The Hilltop Institute

analysis to advance the health of vulnerable populations

Health Reform: Implementing Insurance Coverage Expansion

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UMBC Fall Colloquium

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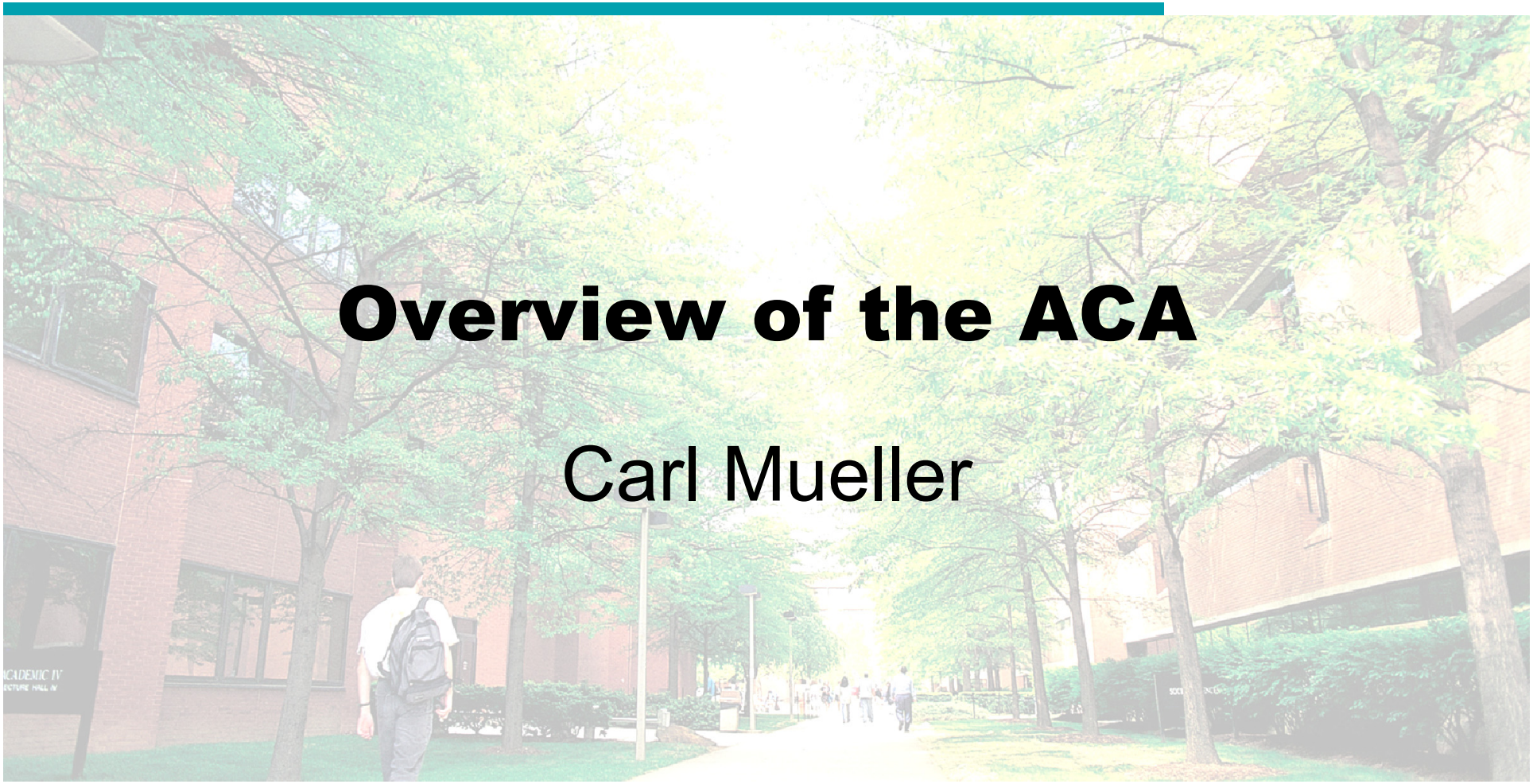
Overview

- Overview of the Affordable Care Act (ACA)
- ACA Implementation Considerations
- Reform Implementation Activities: Maryland



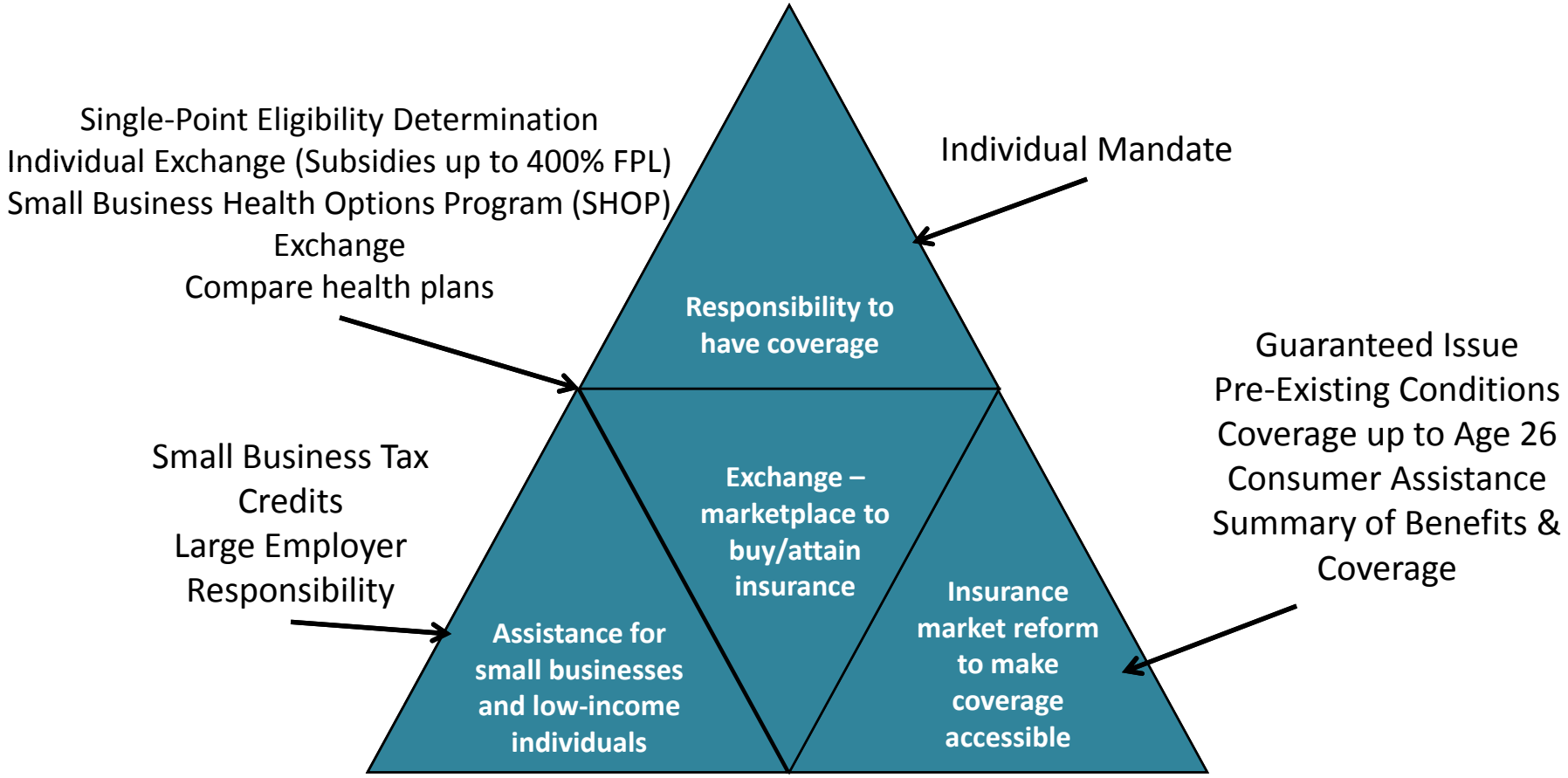
Overview of the ACA

Carl Mueller

What is the ACA?

- Patient Protection and Affordable Care Act (PPACA) – signed into law on March 23, 2010
- Health Care and Education Reconciliation Act of 2010 (HCERA) – signed into law on March 30, 2010
- These laws compose what we call “health reform law” or “Affordable Care Act (ACA)”

What is the ACA? continued



What is the ACA? continued

- Prevention and public health programs
- Enhancing primary care infrastructure
- Initiating changes in long-term care
- Focuses on:
  - Quality
  - Access
  - Slowing the growth of health care costs

Medicaid Expansion & Health Benefit Exchanges

Supreme Court Decision

- *National Federation of Independent Business v. Sebelius* (26 states)
  - Anti-Injunction Act
    - **Did not apply**
  - Medicaid Expansion
    - **Becomes optional**
  - Individual Mandate
    - **Upheld under Congress' specified power to "*lay and collect taxes*"**

Changes to Medicaid Eligibility

- New ~~mandatory~~ *Optional* Medicaid eligibility groups
- New Medicaid eligibility determinations
- New Medicaid rules

Medicaid Eligibility Group:
"Newly Eligible" Individuals

- Individuals under 65 years with income up to 133% FPL
  - Includes non-pregnant, non-disabled adults without children
- Federal government
  - Pays 100% for newly eligible population between 2014 and 2016. By 2020, pays 90%.
- States can expand Medicaid to this group before 2014, but will receive **no** additional federal funds

Medicaid Eligibility Group:

Former Foster Care Children

Those who …

- Are under 26 years old
- Are not eligible for or enrolled in Medicaid
- Were enrolled in foster care under the responsibility of the state on their 18th birthday
- Were enrolled in Medicaid while in foster care

Medicaid Eligibility Determinations:
Modified Adjusted Gross Income (MAGI)

- Income verified through Internal Revenue Service
- For “newly eligibles,” a 5 percentage point income disregard will be applied, increasing the Medicaid eligibility maximum to 138% FPL

Medicaid Eligibility Determinations: MAGI continued

- For certain groups, instead of MAGI, previous income counting rules will be used:
  - Those who are eligible for Medicaid through a different federal or state assistance program (e.g., foster care children)
  - Older adults
  - Some individuals with disabilities
  - The medically needy
  - Those in a Medicare Savings Program

New Medicaid Rules:

"Presumptive Eligibility"

- States are required to keep current Medicaid and CHIP eligibility levels through 2013 for adults and 2019 for children

- States can use "presumptive eligibility"
  - Individuals can enroll in Medicaid **before** their application is processed if a Medicaid provider determines the person is **likely eligible**

Medicaid Expansion for States

Expansion effects will differ based on:

- States with low Medicaid eligibility for adults today (*Alabama and Texas*).
  - Majority of costs financed by federal government between 2014 - 2019.
- States that have broader coverage today for parents but have no Medicaid coverage for childless adults (*California and New Jersey*).
  - Majority of costs financed by federal government between 2014 - 2019. Slightly lower levels because of participation of currently eligible individuals.

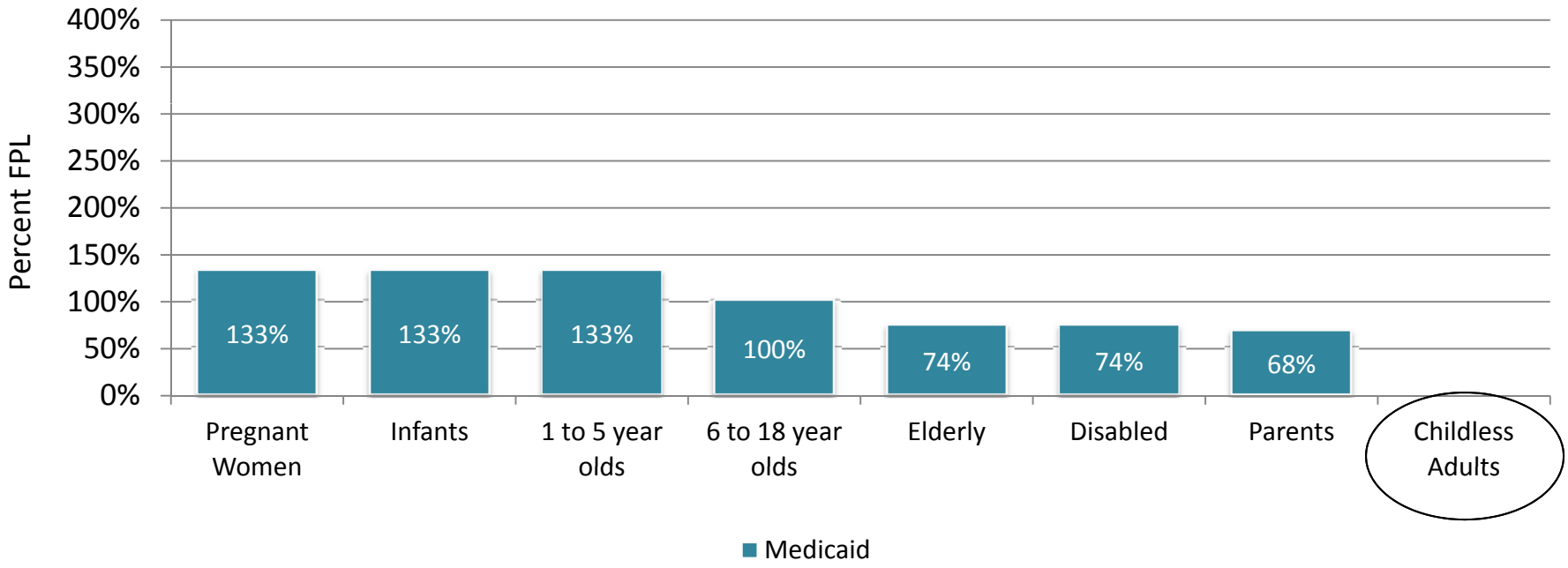
Medicaid Expansion for States

continued

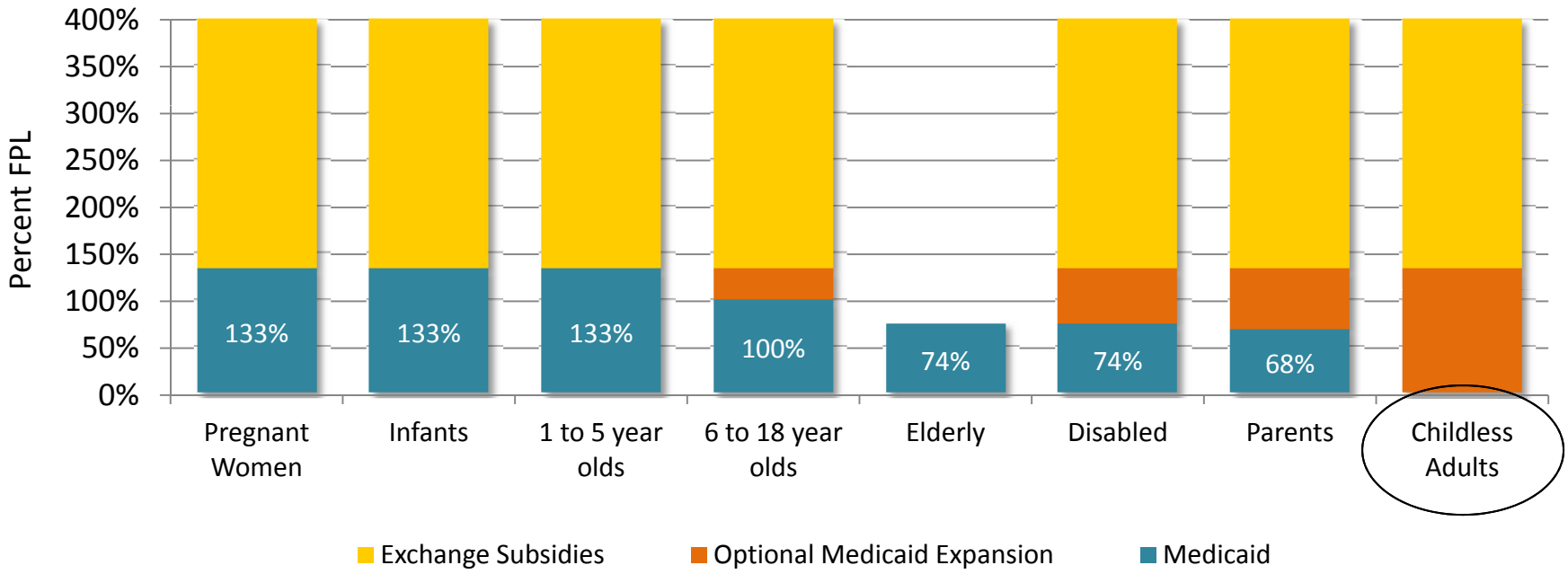
- Expansion states that cover both parents and childless adults in Medicaid today (*Arizona, Delaware, Hawaii, Maine, Vermont, Massachusetts and New York*).
  - Vary with the proportion of current eligibles to newly eligible or those eligible
  - Woodwork Effect

Source: Kaiser Commission on Medicaid and the Uninsured (May 2010). *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133 percent FPL.* Retrieved from http://www.kff.org/healthreform/upload/medicaid-coverage-and-spending-in-health-reform-national-and-state-by-state-results-for-adults-at-or-below-133-fpl.pdf.

National Medicaid Eligibility Levels Pre-ACA



National Medicaid Eligibility Levels Post-ACA



Health Benefit Exchanges

- Individual Exchange
  - Two conditions to receive subsidy
    - Individual not offered employer-sponsored insurance (ESI)
    - Individual is offered ESI that is deemed "unaffordable"

Health Benefit Exchanges continued

- Small Business Health Options Program (SHOP) Exchange
  - If small employer offers and contributes to employee's coverage in Exchange, individual is **ineligible** for subsidy

Exchange Requirements from the ACA

- ACA specifies (per §1311) that an Exchange must:
  - Implement procedures to certify, recertify, and decertify a qualified health plan (QHP)
  - Provide for the operation of a toll-free hotline

Exchange Requirements from the ACA

- The ACA further specifies that an Exchange must:
  - **Maintain a website for individuals to view standardized comparative information**
  - Assign a rating to each Exchange plan based on HHS criteria
  - **Use a standardized format for presenting Exchange plan options**
  - **Establish the Navigator program**

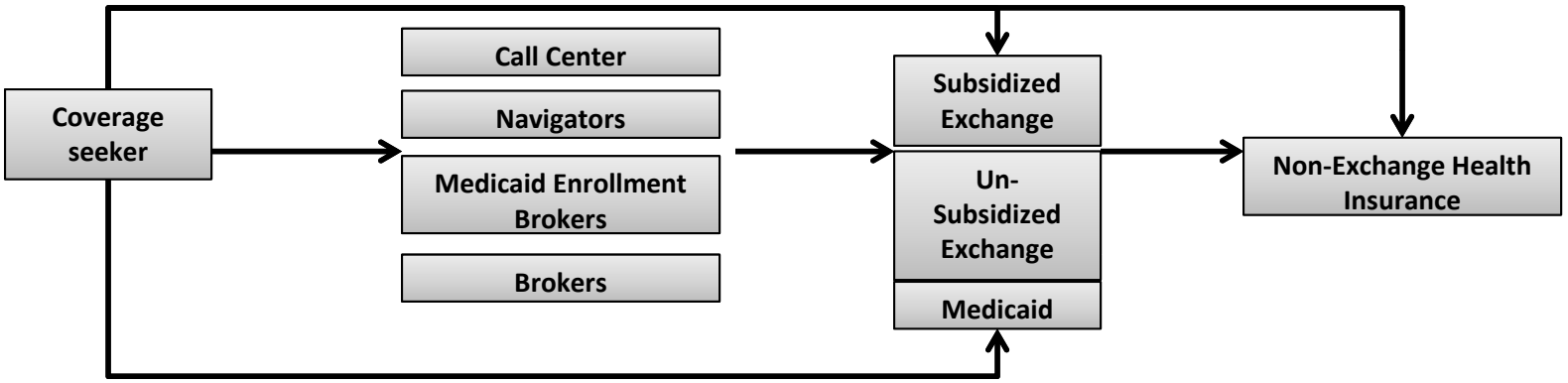
…

Exchange Requirements from the ACA continued

…

- **Inform individuals of eligibility requirements for Medicaid, CHIP, or any other state or local program**
- Provide for a calculator to determine the actual cost of coverage to individuals
- Certify whether individuals are exempt from the individual mandate
- Provide to employers the name of employees who dropped the employer's coverage and received premium tax credits

Seamless Point of Entry



ACA Implementation Considerations

Laura Spicer

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Two Key ACA Implementation Considerations for States

- Medicaid expansion participation
- State-based or federal exchange participation

Medicaid Expansion: State Responses

- 25 challenged constitutionality
- 2 both challenged and supported
- 11 supported (including MD)
- 12 had no position

Medicaid Expansion:

State Participation Considerations

- Size of expansion population
  - Current eligibility standards
  - Uninsured population in the state
  - Woodwork effect
- Cost
  - Federal match 100% in 2014-2016, phasing down to 90% in 2020 and beyond
  - Cost of opting in vs. opting out

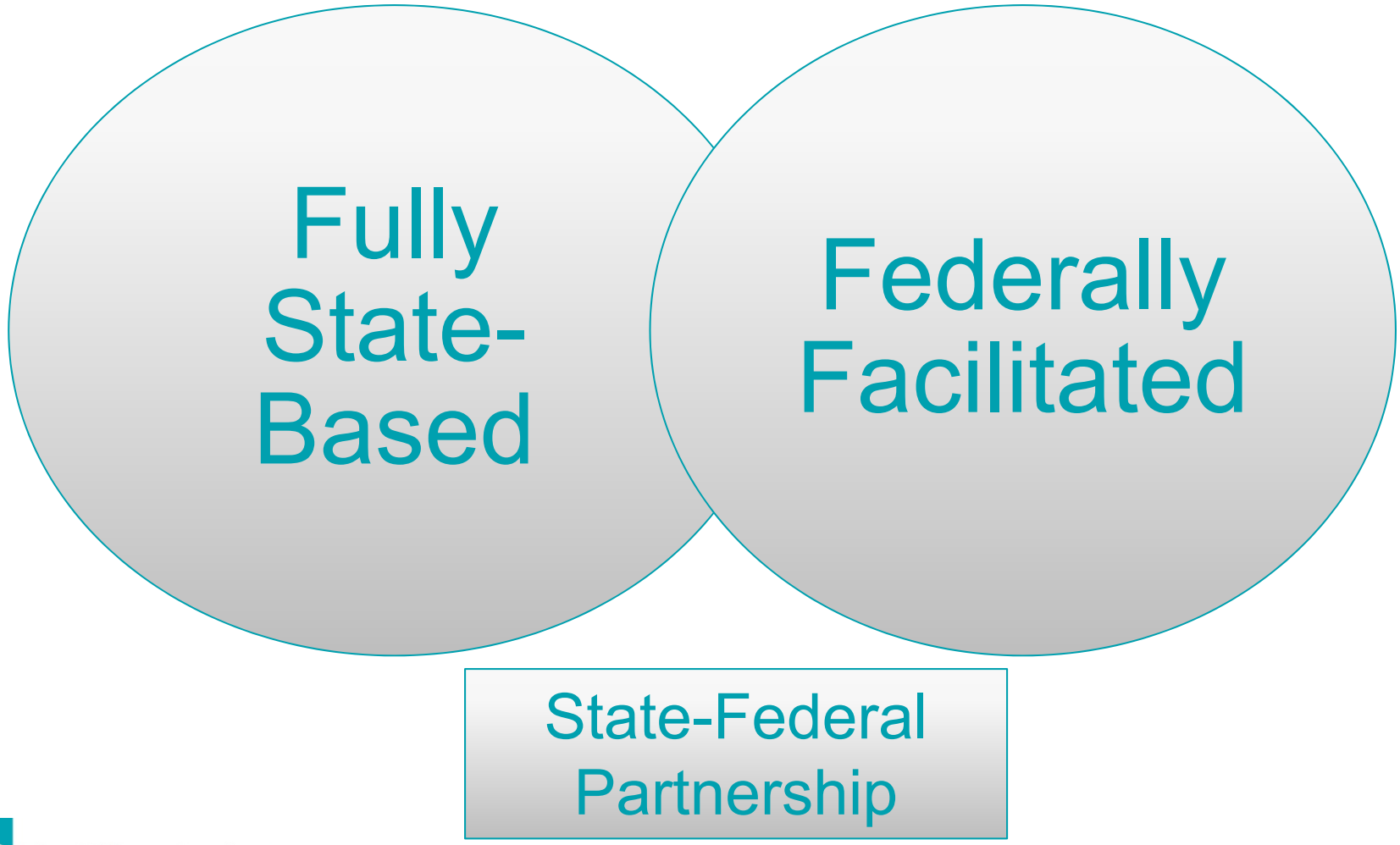
Medicaid Expansion:

State Participation Considerations

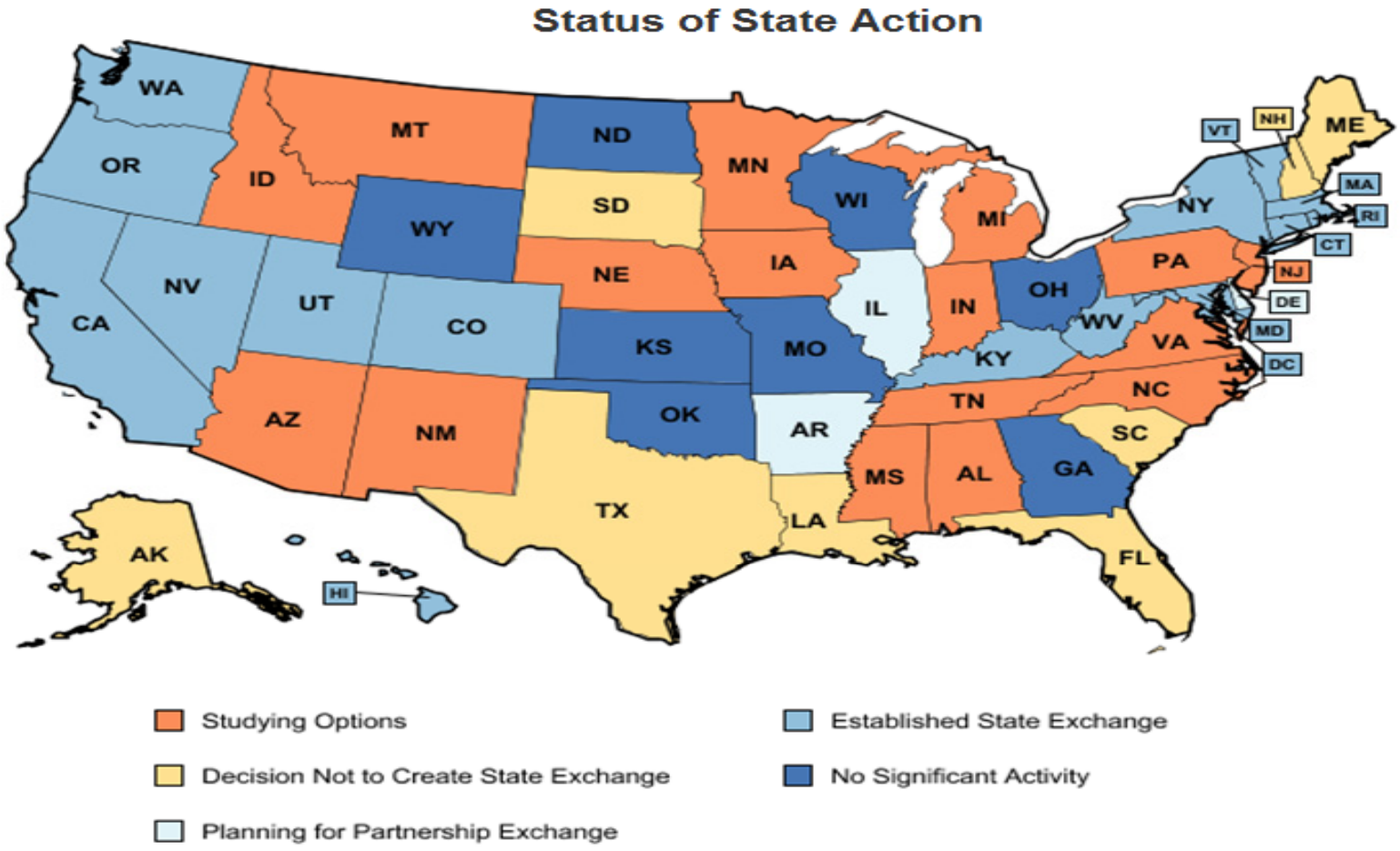
continued

- Federal guidance
- Timing
- Partial expansion

Exchange Participation Options



State Exchange Activity



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statehealthfacts.org

State Exchange Activity continued

Approach	States
Established State-Based Exchange	**16:** CA, CO, CT, DC, HI, KY, **MD**, MA, NV, NY, OR, RI, UT, VT, WA, WV
Plans for State-Federal Partnership Exchange	**3:** AR, DE, IL
Studying Options	**16:** AL, AZ, ID, IN, IA, MI, MN, MS, MT, NE, NJ, NM, NC, PA, TN, VA
Decision Not to Create	**8:** AK, FL, LA, ME, NH, SC, SD, TX
No Significant Activity	**8:** GA, KS, MO, ND, OH, OK, WI, WY

Source: Kaiser Family Foundation State Health Facts
http://www.statehealthfacts.org/comparemaptable.jsp?ind=962&cat=17

State-Based Exchange Considerations

- Financing
- Heath plan participation
- Essential health benefits
- Enrollment and marketing
- Risk mitigation
- Sustainability

Financing

- Funded by federal grants through 2014, but must be self-sustaining by 2015
- State financing options range from narrow assessments to broad-based funding
- Options should consider:
  - Exchange's estimated operating budget
  - Value of Exchange both to individuals/health plans participating and the state/general public
  - How broadly to spread the cost

Financing Options Include:

- Fees from plans sold in the Exchange
- Assessments on participating issuers or all issuers in market
- Repurposing existing revenues
- Assessments on the health care market
- Tax revenue
- General funds

Health Plan Participation Considerations

- Current market concentration
- Requirements for plans to participate
- Standards for certifying health plans

Essential Health Benefits

- Ten categories of services that must be offered by all health plans in the individual and small group markets
- Affects plans both inside and outside the Exchange

Essential Health Benefits
continued

- States have option of selecting from:
  - 3 largest small group plans in the state
  - 3 largest state employee plans
  - 3 largest federal employee plans
  - Largest HMO plan offered in state's commercial market
  - If no selection, default to largest small group plan

Enrollment and Marketing

- Enrollment by individuals and small businesses is critical to attracting carrier participation and creating a large enough risk pool
- Designing a Navigator program to provide information and assistance
- Designing a marketing campaign

Risk Mitigation

- Adverse selection (disproportionate number of enrollees with high health needs) increases costs
- Carrier participation requirements
- Balancing health plan rules inside and outside the Exchange

Long-Term Sustainability

- Flexibility in design
- Data collection and evaluation
- Buy-in from key stakeholders

Reform Implementation Activities: Maryland

Maansi Raswant

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Maryland Health Benefit Exchange (MHBE) Timeline

- **March 2010** – ACA becomes law
- **April 2011** – Maryland Health Benefit Exchange Act becomes law
- **June 2011** – Exchange Board holds first meeting
- **September-November 2011** – Phase 1 of Advisory Committee meetings

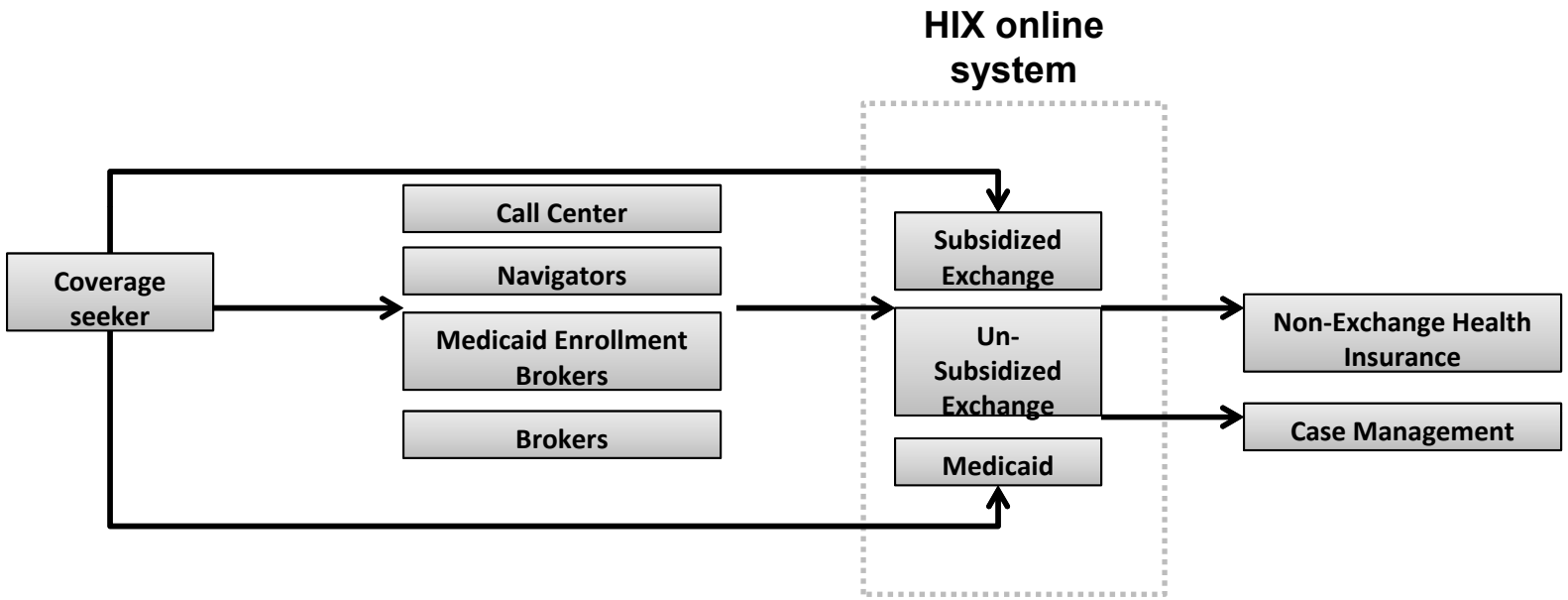
MHBE Timeline continued

- **May 2012** – Maryland Health Benefit Exchange Act 2012 signed into law
- **June 2012 – December 2012** – Phase 2 of Advisory Committee meetings
- **October 2012** – Qualified Plan Certification Interim Policies adopted by MHBE Board

MHBE Timeline continued

- **January 1, 2013** – MHBE must be certified for operation as a state-based Exchange by federal government
- **October 1, 2013** – Open enrollment begins
- **January 1, 2014** – Coverage is effective
- **January 1, 2016** – Exchange must be self-sustaining

Seamless Point of Entry: Maryland



- Navigator Entities
- Navigators
- Call Canter functions
- Interaction with Medicaid Enrollment Broker

- QHP Certification
- Separating the Individual and SHOP Exchanges
- HIX system requirements

- Redeterminations
- Qualifying Events
- Appeals of denial, redeterminations, etc.

Advisory Committee Overview

Advisory committees were charged with critically reviewing the six studies from a Maryland perspective

Advisory Committee	Study Completed
Navigator and Enrollment	▪ Design and operation of Exchange's Navigator Program ▪ Public relations and advertising campaign
SHOP	▪ Design and function of SHOP Exchange
Operating Model and Insurance Rules	▪ Feasibility and desirability of engaging in selective contracting and multi-state or regional contracting ▪ Rules for offering health benefit plans inside and outside the Exchange (*to include risk selection, reinsurance, and risk corridors*)
Finance and Sustainability	▪ Ways to ensure that Exchange is self-sustaining by 2015

Final Recommendations to the General Assembly

Operating Model

1. Exchange should have the **flexibility** to set minimum standards for QHPs above the requirements of the ACA

2. Exchange should have the **flexibility** to modify its approach to contracting over time

Final Recommendations to the General Assembly continued

Market Rules and Risk Mitigation

3. Essential Health Benefits Package should be settled as early as possible

4. **Carriers above the minimum participation threshold should be required to offer products in the Exchange**
   - Small group minimum: $20 million
   - Individual market minimum: $10 million

Final Recommendations to the General Assembly continued

SHOP

10. **Exchange should keep individual and small group market separate in 2014**

11. In 2016, Exchange should reassess merging the two markets

12. **Exchange should not expand the small group market to include employers with 51-100 employees prior to 2016**

Final Recommendations to the General Assembly continued

Navigator Program

16. **Exchange should have separate Navigator programs for individual and small group markets**

17. Exchange should work with Medicaid to integrate Navigator program with Medicaid outreach and enrollment

18. Exchange should adopt producer interface model for SHOP Exchange and Market integration option for the Individual Exchange

Final Recommendations to the General Assembly continued

Navigator Program

19. Exchange should develop and implement certification program, approved by MIA

20. Exchange and MIA should develop enforcement model for Navigator misconduct

Final Recommendations to the General Assembly continued

Financing

22. Foundation for Exchange funding should be a broad-based assessment with additional funding coming from transaction fees tied to enrollment within the Exchange

23. **Decision on financing should be made in early 2013**

Final Recommendations to the General Assembly continued

Continuity of Care

24. Exchange should require transition of care language in contracts as part of QHP certification and work with Medicaid to promote reciprocal care transition provisions in MCO contracts

Maryland Health Benefit Exchange Act of 2012

- Signed by Gov. O'Malley – May 2, 2012
- Includes many of the recommendations
- Exchange must have at least two standing advisory committees reflecting gender, racial/ethnic, and geographic diversity of the state

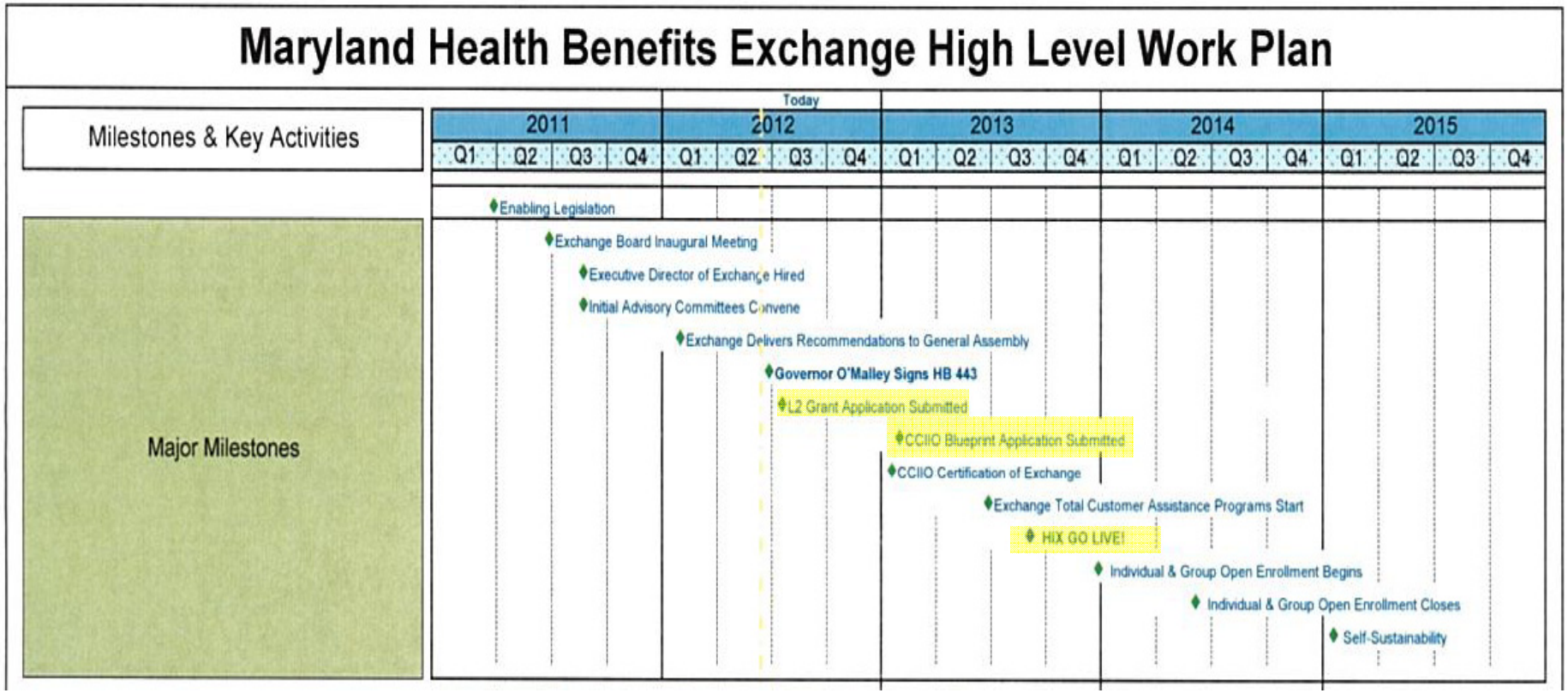
Maryland Health Benefit Exchange Act of 2012 continued

- New Studies
  - Risk Adjustment
    - Whether strategies should be employed to mitigate impact of high-cost MHIP enrollees entering Exchange
    - Whether state should develop its own reinsurance program
  - Exchange Financing
    - Make recommendations on financing mechanisms to fulfill the 2015 self-sustainability requirement

Maryland Health Benefit Exchange Act of 2012 continued

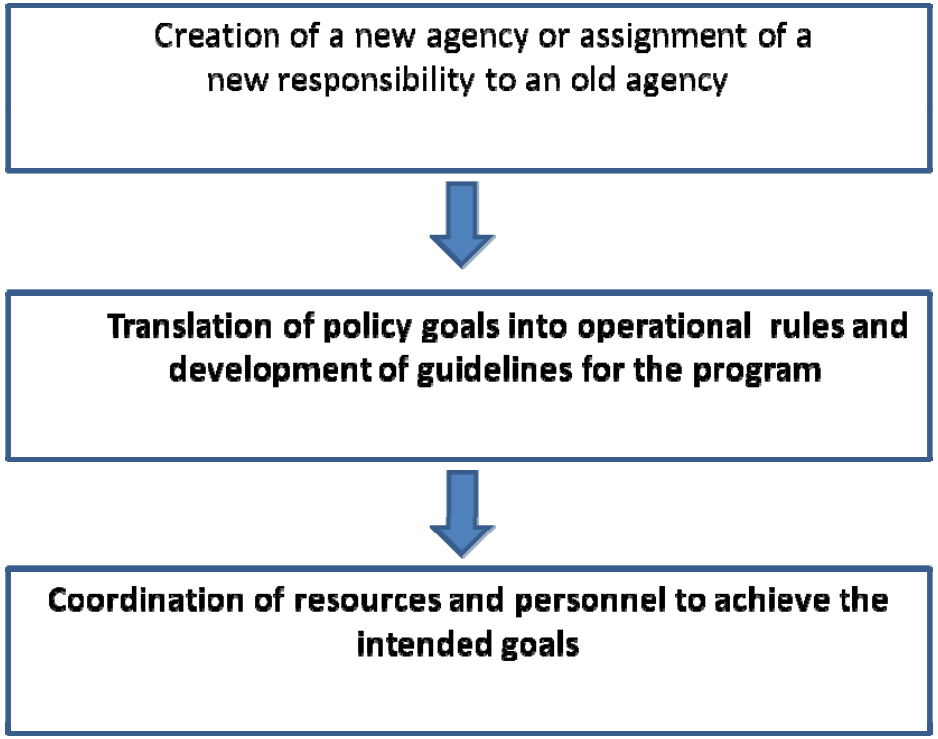
- New Studies continued
  - Transformation of Exchange into nonprofit
  - Merging of SHOP and individual markets
  - Continuity of care
    - Exchange, MIA, and Medicaid to study costs and benefits of continuity of care requirements in Medicaid and health benefit plans offered in individual and small group markets inside/outside the Exchange

Implementing Policy: Major Milestones



Implementing Policy

The 3 elements of public policy implementation



Source: Lineberry, American Public Policy

Implementing Policy, Phase 2: Advisory Committee Process

- Committees
  - New Advisory Committees
    - Plan Management
    - Continuity of Care
    - Navigator
  - Several other “committees” working on Exchange implementation issues

Regulations Development

Maryland defines regulations more broadly than many other states (Division of State Documents (DSD), 1992). Regardless of whether the agency calls it a “guideline,” “rule,” “standard,” “interpretation,” or “policy,” a Maryland agency’s statement is a “regulation” that must be formally promulgated if it (Md. Code Ann., State Gov’t (SGA) § 10-101(g)(1)):

(i) Has general application;

(ii) Has future effect; [and]

(iii) Is adopted by a unit to:

1. Detail or carry out a law that the unit administers;
2. Govern organization of the unit;
3. Govern the procedure of the unit; or
4. Govern practice before the unit.

Source: Somerville, M., Maryland Administrative Regulations

Regulations Development continued

- Compliance with federal deadlines and carriers' timing requirements
  - Exchange may adopt interim policies pending final regulations with respect to preparation and certification of QHPs to be offered in 2014 if necessary to meet federal deadlines and allow carriers sufficient time to develop plans and file rates

Hilltop's Work with the Exchange

- Policy Analysis
  - Continued assistance with day-to-day policy analysis
    - Summarizing and analyzing the impacts of Maryland General Assembly bills
    - Drafting white papers
    - Researching ACA and pursuant regulations to identify authority for Exchange functions
    - SHOP market analysis
    - Comparison of Maryland's Exchange Act to similar bills and laws in other states

Hilltop's Work with the Exchange
continued

- Federal Grant Applications
  - Preliminary projection and impact results were included in the Level II grant application
  - Technical assistance: Content revision and final review
- Regulations Development
- Staffing Advisory Committees

Hilltop's Work with the Exchange
continued

- Financial Model
  - Projection of enrollment in both the Individual and SHOP Exchanges
  - Projection of health care expenditure savings to the state (compared to continuing without health care reform)
  - Continuity of Care Study

Key Takeaways of Maryland Health Reform/Exchange Implementation

- Flexible
  - Flexibility to respond to changing market conditions
- Transparent
  - Numerous forums for public stakeholder input

Key Takeaways continued

- Collaborative
  - Cross-cutting issues require participation among different public agencies/branches of government and private sector
- Data-Driven
  - Key decisions based on Maryland-specific data
  - Prioritizing

Key Takeaways continued

- Deliberative
  - Workgroups to craft Maryland's approach
- Continues in appropriate stages
  - Moving from major aspects of health reform to operational and systems development
  - Prioritizing

About The Hilltop Institute

The Hilltop Institute at UMBC is a non-partisan health research organization—with an expertise in Medicaid and in improving publicly financed health care systems—dedicated to advancing the health and wellbeing of vulnerable populations. Hilltop conducts research, analysis, and evaluations on behalf of government agencies, foundations, and nonprofit organizations at the national, state, and local levels. Hilltop is committed to addressing complex issues through informed, objective, and innovative research and analysis.

www.hilltopinstitute.org

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