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The Road to Implementation

State Based Health Insurance Exchanges

Attached you will find a summary of the key components of the state health care exchanges and a proposal regarding “state advisory councils” which has been prepared by the Chiropractic Summit. State associations are encouraged to familiarize themselves with the structure of the state-based insurance exchanges and to become actively involved in their creation at the state level. We recommend state association leadership take the following actions:

1. Establish a working group within the state association to monitor the creation of your local state-based exchange. These exchanges may be created by executive order, policy creation by the state Insurance Commissioner, or through legislation.
2. Work to develop relationships with key players in the process – the Governor, State Insurance Commissioner, and local Representatives and Senators who sit on committees responsible for healthcare in your state.
3. Determine how local doctors of chiropractic may become members of State Advisory Councils and take every measure to have DC’s appointed to these groups.
4. Relay all information obtained from this process to the Chiropractic Summit Government Relations Working Group (GRWG). The GRWG will be compiling a database on the state-based exchanges so we may share this information with other state associations. Our challenge going forward is to open the door to these exchanges for DC’s at the state level. We must ensure that doctors of chiropractic are included in provider panels and that fee parity is maintained as these plans are created. To do this we must work with state agencies to ensure that chiropractic services are considered an essential component of any health care plan.

Please contact me if you have any questions regarding this action plan.

Jerry DeGrado, DC
Chair, Chiropractic Summit GRWG

MEMORANDUM

DATE: June 8, 2010

SUBJ: State Health Insurance Exchanges

TO: Chiropractic State Association Presidents and Executive Directors

FROM: Jerry DeGrado, DC, Chair, Chiropractic Summit GRWG

Please see attached background information on the state health insurance exchanges referenced in the Federal Patient Protection and Affordable Health Care Act of 2010.

The information is provided to help ensure that chiropractic is fully mobilized in support of patient access safeguards as the new health care overhaul law is implemented through legislative and/or regulatory action in your state. It is strongly recommended that an action plan be developed (and shared with GRWG) designed to fully safeguard patient access to chiropractic care through the exchange in your state. As noted in previous communications, such activity may be through the Governor's Office, the Insurance Commissioner's Office, the Legislature – or a combination of these.

In addition, the GRWG has identified a specific provision contained in Section 1323(d) of the new health care law (see below) aimed at establishing an advisory council in each state for community health insurance options. It is strongly recommended that each state association work to secure adequate representation of chiropractic on the panel in your state.

1323(d) STATE ADVISORY COUNCIL.—

(1) ESTABLISHMENT.—A State (other than a State that elects to opt out as provided for in subsection (a)(3)) shall establish or designate a public or non-profit private entity to serve as the State Advisory Council to provide recommendations to the Secretary on the operations and policies of a community health insurance option in the State. Such Council shall provide recommendations on at least the following:

(A) policies and procedures to integrate quality improvement and cost containment mechanisms into the health care delivery system;

(B) mechanisms to facilitate public awareness of the availability of a community health insurance option; and

(C) alternative payment structures under a community health insurance option for health care providers that encourage quality improvement and cost control.

(2) MEMBERS.—The members of the State Advisory Council shall be representatives of the public and shall include health care consumers and providers.

(3) APPLICABILITY OF RECOMMENDATIONS.—The Secretary may apply the recommendations of a State Advisory Council to a community health insurance option in that State, in any other State, or in all States.

If you have any questions about the provisions in the Federal law, please contact John Falardeau in the ACA Washington office at jfalardeau@acatoday.org; Ron Hendrickson in the ICA Washington office at ron@chiropractic.org; or David O'Bryon with the ACC at Obryonco@aol.com

Please continue to monitor the development of a health insurance exchange in your state and report any activity to the contacts listed above.

ATTACHMENT

Background Information on the “American Health Benefit Exchanges,” state-based health insurance marketplaces created by the 2010 health care overhaul law.

**Source: *Congressional Research Service, Library of Congress*
April 2010**

The Patient Protection and Affordable Care Act (P.L. 111-148, PPACA) was signed into law on March 23, 2010. On March 31, 2010, PPACA was amended by P.L. 111-152, the Health Care and Education Reconciliation Act of 2010. This material has been compiled to offer basic background information on provisions aimed at establishing statebased health insurance exchanges before 2014. PPACA imposes new requirements on individuals, employers, and health plans; restructures the private health insurance market; sets minimum standards for health coverage; and provides financial assistance to certain individuals and, in some cases, small employers. In general, PPACA requires individuals, beginning in 2014, to maintain health insurance, with some exceptions. Individuals will be required to maintain minimum essential coverage, which includes eligible employer coverage, individual coverage, grandfathered plans, and federal programs such as Medicare and Medicaid, among others. Employers are not explicitly required to provide health benefits, although certain employers with more than 50 employees may be required to pay a penalty if either (1) they do not provide insurance, under certain circumstances, or (2) the insurance they provide does not meet specified requirements. Several insurance market reforms will be implemented, including some prior to full implementation in 2014, such as prohibition against lifetime benefit limits and coverage for preexisting health conditions for children.

Explanation of Selected Terms:

AMERICAN HEALTH BENEFITS EXCHANGES -- *In addition to establishing new federal private health insurance standards, PPACA will enable and support states’ creation by 2014 of “American Health Benefit Exchanges.” An exchange cannot be an insurer, but will provide eligible individuals and small businesses with access to insurers’ plans in a comparable way. The exchange will consist of a selection of private plans as well as “multi-state qualified health plans,” administered by the Office of Personnel Management (OPM). Individuals will only be eligible to enroll in an exchange plan if they are not enrolled in Medicare, Medicaid, or acceptable employer coverage as a full-time employee. Based on income, certain individuals may qualify for a tax credit toward their premium costs and a subsidy for their cost sharing; the credits and subsidies will be available only through an exchange. States will have the flexibility to establish basic health plans for low-income individuals not eligible for Medicaid. Individual and small group coverage will be allowed to be offered through nonprofit, member-run health insurance companies. Such nonprofit insurers will be eligible for grants and loans distributed through the new Consume Operated and Oriented Plan (CO-OP) program.*

INDIVIDUAL MANDATE -- Beginning in 2014, PPACA includes a mandate for most individuals to have health insurance, or potentially pay a penalty for noncompliance. Individuals will be required to maintain minimum essential coverage for themselves and their dependents. Those who do not meet the mandate will be required to pay a penalty for each month of noncompliance. The penalty will be calculated as the greater of either (1) a percentage of the amount by which household income exceeds the personal exemption for the applicable tax year¹¹ ("applicable income") or (2) a flat dollar amount assessed on each taxpayer and any dependents (e.g., family), with the total penalty for a family capped at 300% of the flat dollar amount.

QUALIFIED HEALTH PLAN (QHP) – A health plan that is certified as meeting a specified list of requirements related to marketing, choice of providers, plan networks, and other features, or is recognized by each exchange through which such plan is offered; and provides the essential health benefits package. A QHP issuer must be licensed and in good standing with each state in which it offers coverage; must offer at least one QHP each providing silver and gold levels of coverage (levels described below); must charge the same premium for a plan regardless if it is offered in or out of the exchange (including through an insurance agent); and must comply with regulations applicable to exchanges. QHPs will include qualified health plans offered through the CO-OP program

COVERAGE LEVELS -- Beginning in 2014, PPACA will generally require QHPs to provide coverage at one of the following levels: bronze, silver, gold, or platinum. This requirement will apply regardless of whether or not the QHP is offered through an exchange (and premiums must be the same for QHPs inside and outside of the exchange). Health insurance issuers must offer a silver plan and a gold plan in the exchange. Each coverage level will be based on a specified share of the full actuarial value of the essential health benefits. A health insurance issuer that offers coverage in any of these four levels will be required to offer the same level of coverage in a plan specifically designed for individuals under age 21. Another plan option permitted under PPACA in 2014 is a catastrophic plan which will provide coverage for essential health benefits and have deductibles equal to the amounts specified as out-of-pocket limits for HSA-qualified HDHPs. A catastrophic plan will be permitted only in the individual market (1) for young adults (those under age 30 before the plan year begins), and (2) for those persons exempt from the individual mandate because no affordable coverage is available or they have a hardship exemption.

CONSUMER OPERATED AND ORIENTED PLAN -- The creation of new health insurance cooperatives will be encouraged primarily through the distribution of \$6 billion in funding under the Consumer Operated and Oriented Plan (CO-OP) program. The Secretary will use the funds to foster the creation of new nonprofit member-run health insurance issuers that offer QHPs in the individual and small group markets. Federal funds will be distributed as loans for start-up costs and grants for meeting solvency requirements. The funds must ultimately be repaid.

➤ Exchange Structure

PPACA enables and supports states' creation by 2014 of "American Health Benefit Exchanges," similar in many respects to existing entities like the Massachusetts Connector and eHealthInsurance.

Exchanges will not be insurers, but will provide qualified individuals and small businesses with access to insurers' QHP in a comparable way (in a similar way, for example, that Travelocity or Expedia are not airlines but provide access to available flights and fares in a comparable way). Exchanges will be state-established government or nonprofit entities that will have additional responsibilities as well, such as certifying plans and identifying individuals eligible for Medicaid, CHIP, and premium and cost-sharing credits.

Within one year of enactment, the Secretary will determine and make grant awards to states to create exchanges, with such sums appropriated as necessary. The grants can be renewed to states making progress in establishing an exchange, implementing the private health insurance market reforms, and meeting other benchmarks established by the Secretary. However, no grant may be awarded after January 1, 2015. Exchanges will have to be self-sustaining by then, using assessments on insurers or some other way to generate funds to support their operations.

PPACA requires the Secretary, in consultation with the National Association of Insurance Commissioners (NAIC) and others, to set standards for exchanges, offering QHPs through exchanges, reinsurance, and risk adjustment as soon as possible after enactment. It will further require states to implement these standards, as well as the required private insurance market reforms, by 2014. If the Secretary determines before 2013 that a state will not have an exchange operational by 2014, or will not be able to implement the standards, the Secretary is required (directly or through an agreement with a non-profit entity) to establish and operate an exchange in the state and to implement the standards. A state operating an exchange with sizeable enrollment before 2010 is presumed to meet the standards, unless the state is still out of compliance after completion of the process the Secretary is required to establish to assist such a state.

PPACA permits the creation of separate exchanges in each state for individuals versus small employers ("a Small Business Health Options Program ... [or] 'SHOP exchange'"), for which the Secretary will provide technical assistance to states. A state could merge them into a single exchange, "but only if the exchange has separate resources to assist individuals and employers."

An exchange may operate in multiple states, if each state agrees to the operation of the exchange and if the Secretary approves. A state may have more than one exchange ("subsidiary exchanges") if each serves a geographically distinct area and the area served is adequately large. New individual and small-group QHPs may be offered inside and outside of an exchange, but the premiums would have to be the same. However, premium credits and cost-sharing subsidies will only be available through exchanges.

PPACA specifies that an exchange must do the following:

- implement procedures to certify, recertify and decertify QHPs;
- provide for the operation of a toll-free hotline;
- maintain a website through which individuals can view standardized comparative information on plans;
- assign a rating to each exchange plan based on criteria developed by the Secretary;
- use a standardized format for presenting exchange plan options;
- inform individuals of eligibility requirements for Medicaid, CHIP or any other state or local program and, if through the screening process the exchange determines they are eligible for one of those programs, enroll them;
- provide for a calculator to determine the actual cost of coverage to individuals after taking into account any premium credits and cost-sharing subsidies;
- certify whether individuals are exempt from the individual mandate excise tax and transfer the list of such individuals to the Treasury Secretary;
- provide to employers the name of the employees who dropped the employer's coverage and received premium tax credits because the employer's plan was unaffordable or did not provide the required minimum actuarial value; and
- establish the Navigator program. *(PPACA requires exchanges to establish a grant program for Navigators, which would receive funding from exchanges – not the federal government – to conduct public education activities regarding the availability of QHPs, distribute information on enrollment in plans and subsidies, facilitate enrollment in a qualified plan, provide referrals to individuals with grievances or questions and provide information in a culturally and linguistically appropriate manner.)*

The Secretary will also establish procedures under which a state could permit insurance agents or brokers to enroll individuals in an exchange plan and to assist them in applying for premium credits and cost-sharing subsidies. The Secretary, in coordination with the HHS Inspector General, will have authority to investigate exchanges.

Exchanges will be subject to annual HHS audits. If the Secretary finds serious misconduct, payment otherwise due to the exchange may be rescinded, up to 1% of such payments, until corrective actions are taken that are deemed adequate by the Secretary. By January 1, 2019, GAO will conduct an ongoing study on exchange activities and the enrollees in exchange plans, reviewing the operation and administration of exchanges, any significant observations regarding the use and adoption of exchanges, recommendations for their improvement, and how many physicians are not accepting new patients enrolled in federal government health care programs and whether those programs' available provider networks are adequate.

➤ Individual and Employer Eligibility for Exchange Plans

Beginning 2014, individuals may enroll in a plan through their state's exchange if they are (1) residing in a state that established an exchange, (2) not incarcerated, except individuals in custody pending the disposition of charges, and (3) lawful residents. Only lawful residents may obtain exchange coverage; unauthorized aliens will be prohibited from obtaining coverage through an exchange, even if they could pay the entire premium without any subsidy.

Initially, only small employers could opt to offer coverage to their workers through an exchange. (They would have to make all of their full-time employees exchange eligible.) Before 2016, states will have the option to define "small employers" either as those with (1) 100 or fewer employees, or (2) 50 or fewer employees. Beginning in 2016, small employers will be defined as those with 100 or fewer employees. Beginning in 2017, states may allow large employers to obtain coverage through an exchange (but will not be required to do so). Participating employers may limit their workers' choice of exchange plans to a particular benefit level (tier); workers could then choose any available exchange plan at that level.

Members of Congress and their staff can enroll only in health plans created under this Act or offered through an exchange. This provision only applies to those congressional staff who are full- and part-time employees employed by the official office of a Member of Congress.

➤ **Premium Credits and Cost-Sharing Subsidies**

Beginning 2014, some individuals will be eligible for premium tax credits toward their required purchase of health insurance, based on income. However, even when individuals have health insurance subsidized with premium credits, they may be unable to afford the cost-sharing (deductible and copayments) required to obtain health care. Thus, cost-sharing subsidies may also be available to those eligible for premium credits.

➤ **Premium Credits**

Beginning January 1, 2014, qualifying individuals will receive advanceable, refundable tax credits toward the purchase of an exchange plan (although the advance payment will actually go directly to the insurer). Individuals above 400% of the federal poverty level (FPL) will not be eligible for credits.

Eligibility for Medicaid as expanded under the law interacts with the provisions regarding premium credits and cost-sharing subsidies available for exchange coverage. From April 1, 2010, through 2013, states have the *option* to expand Medicaid to all non-elderly, non-pregnant individuals (i.e., childless adults and certain parents, except for those ineligible based on certain noncitizenship status) who are otherwise ineligible for Medicaid up to 133% FPL. Beginning in 2014, states would be *required* to extend Medicaid to these individuals. Thus, in 2014, all nonelderly *citizens* and certain legal aliens up to 133% FPL will be eligible for Medicaid. (If a person who applied for premium credits in an exchange was determined to be eligible for Medicaid, the exchange would have that person enrolled in

Medicaid.) PPACA does not change noncitizens' eligibility for Medicaid. Thus, for example, certain legal permanent residents (LPRs) who are below 133% FPL would be ineligible for Medicaid.

However, when the credits become available in 2014, lawfully present taxpayers below 133% FPL who are not eligible for Medicaid may be eligible for premium credits.

Besides the previously mentioned eligibility criteria, individuals will also generally be ineligible for credits if they are *eligible* for Medicare, Medicaid, CHIP, coverage related to military service, an employer-sponsored plan, a grandfathered plan, and other coverage recognized by the Secretary. An individual eligible for, but not enrolled in, an employer-sponsored plan could still be eligible for subsidies if the employee's contribution to premiums exceeded 9.5% of household income or if the plan's payments cover less than 60% of total allowed costs, as long as the individual qualified for the credit on the basis of their income.

➤ **Cost-Sharing Subsidies**

Those who qualify for premium credits and are enrolled in an exchange plan at the silver tier beginning in 2014 will also be eligible for assistance in paying any required cost-sharing for their health services. Exchange plans will be required to limit out-of-pocket costs based on high deductible health plans (HDHPs) that qualify individuals for health savings accounts (HSAs). For 2010, the out-of-pocket maximum for HSA-qualified HDHPs is \$5,950 for single coverage and \$11,900 for family coverage. The cost-sharing subsidies will further reduce those out-of-pocket maximums by two-thirds for qualifying individuals between 100% and 200% FPL, by one-half for qualifying individuals between 201% and 300% FPL, and by one-third for qualifying individuals between 301% and 400% FPL. The Secretary will make periodic payments to insurers (potentially using capitated, risk-adjusted payments) for the cost-sharing subsidies of their qualified enrollees.

➤ **Multi-state Qualified Health Plans**

The Director of the Office of Personnel Management (OPM) will enter into contracts with health insurance issuers to offer at least two multi-state qualified health plans (MSQHPs) ultimately through every exchange in all the states, to provide individual and small group coverage. Any individual eligible to purchase insurance through the exchange may enroll in a MSQHP. Enrollment is voluntary, and individuals may be eligible for premium credits and cost-sharing assistance.

A health insurance issuer offering a MSQHP must do the following: meet the requirements in every state's exchange; be licensed in each state and subject to all requirements of state law not inconsistent with MSQHPs; comply with the minimum standards prescribed for carriers offering health benefits plans under the Federal Employees Health Benefits Program (FEHBP); meet other requirements as determined appropriate by the OPM Director, in consultation with the Secretary; offer a uniform benefits package in each state consisting of the essential benefits; meet all requirements of a qualified health plan, "including requirements relating to the offering of the

bronze, silver, and gold levels of coverage and catastrophic coverage in each State Exchange”; meet the rating requirements of PPACA (except for certain state rating requirements); and also offer the plan in all geographic regions, and in all states that adopted adjusted community rating before the date of enactment of PPACA.

Each contract for an MSQHP will be for at least one year and can be automatically renewed if neither party provides notice to terminate. At least one contract will be with a nonprofit entity. The OPM Director will enter into a contract with a health insurance issuer if the issuer offers the plan in at least 60% of states in the first year, at least 70% in the second year, at least 85% in the third year, and in all states thereafter.

The OPM Director will implement MSQHPs with similar contracting provisions affecting carriers under FEHBP—through negotiating with each MSQHP on (1) medical loss ratio, (2) profit margin, (3) premiums to be charged, and (4) such other terms and conditions of coverage as are in the interests of enrollees in such plans. The OPM Director can prohibit the offering of any MSQHP that does not meet these criteria. The requirements of the FEHBP program will apply only to MSQHPs to the extent that they are not in conflict with the requirements of PPACA. The OPM Director cannot reduce financial or personnel resources to the functions of OPM related to the administration of FEHBP. The Director can (1) establish separate units or offices within OPM to ensure that the administration of MSQHPs do not interfere with the administration of FEHBP, and (2) appoint additional personnel to carry out MSQHP activities. MSQHPs will be separate from FEHBP, with a separate risk pool, and FEHBP plans will not be required to offer a MSQHP.

➤ **Additional State Options: State Flexibility to Establish a Basic Health Program**

PPACA will establish a program to support coverage of low-income individuals not eligible for Medicaid modeled after the Washington State Basic Health (BH) Plan program administered and financed by the Washington State Health Care Authority (HCA). The BH Plan started as a pilot program established by the Washington State “Health Care Access Act of 1987.” PPACA will create a similar state option for individuals who are not eligible for Medicaid, have not reached the age of 65, and whose household income exceeds 133%, but does not exceed 200% of the poverty line for the size of the family involved.⁸⁸ Generally eligible individuals would be those under 200% of poverty who would otherwise be eligible for premium credits in an exchange. However, under PPACA, an individual eligible for a state’s basic health program would not be eligible for exchange coverage.

The law will require the Secretary to establish a program where a state or a regional compact of states could establish one or more standard health plans. The Secretary will transfer to the state for each fiscal year for which one or more standard health plans are operating within the state the amount equal to 95% of the premium tax credits under section 36B of the IRC of 1986, and the cost-sharing reductions under section 1402, that will have been provided for the fiscal year to eligible individuals enrolled in standard health plans if such eligible individuals were allowed to enroll in QHPs

through an exchange. A standard health plan will be defined as a health benefits plan that the state contracts with that:

- will not be open for enrollment to a broad group of individuals, but only to individuals eligible for the program;
- provides at least the essential health benefits defined in the law; and in the case of a plan that provides health insurance coverage offered by a health insurance issuer, has a medical loss ratio of at least 85%. PPACA will provide that a state basic health program establish a competitive process for entering into contracts with standard health plans including negotiation of premiums and cost-sharing and negotiation of benefits in addition to the essential health benefits. The competitive process will consider the following:
 - innovative features including, but not limited to care coordination and care management (emphasizing chronic conditions);
 - incentives for use of preventive services, and establishment of patient/doctor relationships that maximize patient involvement in health care decision-making;
 - contracting with managed care systems or with systems that offer as many of the attributes of managed care as feasible in the local health care market; and
 - specific performance measures and standards for coverage of providers that focus on quality of care and improved outcomes, in addition to requiring providers to report measures and standards.

Under the law, states will be instructed to seek participation by multiple health plans to allow enrollees a choice between two or more plans, whenever possible. States will also be allowed to negotiate a regional compact with other states to include coverage of eligible individuals in all such states. State administrators will be encouraged to find ways to integrate their negotiations with any Medicaid or other state administered health care programs to maximize efficiency and improve the continuity of care between all state administered health programs.

➤ **Waiver for State Innovation**

Beginning in 2017, the law will permit states to apply for a waiver for up to five years of requirements relating to QHPs, exchanges, premium tax credits, cost-sharing subsidies, the individual mandate, and certain employer requirements. The state applying for the waiver will be required to enact a law, provide a 10-year budget plan ensuring budget neutrality for the federal government, and to comply with regulations that ensure transparency.

The Secretary will be required to provide to a state the aggregate amount of premium credits and cost-sharing subsidies that would have been paid to residents of the state in the absence of a waiver. The Secretary will only be permitted to grant a request for a waiver if the Secretary determined that the state plan will do the following:

- provide coverage that is at least as comprehensive as the coverage offered through exchanges

as certified by Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the state and from comparable states about their experience with programs created under PPACA;

- provide coverage and cost-sharing protections against excessive out-of-pocket spending;
- provide coverage to at least a comparable number of its residents as will be provided without the waiver; and
- not increase the federal deficit.

➤ **Offering Plans in More Than One State**

Under PPACA, not later than July 1, 2013, the Secretary, in consultation with NAIC, will promulgate regulations for interstate health care choice compacts, which can be entered into beginning in 2016. Under such compacts, QHPs will be offered in all participating states, but insurers will still be subject to the consumer protection laws of the purchaser's state. Insurers will be required to be licensed in all participating states and to clearly notify consumers that a policy may not be subject to all the laws and regulations of the purchaser's state. The law also will require that states enact a law to enter into compacts and to obtain approval of the Secretary, but only if the Secretary determines that the compact will provide coverage that is at least as comprehensive and affordable, to at least a comparable number of residents, as would otherwise be provided. Moreover, the law will require that the compact will not increase the federal deficit or weaken enforcement of state consumer protection laws.

This provision will also allow insurers in the individual and small group markets to offer a QHP nation-wide, which will be subject not only to the state benefit mandate laws of the state in which the plans are issued, but would require such plans to provide the essential benefits package. States will be permitted to enact a law to opt out of allowing the offering of nationwide plans. Insurers will be required to file plan forms for review with each state.