State Health Exchanges and Qualified Health Plans

Briefing for Medicaid Health Plans of America

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Webinar
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Agenda

1. Overview of State Exchanges and Qualified Health Plans
2. Benefit Designs and Plan Offerings
3. Premiums and Cost Sharing
4. Federal Subsidies
5. Requirements for Qualified Health Plans
6. State Health Insurance Exchanges
7. National and Multi-State Plans
8. Interaction with Medicaid
9. State Flexibility and Waivers

Caveat: Presentation is based on PPACA language and preliminary assessment. The following is therefore subject to change based on future federal and state decisions.

Overview of
State Exchanges and Qualified Health Plans

- ✓Starting January 1, 2014
- ✓Individual, Small Group, Large Group Markets
- ✓Consumer Choice of Plans
- ✓Projected Enrollment in Exchanges
- ✓Advantages for Individuals and Employers
- ✓Advantages for Medicaid Health Plans
- ✓Office of Consumer Information & Insurance Oversight

Starting January 1, 2014

1. Every state must establish an "**American Health Benefit Exchange**" for individuals and small groups to buy health insurance from "**Qualified Health Plans**."

2. States must create a **Small Business Health Options Program Exchange** (SHOP) for small businesses. Separate or part of single state exchange.

3. States may join together to operate **multi-state, regional Exchanges**.

4. States may operate Exchange in **existing agency**, create a **new state agency**, create **new quasi-public independent agency**, or contract with a **non-profit non-insurer organization**.

5. If state **fails to create a fully functioning Exchange** in time, HHS will operate an Exchange for that state. HHS will assess state readiness by January 2013.

6. Individuals and small businesses may buy health coverage insurance **in or outside** an Exchange. Must use Exchange to access federal premium subsidies and tax credits.

7. Exchanges serve as a **gateway for Medicaid and CHIP**. Screen and enroll.

8. Qualified Health Plans **may also offer coverage outside** the Exchange. Federal rules will vary somewhat for QHP coverage outside Exchanges.

Individual, Small Group, and Large Group Markets

Three Market Segments:

1. Individual / Non-Group Market.

2. Small Group Market: In 2014-2015, states define Small Group as small employers with 1-100 or 1-50 employees. In 2016 and after, small employer is 1-100 employees.

3. Large Group Market: Employer with more than 100 employees.

Buying Coverage Through Exchange:

- Starting 2014, through State Exchanges:

  ✓ Any citizen or legal resident may buy individual (non-group) coverage from a Qualified Health Plan. Unauthorized immigrants and incarcerated individuals may not enroll.

  ✓ Any small employer may buy coverage from one or more Qualified Health Plans.

- Starting 2017, states may permit large employers to buy coverage through Exchange.

Consumer Choice of Plans

- Individuals enrolling through the State Exchange may choose any Qualified Health Plan (QHP) for which they are eligible.
- Employers specify level of coverage they support (Bronze, Silver, Gold, Platinum). Employees may then select any QHP at that level.
- Individuals applying for Exchange coverage are screened for Medicaid and CHIP. Automatically enrolled in Medicaid or CHIP if eligible. May not enroll in QHP.
- Individuals may pay premiums directly to their QHP.
- Members of Congress and Congressional staff must use Exchange to select a QHP.

Projected Enrollment in Exchanges

- Congressional Budget Office (CBO) projects enrollment in Exchanges to **reach 24 million by 2018**:

2014	2015	2016	2017	2018	2019
8 million	13 million	21 million	23 million	24 million	24 million

- Of the 24 million projected enrollees in Qualified Health Plans in Exchanges, CBO assumes:
  - **16 million newly insured (net, previously uninsured).**
  - **3 million move from employer coverage to Exchange.**
  - **5 million move from non-group / individual market to Exchange.**
  - **19 million receive federal subsidies and 5 million are unsubsidized.**
- Crowd-out of employer coverage would increase Exchange enrollment **considerably**.

Source: Congressional Budget Office. Letter to House Speaker. March 20, 2010.
www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

Advantages for Individuals and Employers

- For individuals and small employers, buying health coverage through State Exchange will present **several advantages**.
- For example:
  - ✓ Individuals may access **federal subsidies** for premiums and cost sharing.
  - ✓ Small businesses may access **federal tax credits**.
  - ✓ Screening and automatic enrollment in **Medicaid and CHIP when eligible**.
  - ✓ Reduce some HR **administrative burdens** of employers.
  - ✓ Competition and rate review authority **may constrain premiums**.
  - ✓ Adjusted **community rating with risk adjustment**.
- At state option, large employers may begin buying via Exchange in 2017.

Advantages for Medicaid Health Plans

- Qualified Health Plans are **major new, nationwide market** for Medicaid health plans.

- As a group, **Medicaid health plans are well positioned** to meet federal and state requirements to sell Qualified Health Plan (QHP) coverage through State Exchanges.

- **Many examples of competitive advantages of Medicaid health plans,** including:

  ✓ Experience with state contracting and meeting complex federal and state rules.
  ✓ Strong local presence, with relationships with state and community based organizations.
  ✓ Experience serving with diverse, low and moderate income populations.
  ✓ Similarity of benefit designs for Medicaid benchmark plans, CHIP plans, and new QHPs.
  ✓ Already partner or contract with essential community providers.
  ✓ Already offer high value for dollar.
  ✓ Strong quality improvement activities and reporting capacity.
  ✓ Offer continuity since many eligibles will move between Medicaid, CHIP, and Exchange plans.

- In addition to sheer size of new market, other opportunities for Medicaid health plans include **diversification, increased pricing power, and greater rate stability** compared to Medicaid.

- Participating in Exchanges also **compatible with mission** of Medicaid health plans.

Office of Consumer Information and Insurance Oversight

- The new HHS **Office of Consumer Information and Insurance Oversight** (OCIIO) will oversee State Exchanges and issue federal rules and guidance for Exchanges and Qualified Health Plans:
  - **Office of Health Insurance Exchanges** – Establish policies and rules governing exchanges, give planning grants to states, and federal oversight of exchanges.
  - **Office of Oversight** – federal governance of health insurance market, federal level rate reviews, medical loss ratio enforcement.
  - **Office of Insurance Programs** – Temporary high-risk pool and early retiree reinsurance.
  - **Office of Consumer Support** – Information and assistance for consumers.
  - **Director's Office** – Leadership, planning, evaluation, regulatory affairs, external affairs, and administrative management.
- OCIIO leadership and staff come largely from state insurance regulatory backgrounds.
- OCIIO Website: **www.hhs.gov/ociio**

Benefit Designs and Plan Offerings

- ✓Basics of Qualified Health Plans
- ✓Essential Health Benefits
- ✓Four Levels of Plans
- ✓Minimum Offerings of QHPs
- ✓Additional Rules for Benefit Designs

Basics of a Qualified Health Plan

Qualified Health Plan (QHP) is a health plan:

1. State licensed in states where offered.
2. Certified by each State Exchange where plan is offered.
3. Provides essential benefit package.
4. Offers at least one silver plan ad one gold plan.
5. Offers a catastrophic plan and a child-only plan.
6. Charges same premiums inside and outside the Exchanges.
7. Complies with all other requirements of HHS/OCIIO and the State Exchange. HHS has broad authority to impose additional requirements on QHPs offered inside Exchanges.
8. May be an HMO, PPO, or fee-for-service plan.

Essential Health Benefits

- At a minimum, "**essential health benefits**" offered by Qualified Health Plans must include:

  - ✓ Ambulatory patient services
  - ✓ Emergency services
  - ✓ Hospitalization
  - ✓ Maternity and newborn care
  - ✓ Mental health, substance abuse, behavioral health treatment
  - ✓ Prescription drugs
  - ✓ Rehabilitative and habilitative services and devices
  - ✓ Laboratory services
  - ✓ Preventive and wellness services
  - ✓ Chronic disease management
  - ✓ Pediatric services, including oral and vision care

- Based on **typical employer-sponsored health plan**, HHS will define specifics by rule.

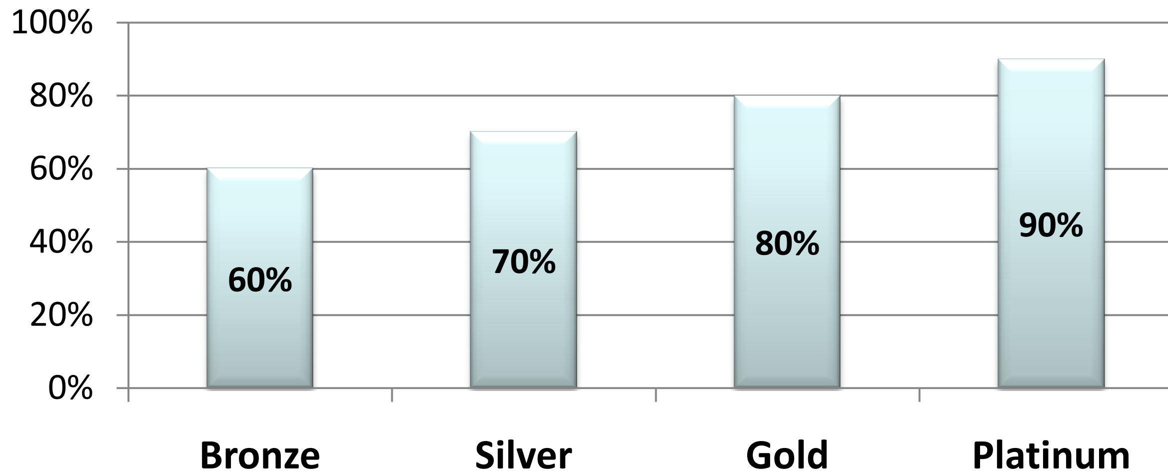
- **Therefore, QHP benefit packages will be similar to Medicaid benchmark plan packages for Medicaid expansion population. Easier for Medicaid plans to participate in new market.**

- QHP may offer more services in its benefit package.

Four Levels of Coverage in Qualified Health Plans

Qualified Health Plans (QHPs) may offer four different levels of coverage:

- **Bronze:** Equivalent to **60%** of the full actuarial value of benefits under the plan.
- **Silver:** Equivalent to **70%** of the full actuarial value of benefits under the plan.
- **Gold:** Equivalent to **80%** of the full actuarial value of benefits under the plan.
- **Platinum:** Equivalent to **90%** of the full actuarial value of benefits under the plan.



Minimum Offerings of Qualified Health Plans

- Every Qualified Health Plan **must** offer at least four distinct kind of plans in each Exchange where it participates:

  ✓ **One Silver Plan** (70% actuarial value of covered benefits)

  ✓ **One Gold Plan** (80% of actuarial value of covered benefits)

  ✓ **Catastrophic Plan** for enrollees under age 30 or who lack access to affordable insurance (as determined by the State Exchange)

  ✓ **Child-Only Plan** for enrollees under age 21.

Additional Rules for Benefit Designs

- Federal rules on health plans generally will **also apply** to Qualified Health Plans, including:

  ✓ Minimum Medical Loss Ratio (MLR)
  ✓ Coverage of federally-designated preventive services
  ✓ Guaranteed issue
  ✓ No annual or lifeline limits
  ✓ No exclusion of pre-existing conditions

- Insurer may offer a **standalone dental plan** covering pediatric dental benefits.

- If state law mandates small group and individual (non-group) plans cover certain benefits above federal minimums, the **state must reimburse added cost** associated with the state benefit mandate.

- State may prohibit QHPs from covering elective abortions.

Premiums and Cost Sharing

✓Community Rating and Risk Adjustment
✓Cost Sharing Limitations
✓Bidding, Review, and Selective Contracting

Community Rating and Risk Adjustment

Adjusted Community Rating:

- Qualified Health Plans must set premiums based on adjusted community rating of risk in *and* outside the exchanges for the individual (non-group) and small-group markets.
- Adjustment limited to age, family composition, tobacco use, and location.

Risk Adjustment:

- Each State exchange will adopt a risk adjustment methodology.
- Must create mechanism to collect and review claims data, verify medical spend.
- Must then make transfer payments between QHPs based on relative risk experience.
- Highly complex to setup and administer. Likely very contentious issue.

Risk Pools: The individual and small group markets are separate risk pools. However, states may combine them into one risk pool.

Cost Sharing Limitations

Total Cost Sharing is Limited:

- Total cost sharing in QHPs may not exceed cost sharing in high deductible health plans:
  - In 2014, **$5,950 for individuals and $11,900 for families**.
  - Thereafter, indexed to rate of average premium growth.

Deductibles are Capped:

- Deductibles in 2014 capped at **$2,000 for individuals and $4,000 for families**.
- Thereafter, deductible cap is indexed to average premium growth.

Wellness Programs:

- QHPs may offer premium discounts or rewards for enrollee participation in a wellness program.

Certification, Bidding, State Review, and Selective Contracting

- **Certification of QHPs:** State Exchanges will create a process for health plans to apply to be certified as a Qualified Health Plan.

- **Premium Review:**
  - Premiums and increases must be justified. Likely include some form of "bidding."
  - State has authority to review appropriateness of premiums. In addition to current authority of State Insurance Commissioners. HHS will also review premiums but has less authority.

- **Selective Contracting:**
  - State Exchange may selectively contract with Qualified Health Plans based on cost and quality.
  - Exchange may exclude QHPs determined of low value. Conceptually: Value = Quality ÷ Cost.

- **Balancing Choice, Value, and Competition:**
  - Exchanges will need to balance the number of QHPs allowed in the Exchange.
  - Enough to ensure choice. Not too many or too few to adversely affect value or competition.
  - Some risk of adverse selection between Exchange and non-Exchange markets.

Reinsurance and Risk Corridors

- ✓Temporary Reinsurance
- ✓Temporary Risk Corridors

Temporary Reinsurance

- States must create a **temporary reinsurance program for individual market**.
- Operates from 2014 through 2016.
- Federal funding from assessment on health insurers and group TPAs:

  $12 billion in 2014
  $8 billion in 2015
  $5 billion in 2016

- States may impose additional assessments on insurers to fund reinsurance.
- States likely to eliminate or substantially modify existing high-risk pools in 2014 or 2015.

Temporary Risk Corridors

- HHS/OCIIO will create and administer a **temporary risk corridor**.
- In 2014-2016 for individual and small group markets.
- Modeled after the risk corridors used to phase in Medicare Part D drug benefit.
- QHP payments will be adjusted up or down based on QHPs expenses compared to target:
  - If plan's expenses exceed a certain percentage above the target, the plan's payment is increased.
  - If plan's expenses exceed a certain percentage below the target, the plan's payment decreased.

Federal Subsidies

- ✓ Federal Funding for Coverage in Exchanges
- ✓ Premium Credits
- ✓ Cost Sharing Subsidies

Federal Funding for Coverage in Exchanges

- CBO Estimate of Cost of Federal Subsidies and Tax Credits:
  - ✓ **Federal Premium Subsidies = $350 billion over 2014-2019**
  - ✓ **Exchange Premium Credits = $107 billion over 2014-2019**
- Average federal subsidy per Exchange enrollee:

  ~$5,200 in 2014

  ~$6,000 in 2019
- Federal costs are rough estimates because individual and employer behavior is difficult to predict. Employer crowd-out would dramatically increase federal spending, of course.

Source: Congressional Budget Office. Letter to House Speaker. March 20, 2010.
www.cbo.gov/ftpdocs/113xx/doc11379/AmendReconProp.pdf

Premium Credits

- Starting 2014, qualifying individuals may receive advanceable, refundable **federal tax credits** toward to purchase of a Qualified Health Plan in an Exchange. **Funds go directly to the QHP**.

- Establishes **maximum out-of-pocket premium** using sliding scale based on income and family size:

  - 100-133% FLP = 2% of household income
  - 133-150% FPL = 3% of household income
  - 150-200% FPL = 4% of household income
  - 200-250% FPL = 6.3% of household income
  - 250-300% FPL = 8.05% of household income
  - 300-400% FPL = 9.5% of household income

- Based on premium of 2nd lowest cost Silver plan. Enrollee may select Gold or Platinum plan but must pay any difference and is ineligible for cost-sharing subsidy (see next slide).

- Generally, individuals are ineligible for premium tax credits if they are *eligible* for Medicaid, CHIP, Medicare, TRICARE, employer-sponsored coverage, or a grandfathered plan.

- Individual below 400% FPL who is eligible for *but not enrolled in* an employer-sponsored plan could receive premium credit if employee premium exceeds 9.5% of household income or if plan coverage is below Bronze level (60% actuarial equivalence).

Cost Sharing Subsidies

- **Out-of-pocket cost sharing is capped for all QHP enrollees at HSA levels**. $5,950 for individuals and $11,900 for families, of which no more than $2,000/$4,000 for deductibles. Annually indexed.

- Federal subsidies to help cover cost sharing will be available for individuals who (1) qualify for federal premium credits **and** (2) are enrolled in a Silver tier plan.

- Starting in 2014, this **further reduces out-of-pocket maximums** by:

  - Two-thirds for individuals between 100% and 200% of Federal Poverty Level (FPL).

  - One-half for individuals between 201% and 300% of FPL.

  - One-third for individual between 301% and 400% of FPL.

- For example, at 150% FPL the maximum out-of-pocket cost sharing co-payments is roughly $2,000 for individuals and $4,000 for families (a third of the standard cap).

Requirements for Qualified Health Plans

- ✓Provider Networks
- ✓Marketing and Consumer Information
- ✓Quality of Care and Care Delivery
- ✓Information and Data Reporting

Provider Network Requirements

- Qualified Health Plans must demonstrate provider network in adequate to "**ensure a sufficient choice of providers**."

- QHP network must include "**essential community providers, where available, that serve predominately low-income, medically underserved individuals**."

  ✓ To be defined by HHS/OCIIO rules.

  ✓ Likely include community health centers, tribal clinics, children's hospitals, etc.

- QHP **may only contract with hospitals** (50+ beds) if facility **(1)** uses patient safety evaluation system, **(2)** provides patient education and counseling upon discharge, **(3)** provides comprehensive discharge planning, and **(4)** has post-discharge reinforcement.

- QHP must give enrollees and prospective enrollees information on availability of in-network and out-of-network providers.

Marketing and Consumer Information

- Use **uniform enrollment form** for use by individuals or employers. Electronic or paper.
- Meet all **federal marketing requirements**:
  - ✓ To be defined in HHS/OCIIO rules.
  - ✓ Perhaps modeled after some combination of strongest state rules and marketing requirements for Medicaid health plans and Medicare Advantage plans.
- Use Exchange's standard format for **presenting health benefits plan options**. Includes how QHP compares to other plans.
- Educate prospective enrollees and enrollees on **cost sharing implications**.
- Prohibited from using any marketing practices or benefit designs "that have the effect of discouraging the enrollment in such plan by individuals with significant health needs."

Quality of Care and Care Delivery

- **Accredited by body recognized by HHS** (likely NCQA and perhaps alternative).
- **Public reporting of quality.** For enrollees, prospective enrollees, and Exchange. Plus annual report to HHS on pediatric quality.
- **Quality improvement strategy** with incentives to improve outcomes through following, consistent with HHS/OCIIO guidelines:

1. Quality reporting, case management, care coordination, chronic disease management, medication and care compliance, and medical homes.
2. Activities to prevent hospital admissions, reduce medical errors.
3. Use of best clinical practices and evidence-based medicine.
4. Health information technology (electronic health records, electronic prescribing).
5. Wellness and prevention activities.
6. Activities to reduce health and health care disparities. Includes language services, community outreach, and cultural competency training.

Information and Data Reporting

- QHPs required to report mass of information on **premiums, benefit designs, network capacity, and performance compared to quality measures**.
- QHPs in Exchange must also report – publicly and in plain language – a wide range of other data, including:
  - ✓ Periodic financial disclosures
  - ✓ Claims payment policies and practices
  - ✓ Data on enrollment and disenrollment
  - ✓ Rating practices
  - ✓ Claim denials
  - ✓ Out-of-network cost sharing and provider payments
- HHS/OCIIO has wide discretion to require **additional information**.
- Data reported to HHS, State Insurance Commissioner, and Exchange. **Available to public**.
- Everything subject to **federal and state auditing**.
- Timeliness and accuracy are critical. **Severe compliance risks for plans and their executives**.

State Health Insurance Exchanges

- ✓Establishing State Exchanges
- ✓Federal Fall-Back Exchange
- ✓Functions of State Exchanges
- ✓Federal Grants and State Costs

Establishing State Exchanges

Requirement to Create State Exchange:

- Every state must establish an American Health Benefit Exchange **on or before January 1, 2014**.
- States must create a Small Business Health Options Program Exchange (SHOP). Either separate or part of the American Health Benefit Exchange.

State Options in Creating an Exchange:

- States may join together to operate **multi-state, regional Exchanges**.
- States may operate Exchange in **existing agency**, create a **new state agency or quasi-public agency**, or **contract out** function to a non-profit.
- Exchange may **contract out functions** to State Medicaid agency or private entities. Private contractors cannot be health insurers.
- Governing boards for State Exchanges are highly likely.
- States must engage in **extensive consultation with stakeholders**.

Basic Functions of State Exchange

- State exchange must perform a **wide range of functions**. Basic functions include:
  - ✓ Certify and oversee Qualified Health Plans.
  - ✓ Facilitate enrollment in QHPs.
  - ✓ Screen and enroll eligibles in Medicaid and CHIP.
  - ✓ Facilitate federal subsidies and tax credits. Determine exemptions from individual mandate.
  - ✓ Rate QHPs based on relative quality and price (using federal method).
  - ✓ Inform individuals about Medicaid / CHIP.
  - ✓ Operate comprehensive navigator program, with state grants for public education and outreach.
  - ✓ Set role, if any, of brokers and agents in selling QHPs inside Exchange.
  - ✓ Anti-fraud, anti-waste activities. Financial reporting.
- HHS/OCIIO will set specifics by rule.

Federal Fall-Back Exchange

Readiness Assessment:

- In 2012, HHS/OCIIO will assess each state's readiness.
- OCIIO must report on state readiness by January 2013.
- Determine if state will have a fully functioning and compliant Exchange by 2014. Or if state is unable (or unwilling?) to meet Exchange standards.

Federal Fall-Back Exchange:

- If state fails to create a functioning Exchange in time, HHS will operate an Exchange for that state.
- Federal fall-back Exchange may be run by HHS or by federal contract with a non-profit.
- As contingency, HHS/OCIIO may consider contracting for a "hot site" Exchange.

Federal Grants and State Costs of Operating Exchange

Federal Grants:

- HHS/OCIIO will give states grants to help cover cost of planning and implementing Exchanges.
- Grants start March 2011. Renewable through 2014.
- Amount of federal grants to be determined. Might not cover all state costs.
- Grant application process will likely start in Fall 2010.
- Plus $51 million in Health Insurance Premium Review Grants.

Exchanges Must Be Self Supporting:

- By 2015, State Exchanges must be fully self supporting financially.
- Exchange operating costs supported by user fees or taxes imposed on Quality Health Plans operating in Exchange.
- No federal funds to operate Exchange after 2014.

National and Multi-State Plans

- ✓ Consumer Operated and Oriented Plans
- ✓ Multi-State Qualified Health Plans

Consumer Operated and Oriented Plan (CO-OP)

- Law encourages creation of **Consumer Operated and Oriented Plans** (CO-OPs).
- CO-OPs will be new, **non-profit, member-run** insurers to compete as Qualified Health Plans in Exchanges.
- **$6 billion** in federal loans for start-up costs and grants for meeting state solvency requirements.
- Must be repaid. Loans in 5 years and grants in 15 years.
- Priority to statewide QHPs with integrated care model and significant private support.
- Cooperative governance.
- Insurers existing on July 16, 2009, states, and local government may not be a CO-OP.
- HHS has appointed advisory committee.

Multi-State Qualified Health Plans

Multi-State Qualified Health Plans:

- The federal **Office of Personnel Management** (OPM) will contract with at least two **Multi-State Qualified Health Plans** (MSQHPs). At least one MSQHP must be a non-profit.
- Goal to eventually have **two or more MSQHPs in every State Exchange by 2017**.
- MSQHPs must:
  - Be state licensed and meet requirements of every State Exchange.
  - Comply with OPM's standards for insurers participating in the Federal Employees Health Benefits Program (FEHBP).

Interstate Health Care Choice Compacts:

- Starting in 2016, states may enter into interstate compacts to allow insurers to offer QHPs nationwide across state lines.
- HHS/OCIIO rules required by July 2013.

Interaction with Medicaid

- ✓ Interaction with State Exchanges
- ✓ Medicaid Screen and Enroll

Interaction with State Health Insurance Exchanges

- Starting in 2014, considerable interface required between Medicaid, CHIP, and the new **State Health Insurance Exchanges**.

- States must:

  - ✓ Allow individuals to apply for Medicaid, CHIP, **and** Exchange plan coverage through a **single state-run website**.

  - ✓ Allow Medicaid applications and renewals **on the web, with electronic signatures**.

  - ✓ In Exchange, screen everyone for Medicaid and CHIP eligibility and automatically enroll.

  - ✓ Conduct outreach to uninsured and underinsured.

- At state option, Exchange may determine eligibility for premium subsidies. Likely.

- New Exchanges, coupled with Medicaid expansion at same time, will require states to work out an **extraordinary array** of regulatory, governance, enrollment, systems, data, contracting, staffing, educational, and program integrity issues.

Medicaid Screen and Enroll

- Starting 2014, law requires a "**screen and enroll**" process for Medicaid and CHIP eligibles identified through the State Exchange.

- If applicant for Exchange coverage is determined eligible for Medicaid or CHIP:

  ✓ State must **automatically enroll** individual in Medicaid or CHIP, as appropriate.

  ✓ Individual **may not enroll in a Qualified Health Plan** via Exchange. They will not receive Exchange premium subsidy.

- Outside the Exchanges, Medicaid eligibles may buy individual (non-group) coverage if available and then only at their own expense.

State Flexibility and Waivers

- ✓Consumer Operated and Oriented Plans
- ✓Multi-State Qualified Health Plans

State Option to Create Basic Health Program

- States may create a **Basic Health Program**.
- Modeled after the Washington State Basic Plan, started in 1987.
- For individuals under age 65 with incomes between 133% and 200% who are not eligible for Medicaid.
- Individuals eligible for a Basic Health Plan may not enroll in Exchange coverage.
- HHS/OCIIO will established rules for the state option.
- States may enter into regional compacts to operate a Basic Health Program.

Waivers for State Innovation

- Starting in 2017, states may request waivers of federal requirements relating to **Exchanges, QHPs, individual mandate, premium tax credits, cost-sharing subsidies, and certain employer requirements**.

- Waivers for up to **five years**.

- Waivers must:

  ✓ Demonstrate 10-year federal budget neutrality.

  ✓ Benefits at least as comprehensive as that offered through Exchanges.

  ✓ Protect against excessive out-of-pocket spending.

  ✓ Insure at least as many state residents as PPACA requirements would without waivers.

- Opportunity for states to combine these **PPACA waivers with Medicaid s. 1115 waivers** for larger reform initiative.

Basic Timeline for HHS Policy

March 2011 through December 2014:

- HHS/OCIIO awards grants to states to plan and implement Exchanges.

As Soon as Practicable (or no date specified):

- HHS/OCIIO rules for Exchanges, Qualified Health Plans, reinsurance, risk adjustment, risk corridors, navigators, essential benefits, essential community providers, quality improvement strategies, hospital requirements, etc.

July 1, 2012:

- Define enrollment periods for Exchanges (initial, annual, special).

January 1, 2013:

- HHS/OCIIO determines state readiness for Exchanges.

January 1, 2014:

- State Exchanges must be fully operational.
- Federal-run Exchange where necessary.
- Establish procedures for determining eligibility for exchange, premium tax credits, cost-sharing subsidies, and individual mandate exemptions.
- With states, monitor premium increases in and outside Exchanges.

State Health Exchanges and Qualified Health Plans

Briefing for Medicaid Health Plans of America

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Questions and Discussion

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