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

Health Improvement

- Quality is improving but unequal
- Too little consumer engagement

Consumer Experience

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

Affordability

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

- Imperfect Information
- Lack of Consumer Engagement
- Lack of Mobility and Portability
- Too Few Sellers

Barriers to Health Care Market Competition
What is an Exchange?

Individuals

Employers / Employees

Navigators / Brokers

Federal Hub

Insurers

Commerce

DHS

MDH

Other
## 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:
  – 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

<table>
<thead>
<tr>
<th></th>
<th>Massachusetts</th>
<th>Utah</th>
<th>Private (i.e. CT, CA)</th>
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</thead>
<tbody>
<tr>
<td><strong>Started</strong></td>
<td>2006</td>
<td>2009</td>
<td>mid 1990s</td>
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<tr>
<td><strong>Market</strong></td>
<td>public, individual, and small group</td>
<td>small group (testing larger groups)</td>
<td>small and larger groups</td>
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<tr>
<td><strong>Governance</strong></td>
<td>public/private entity</td>
<td>agency</td>
<td>private</td>
</tr>
<tr>
<td><strong>Role</strong></td>
<td>• negotiate terms</td>
<td>• defined contribution</td>
<td>• defined contribution</td>
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<tr>
<td></td>
<td>• comparison of standard tiered plans</td>
<td>• voluntary insurer participation</td>
<td>• contractual requirements for insurers</td>
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<tr>
<td></td>
<td>• facilitate subsidy for those &lt; 300% FPL</td>
<td>• transparency of comparison info</td>
<td>• human resources functions and other benefits</td>
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<tr>
<td></td>
<td></td>
<td>• aggregate contributions</td>
<td></td>
</tr>
<tr>
<td><strong>Rating and Risk Sharing</strong></td>
<td>• CR and GI inside and outside</td>
<td>• group rated</td>
<td>• group rated</td>
</tr>
<tr>
<td></td>
<td>• merged individual and small group pools</td>
<td>• same rating rules inside and outside</td>
<td>• same general rules inside and outside</td>
</tr>
<tr>
<td></td>
<td>• risk adj for public</td>
<td>• risk adj inside</td>
<td></td>
</tr>
<tr>
<td><strong>Enrollment</strong></td>
<td>200,000 (160K public, &lt; 5K sm grp)</td>
<td>&lt; 3,000</td>
<td>75,000 – 150,000</td>
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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

First Half of 2013: System testing

Fall 2013: Open enrollment

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

January 1, 2014: Coverage through Exchange starts
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