if a state is making progress toward establishing an exchange, implementing insurance market reforms, and meeting other benchmarks in the law.[2] Grants also will be available to certain states to support innovative information technology infrastructure that can be used as models for other states.

Resources

American Health Benefit Exchange: http://www.ncsl.org/?TabId=21393

Massachusetts Connector: www.mahealthconnector.org/portal/site/connector

National Association of Insurance Commissioners Model Legislation: www.naic.org/documents/committees_b_exchanges_exposure_100927_health_benefit_exchanges.pdf

State Actions to Implement the American Health Benefit Exchange: http://www.ncsl.org/?TabId=21388

Utah Exchange: http://www.exchange.utah.gov

Notes

1. Congressional Budget Office, August 2010 Baseline: Health Insurance Exchanges, (Washington, D.C.: CBO, August 2010); http://www.cbo.gov/budget/factsheets/2010d/ExchangesAugust2010FactSheet.pdf.

2. U.S. Department of Health and Human Services, Exchange Planning Grants: Grant Award List, (Washington, D.C.: HHS, July 29, 2010); http://www.healthcare.gov/news/factsheets/grantawardslist.html.

NCSL Staff Contact: Martha Saenz

National Conference of State Legislatures
The Forum for America's Ideas

7700 East First Place
Denver, Colorado 80230
(303) 364-7700

National Conference of State Legislatures
William T. Pound, Executive Director
www.ncsl.org

444 North Capitol Street, N.W., #515
Washington, D.C. 20001
(202) 624-5400