Washington State Health Benefits Exchange: Policy Issues

Douglas A. Conrad, PhD, Professor of Health Services
University of Washington
Member: Washington Health Benefits Exchange Board
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Sources & Disclaimer

- This presentation draws on materials available from research sources and on the website of the Washington State Health Benefit Exchange:

  http://www.hca.wa.gov/hcr/exchange

- Any opinions expressed are my own and do not represent positions or opinions of the Exchange Board or Staff

Policy Issues for Consideration

- Essential Health Benefits
- Criteria for Qualified Health Plans
- Federal Basic Health Plan Option
- Market Rules
- Risk-Leveling, Including Future of WSHIP
- Navigator Roles and Functions

Essential Health Benefits (EHB)

Statutory Provisions

- Non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges, Medicaid benchmark and benchmark-equivalent, and Basic Health Programs must cover the EHB beginning in 2014.
- Self-insured group health plans, health insurance coverage offered in the large group market, and grandfathered health plans are not required to cover the essential health benefits.

Essential Health Benefits (continued)

Similarities and Differences in Benefit Coverage Across Markets

- Generally, products in the small group market, State employee plans, and the Federal Employees Health Benefits Program (FEHBP) Blue Cross Blue Shield (BCBS) Standard Option and Government Employees Health Association (GEHA) plans do not differ significantly in the range of services they cover. (IOM research)
- They differ mainly in cost-sharing provisions, but cost-sharing is not taken into account in determining EHB.
- Similarly, these plans and products and the small group issuers surveyed by the IOM appear to generally cover health care services in virtually all of the 10 statutory categories. (as outlined in Phil Dyer's presentation)

Criteria for Qualified Health Plans

- Patient Protection and Affordable Care Act (ACA) established the Exchange as another health insurance market for individuals and small businesses.
- ACA provides states with the flexibility to distinguish the Exchange from the private health insurance markets that will continue to exist outside of the Exchange.
- How qualified health plans are certified will begin to shape the type of Exchange the state wants to develop and how it might be similar or different from the outside markets[1].

[1]Options paper accessed at: http://www.hca.wa.gov/hbe/documents/criteria_for_qhps.pdf

Policy Options for QHP Criteria

- Option 1: The Exchange would certify all health plans that meet and agree to comply with the minimum requirements specified in the ACA.
- Option 2: The Exchange would certify selected plans with the intent of improving quality and/or access to care in underserved areas or for underserved populations.
- Option 3: The Exchange would certify selected plans with the intent of better managing the cost of health plans available through the Exchange.
  - Additional selection criteria might include the reasonableness of the plan's premium and cost-sharing levels, past premium increases, and proposed rate increases.

Federal Basic Health Plan Option[1]

- ACA offers states the option to implement a Federal Basic Health Program to citizen adults with incomes between 134 and 200 percent of the Federal Poverty Level (FPL) ($15,000 to $21,800) and legally resident immigrants with incomes no greater than 133 percent FPL whose immigration status disqualifies them from Federally-matched Medicaid.
- The Federal government will give states 95 percent of what they would have spent on premium tax credits and cost-sharing reductions to eligible individuals enrolled in standard health plans in the state if such eligible individuals had been enrolled in a qualified health plan through an Exchange.
- The Federal Basic Health Program must include at least the Essential Health Benefits under the ACA and consumers may not be charged more than what they would have paid in premiums in the Exchange. In addition, cost sharing must be no greater than a platinum plan (90 percent actuarial value) for individuals with incomes less than 150 percent FPL or gold (80 percent actuarial value) for individuals with incomes between 150 and 200 percent FPL.
- If states choose to implement a Federal Basic Health Program, eligible individuals cannot receive tax credits through the State's Health Benefit Exchange. According to the ACA, Health and Human Services will make a single payment to the State at the start of the fiscal year based on best available estimates and will make corrections (if the amount was too high or low) in the next year's payment.

[1] Option paper accessed at:
http://www.hca.wa.gov/hbe/documents/bh_option_paper_final.pdf

Three Federal Basic Health Plan (FBHP) Options for Washington[1]

- Option 1: Under this option, adults with income less than 134 percent FPL will be eligible for Medicaid, and a standalone Federal Basic Health Program will be established for adults 134 – 200 percent FPL. Children and pregnant women will remain eligible for Apple Health and Medicaid, respectively. Adults with incomes above 200 percent to 400 percent FPL will be eligible for premium tax credits and cost-sharing subsidies in the Exchange.

- Option 2: Under this option, adults between 0 – 200 percent FPL will be eligible for coverage through a rebranded Medicaid + Federal Basic Health Program. This new re-branded low-income program will have consistent plans and benefits across income groups but different risk pools. Children and pregnant women would be included in this re-branded program but their cost sharing and benefits would remain unchanged from Apple Health and Medicaid, respectively.

- Option 3: Adults with income less than 134 percent FPL will be eligible for Medicaid, and premium tax credits and cost-sharing subsidies will be available in the Exchange for adults 134 – 400 percent FPL (Essential Health Benefits). Children and pregnant women will remain eligible for Apple Health and Medicaid, respectively.

[1] Option paper accessed at:
http://www.hca.wa.gov/hbe/documents/bh_option_paper_final.pdf

Framework Proposed for Assessing FBHP Options for Washington[1]

Table 7: Framework for Assessing Issues Best Addressed by the Various Options

Issues for the State	*Option 1*	*Option 2*	*Option 3*
Exchange sustainability	C	C	A
Complexity of insurance affordability programs	B	C	A
Federal Funds to support establishment and on-going operation	C	C	A
Adequate take-up of insurance coverage	A	A	A
Issues for Consumers			
Affordability (premiums and cost sharing)	B	A	C
Access to providers	B	C	A
Choice of Plans and Providers	B	C	A
Complexity navigating the system	C	A	B
Issues for other stakeholders			
Provider stability and cost-shifting	B	C	A

[1] A = Can most easily address that issue; B = Issue is likely to remain; C = Exacerbates the issue

FBHP Option (FBHO)Questions

First, will the revenue provided by the Federal government be sufficient to cover individuals enrolled in a Federal Basic Health Program (FBHO)?

Second, what is the risk that the establishment of a Federal Basic Health Program causes the resulting Exchange to be unsustainable?

Third, what level of State funds will be available to complement Federal funding for the FBHO?

Market Rules: Options to Avoid Unstable Risk Pools[1]

- Beginning in 2014, tens of thousands of consumers will become insured through Washington State's Health Benefit Exchange (Exchange). Stable risk pools will help to offer these enrollees an affordable Exchange.

- Enrolling individuals with a balance of high and low health care needs will help the Exchange to offer coverage in stable risk pools in the Exchange. If the Exchange does not maintain a balance, and enrolls too many individuals with high health care needs, then premiums will rise.

- ACA designed ways to increase the availability of private health care coverage, maintain risk pools with a balanced mix of enrollees, and aid the creation of a health insurance market that competes on the basis of price, quality, service, and other innovative efforts.

[1] Options paper accessed at http://www.hca.wa.gov/hbe/documents/market_rules_option.pdf:

ACA "Risk-Leveling" Steps (Prior to State Exchange Rules

ACA established three "risk-leveling" programs that are designed to help issuer's manage the expenses of covering high-cost populations:

- Two of these programs are temporary.
  1) A temporary reinsurance program for the state's individual plans offered inside and outside of the Exchange. The transitional reinsurance program shares the cost of covering extraordinarily high-cost enrollees in individual market plans.

ACA "Risk-Leveling" Provisions (continued)

2) A temporary "risk corridor program" program will apply to plans offered in the Exchange ("qualified health plans"). The risk corridor program will is intended to limit the losses and gains of plans offered in the Exchange.

- ACA also implements a permanent risk adjustment program. This program applies to all individual and small group plans offered inside and outside of the Exchange. The goal of risk adjustment is to stop rewarding or penalizing issuers based on the risk of the population they enroll. Risk adjustment requires issuers to compensate others when the risk of their enrolled population is lower than average.

Market Rules (continued): Potential State Exchange Options

- Option A: **Requiring issuers to offer gold and silver plans outside of the Exchange.** Promotes a mix of healthy and unhealthy individuals inside and outside of the Exchange. Does not require issuers to offer plans in the Exchange.

- Option B: **Only catastrophic and bronze plans offered inside the Exchange could be offered outside of the Exchange.** Promotes a mix of healthy and unhealthy individuals inside and outside of the Exchange. Encourages additional young, healthy individuals to participate in the Exchange. Requires issuers to offer gold, silver, along with bronze and/or catastrophic plans in the Exchange to be able to offer bronze and catastrophic plans in the individual and small group markets. Requires all bronze and catastrophic plans in the market to meet qualified health plan criteria.

Market Rules (continued): Additional Potential State Exchange Options

- Option C: **To offer a plan in the individual and small group markets, issuers must participate in the Exchange.** Promotes a mix of healthy and unhealthy individuals inside and outside of the Exchange. Requires issuers to offer at least gold and silver plans in the Exchange to participate in the outside markets.

- Option D: **All plans offered inside and outside of the Exchange must meet qualified health plan criteria.** Promotes uniform standards across all plans inside and outside of the Exchange. Increases transparency. Does not require plans to be offered in the Exchange.

“Essential Requirements” for Navigators (research-based)

- Navigators must be knowledgeable about all aspects of the Exchange, including the benefits and costs of all plans offered and eligibility requirements for tax credits, subsidies, and Medicaid
- Washington residents and small businesses are looking for clear, simple explanations and guidance.
- Navigators must be viewed as trustworthy sources of impartial information.

Navigator Essential Requirements (continued)

- Navigators will need to offer support in a variety of ways and be easily accessible to the communities they serve during and after the enrollment process.

- A diverse array of Navigators will be necessary to serve the diverse array of consumers. Additionally, building on existing networks will be key to success: community-based organizations, local health departments, health insurance brokers, … (but not issuers)

- Navigators must reach patients and consumers in settings where or when health care is top of mind.

Conclusions and Audience Q&A

Policy and Practical Challenges are Considerable, but Tractable, for the Exchange:

What are Optimal Choices for Washington State?

in terms of …

- Essential Health Benefits
- Criteria for Qualified Health Plans
- Federal Basic Health Plan Option
- Market Rules
- Risk-Leveling, Including Future of WSHIP
- Navigator Roles and Functions