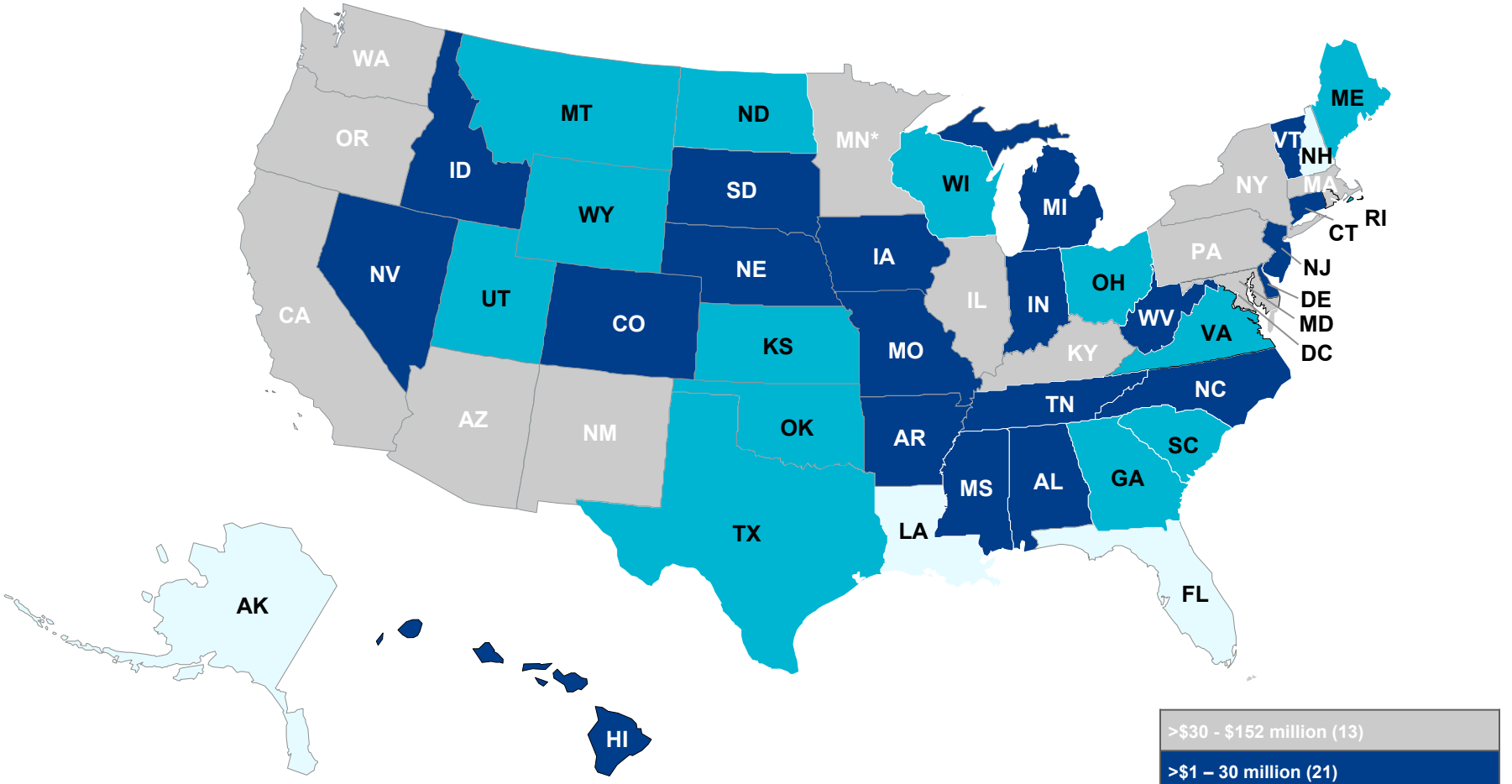
ACA
Why state health insurance exchanges?

- The Patient Protection and Affordable Care Act (ACA, P.L. 111-148) requires, "states to provide a continuous source of subsidized health insurance coverage …"
- Expands health insurance between TWO Mechanisms:
  - Expanding Medicaid
  - Establishing "Exchanges" to purchase health insurance (state and private employer exchanges)
- Requires **every state** to have a health insurance exchange in 2014, but is not mandatory to expand Medicaid (U.S. Supreme Court Decision)
- "State-run" exchanges must be operated by a government agency or non-profit entity established by the state
- States must select one of three options for the "state-run" exchange

Total grants for state health insurance exchanges



Note: Grant totals include Planning grants for up to $1million, Level One and Two Establishment grants, and Early Innovator grants
Source: Kaiser Family Foundation, "Establishing Health Insurance Exchanges: An Overview of State Efforts, Aug 2012"

Three options for states
State health insurance exchange

1. State-run exchange

State operates all exchange activities

State uses "Federal data hub" to verify certain information

State may use federal government services for:

- Risk adjustment program
- Reinsurance program

2. Partnership exchange

State partners with the Department of Health and Human Services (HHS) and takes responsibility for activities related to
plan management, consumer assistance or both

State plan management partnership. State certifies, manages QHPs

State consumer partnership exchange. State manages navigators, in-person assistance program; may also manage outreach, education. HHS operates call center, website; funds navigator grants

3. Federally-Facilitated Exchange

HHS operates exchange

State may opt to perform the following:

- Certain Medicaid and CHIP eligibility determinations
- Collect additional contributions for the reinsurance program

Sources: National Conference of State Legislatures; HHS.gov

States' design choices and implications
State health insurance exchange

Type of exchange

- All exchanges are required to contract only with health plans that meet minimum federal requirements for Qualified Health Plans (QHP)

Structure of exchange

- States have the option of establishing the exchange as:
  - Part of an existing state agency or office (operated by state)
  - An independent public agency
  - A non-profit entity (non-profit)
  - Exchange will categorize levels of coverage into four standard tiers: bronze, silver, gold and platinum

Governing board

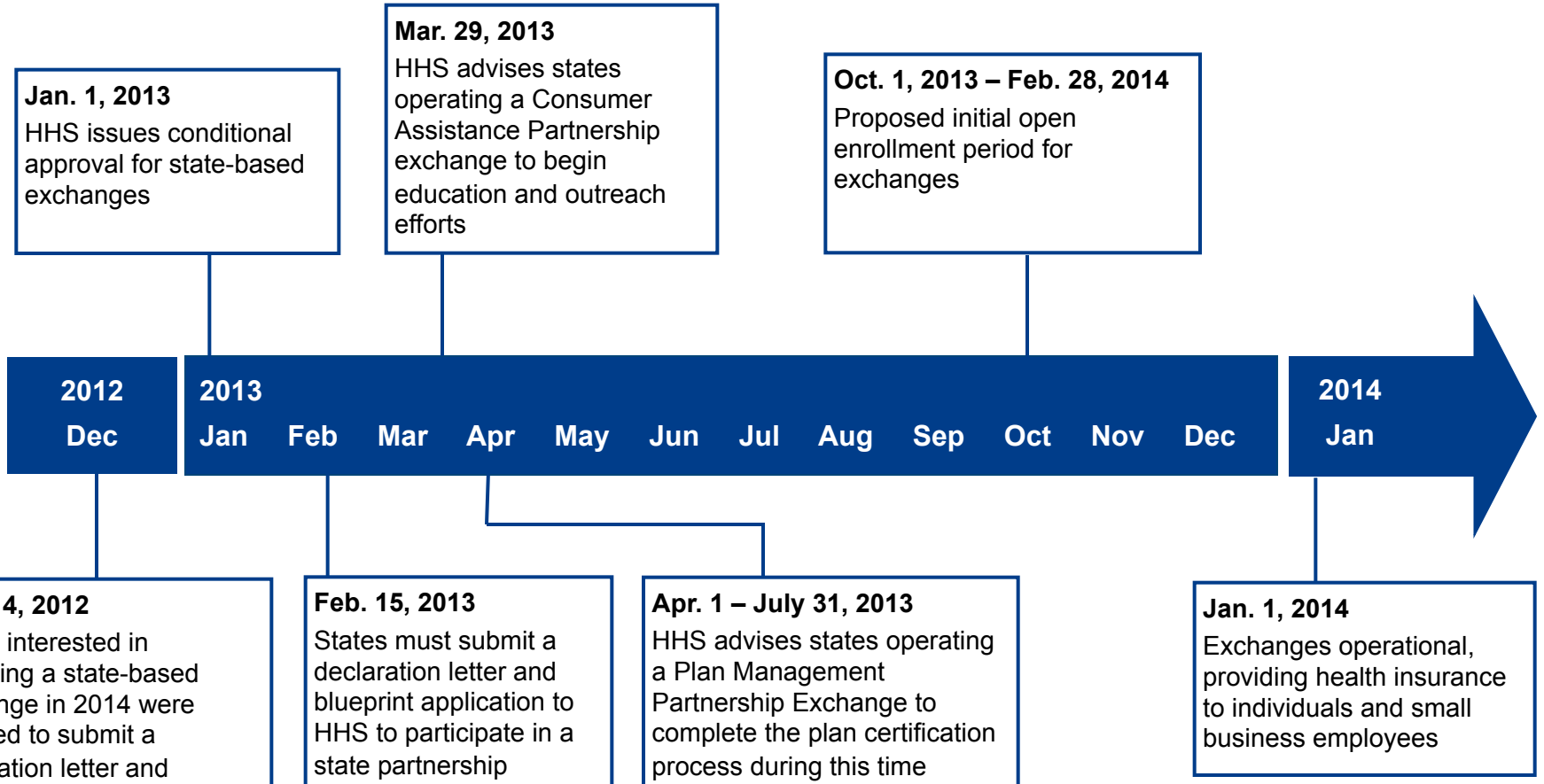
- Almost every state with an established exchange has created an independent governing Board responsible for planning and operating the exchange

Other considerations

- How will states finance the exchanges?
- What IT systems will the exchanges use?
- Will there be a layer of rate review on the exchanges?
- What will third-party access to the exchange look like?
- How will broker compensation be addressed?
- How will consumer assistance and outreach work?

Source: Oliver Wyman Analysis; Kaiser Family Foundation, "State Action Toward Creating Health Insurance Exchanges, as of November 9, 2012"; Kaiser Family Foundation, "Establishing Health Insurance Exchanges: An Overview of State Efforts, Aug 2012"

Timeline for 2014
State health insurance exchange



Jan. 1, 2013
HHS issues conditional approval for state-based exchanges

Mar. 29, 2013
HHS advises states operating a Consumer Assistance Partnership exchange to begin education and outreach efforts

Oct. 1, 2013 – Feb. 28, 2014
Proposed initial open enrollment period for exchanges

Dec. 14, 2012
States interested in operating a state-based exchange in 2014 were required to submit a declaration letter and an blueprint application to HHS. In January 2013, HHS said it will give states more time to decide whether to create a state-run exchange

Feb. 15, 2013
States must submit a declaration letter and blueprint application to HHS to participate in a state partnership exchange. Approvals will be made on a rolling basis

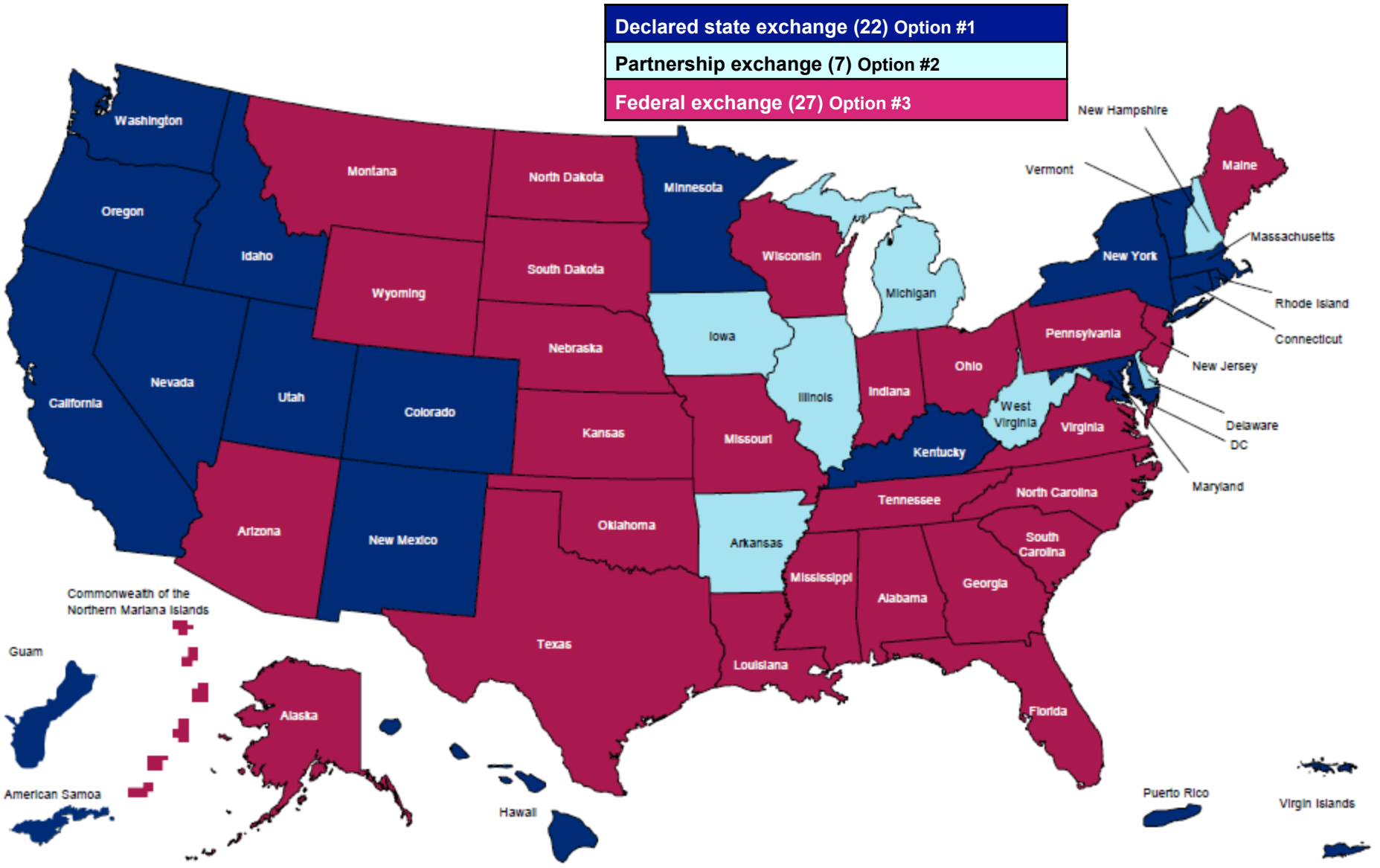
Apr. 1 – July 31, 2013
HHS advises states operating a Plan Management Partnership Exchange to complete the plan certification process during this time

Jan. 1, 2014
Exchanges operational, providing health insurance to individuals and small business employees

Federal update: Hot off the presses (as of March 1, 2013)
State health insurance exchange

- Twenty-two states and the District of Columbia are pursuing state implemented marketplaces (Option #1)
- HHS **conditionally approved** state partnership marketplaces, or exchanges, in four of the seven states (Option #2):
  - Iowa
  - Michigan
  - New Hampshire
  - West Virginia
- Twenty-seven states will default to a federally-facilitated exchange (Option #3)
- Open enrollment in the marketplaces is scheduled to begin in October 2013

State and territory exchange decisions for 2014 (as of Mar. 1, 2013)



Sources: Kaiser Family Foundation (states); HHS, HealthCare.gov (territories)

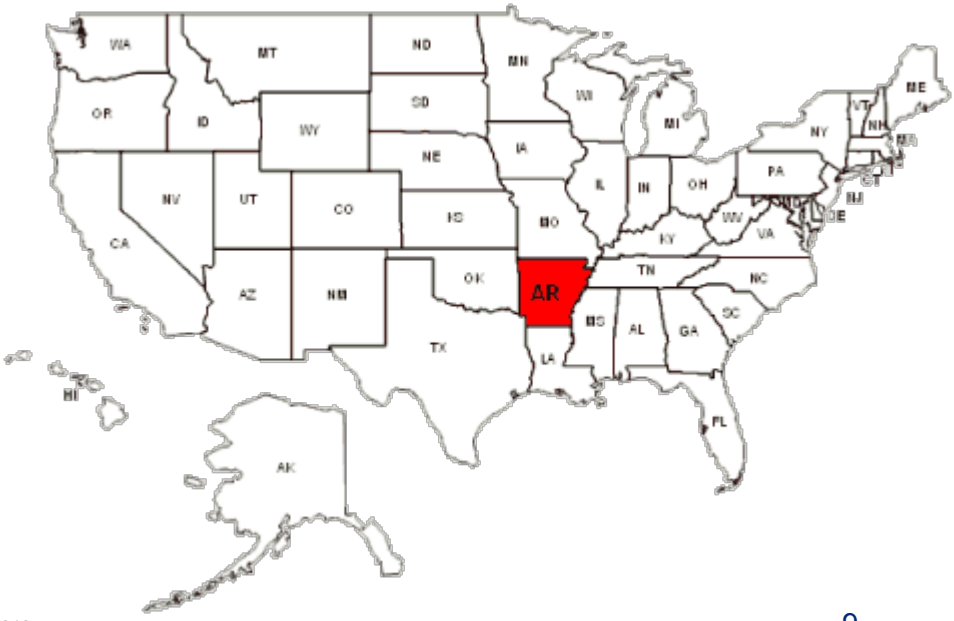
Highlight of state health exchange (three options)
Spotlights on: California, Illinois and Georgia

State-implemented #1	Partnership model #2	Federally-Facilitated #3
		
• The exchange is governed by a five-member board • The board will selectively contract for coverage offered through the exchange: – The state will limit the number of carriers permitted to sell on the exchange to those that it chooses	• While the state is pursuing a partnership exchange, the administration still intends to transition to a fully, state-based exchange in 2015 • The state intends to pursue plan management functions in the partnership exchange • Illinois will not operate its own reinsurance program for 2014 and instead will allow the federal government to do so	• The federal government will assume full responsibility for running a health insurance exchange – Plan certification, oversight functions, consumer assistance and outreach, and streamlining eligibility determinations

1. Coordinate with Medicaid and CHIP Services (CMCS) on decisions and protocols.
Source: National Conference of State Legislatures; HHS.gov; Kaiser Family Foundation, "State Exchange Profiles"

What's up in Arkansas?
Public / private partnership proposal (March 2013)

- Arkansas's Democratic Governor, Mike Beebe, proposed to reject Medicaid expansion
- Wants to use "federal money to purchase private health insurance" for its uninsured residents who qualify
- Other states are looking at Arkansas model:
  - Louisiana
  - Indiana
  - Ohio
  - Florida
- Not formally approved by HHS at this time



ACA — Uninsured solution
Medicaid expansion

- The Medicaid program at-a-glance:
  - Required to cover pregnant women and children younger than six (6) with family income under 133% of the federal poverty level (FPL)
  - Children aged 6-18 with family income under 100% of FPL through Children's Health Insurance Programs (CHIP)
  - Other eligible populations, such as people with disabilities, certain low-income parents, and low-income Medicare beneficiaries
- The federal government provides matching funds to states, using a formula called the Federal Medical Assistance Percentage, or FMAP
- On average, Feds will spend $57 for every $43 that states spend on Medicaid

ACA – Uninsured population
Medicaid expansion costs

- Starting in 2014, everyone with income below 133% of FPL will be eligible for Medicaid
- For the first three years of the expansion, Feds will pick up the **full cost** of the expansion
- 100% funding rate will phase down:
  - 95 percent in 2017
  - 94 percent in 2018
  - 93 percent in 2019
  - 90 percent in 2020
- No "wrong door" policy. No matter where people apply for coverage, states must establish procedures for screening applicants for the right program (whether through an Exchange, Medicaid, CHIP, etc.)
- Many states are concerned, given federal budget pressures, the Feds won't continue to cover 90 percent of the costs after 2020

"Woodworking" is not just for carpenters anymore …
Warning for state governors

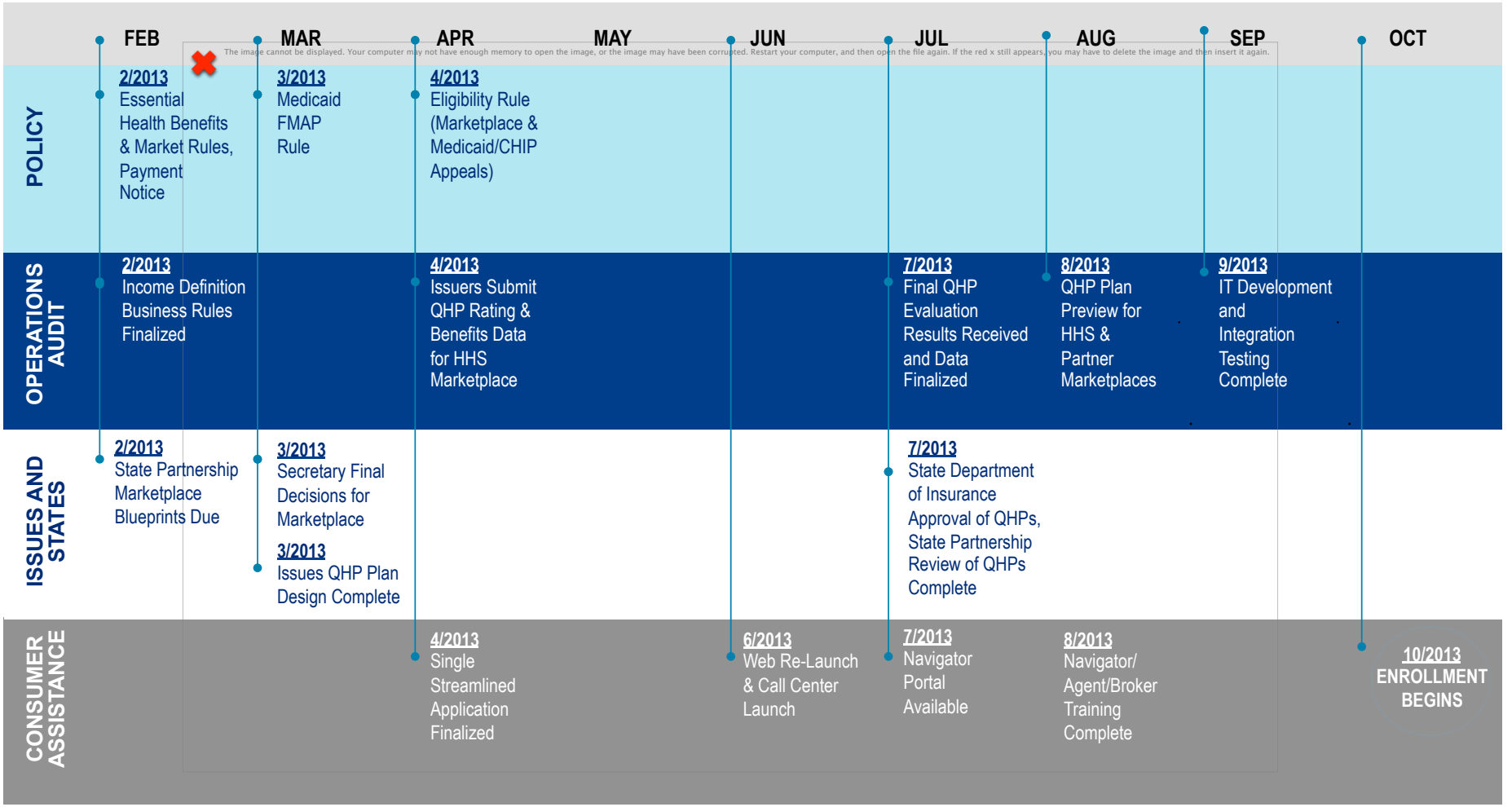
- Nationally, more than nine (9) million uninsured Americans were already eligible for Medicaid, pre-Obamacare, while failing to enroll
- Only 62 percent of people who are eligible for Medicaid today have actually signed up for the program – ***New England Journal of Medicine, 2010***
- Participation rates are below 50 percent in large southern states like **Florida** (44 percent) and **Texas** (48 percent)
- "Woodwork" population, that was already eligible for Medicaid but not enrolled, won't get the 90-100% funding rate
- Expenses will be covered under the traditional FMAP percentage, meaning that states will be required to cover 43% of the costs

Sources: "Why States Have a Huge Fiscal Incentive to Opt-Out of Obamacare's Medicaid Expansion", Forbes, July 13, 2012, Avik, R.

What's coming next?
State health insurance exchange

- ***Congressional Research Service (CRS) report on Comparing Medicaid and Exchanges: Benefits and Costs for Individuals and Families***
- On February 28, 2013, CRS released a report on comparing federal statutorily required benefits and costs associated with Medicaid and the Exchanges
- Addresses the potential implications on populations less than 65 years of age
- Compares the federal requirements that will shape the choices available to states in designing their programs
- ***CMS Marketplace Timeline (Centers for Medicare and Medicaid Services)***
- On February 15, 2013, CMS testified before the Senate Finance Committee on the progress of the federal side of health insurance exchange implementation
- Insurers will begin submitting their plans to CMS on March 28
- Very confident that CMS will meet the October 1 enrollment date
- Released a ***Marketplace Timeline*** that displays their planned timeline for Policy, Operations / IT, Issuers and States, and Consumer Assistance

CMS implementation timeline - 2013



CHIP:	Children's Health Insurance Plan
QHP:	Quality Health Plan
FMAP:	Federal Medical Assistance Percentages (Matching funds for Medicaid and other State-administered programs)

What's coming next?
Impact of ACA provisions for employers

- Penalties for noncompliance, which start in 2014, apply to an employer's size from the prior year. 2013 is the year of planning….
- Small employers (< 50 workers)
  - No new requirements
  - Access to new insurance options through State Exchange /Small Business Health Options Program (SHOP)
  - Eligible for tax credits to subsidize premiums if their income is at or below 400 percent of the federal poverty level ($89,400 for a family of four in 2011)
- Medium employers (50-100 workers)
  - Will face new requirements
  - "Play or Pay" Rule
  - Access to new SHOP insurance options for qualified employers
- Large employers (101+ workers)
  - May face new requirements
  - "Play or Pay" Rule
  - No access to SHOP options, at least until 2017

What's coming next?
Impact of ACA provisions for employers

"Pay to Play" Rule

- Employers with 50+ full-time employees will be subject to penalties, if no coverage
- Employer does not offer coverage (and has at least one employee receiving a federal subsidy to purchase health insurance in 2014)
- Penalty of $2,000 per full-time employee per year, beyond the first 30 employees
- Exclude part-time workers (>30 hours) / seasonal workers (>120 days per year)
- Penalty will increase by the rate of premium inflation after 2014

- New reporting requirements on employers
- The IRS will need employers to supply information to help make determinations about tax credits and penalties
- The new data that the ACA will require employers to report to the IRS includes:
  - Timing, format, content and reporting process which have not been finalized by the federal agencies
  - Other outstanding data issues

    (For example, not all employer health plans operate on a January-January timeline, and plan year does not always coincide with calendar year)

Questions?


MERCER