

FEDERAL HEALTH CARE REFORM

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Federal Legislation

- HR 3590, Patient Protection and Affordable Health Care Act
- HR 4872, Health Care and Education Reconciliation Act of 2010

STATE DECISIONS

1. Should Utah's health insurance exchange be one model for the federal exchange?
2. Should Utah run a state based high risk pool, or turn it over to the federal government?
3. What is the state's role in regulating insurance plans, how do we keep the state relevant?
4. What are the rules of engagement with federal health care reform?
5. How do we prepare for the changes to Medicaid eligibility?

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IN A NUTSHELL

Expand insurance coverage

Increase the primary care and public health workforce

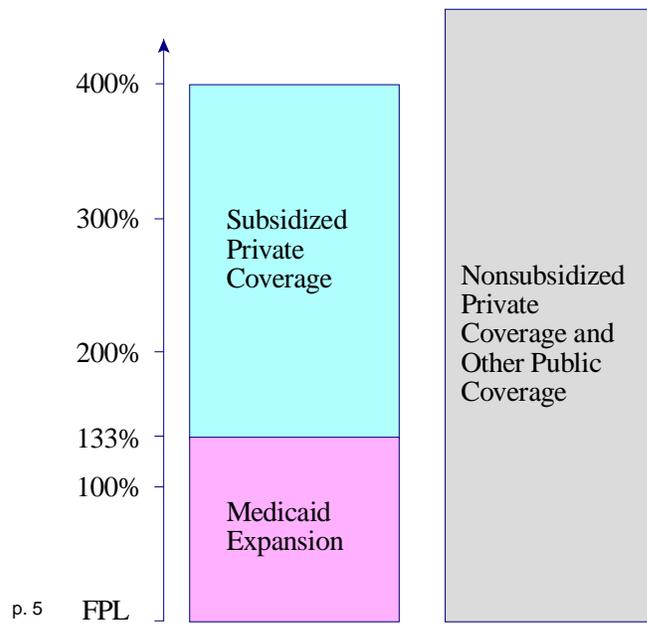
Promote prevention

Strengthen quality measurement

Develop models of payment and delivery reform

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PUBLIC AND SUBSIDIZED COVERAGE



COVERAGE FEATURES

- INDIVIDUALS** Required to have minimum essential coverage
Eligible for subsidies
- EMPLOYERS** Penalized if employee receives a subsidy
Eligible for subsidies
- EXCHANGES** Created to administer subsidies and facilitate choice
- INSURERS** Required to meet rating, plan design, reporting, and administrative requirements that restructure the market
- MEDICAID** Eligibility expanded to 133% FPL

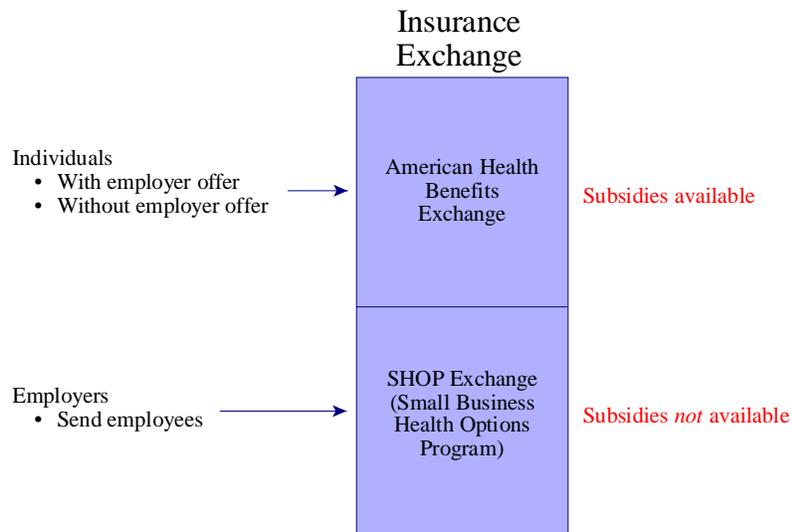
INSURANCE PROVISIONS—EXCHANGE



- State-based government or nonprofit entity
- Certifies qualified health plans
- Allows for standardized plan comparison
- Rates participating plans
- Identifies and enrolls Medicaid and CHIP eligibles
- Permits individuals to receive subsidies
- Offers qualified health plans, including at least two multi-state plans
- Applies to:
 - 2014, 2015: ≤ 50 or 100 employees
 - 2016: ≤ 100 employees
 - 2017: >100 employees (option)

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INSURANCE PROVISIONS—EXCHANGE



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INSURANCE PROVISIONS—TIMELINE

Effective in 2014:

1. Exchanges
2. Individuals:
 - Required to have coverage
 - Subject to penalties
 - Eligible for subsidies
3. Employers:
 - Eligible for expanded subsidies
 - Subject to penalties

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INSURANCE PROVISIONS—TIMELINE

Effective in 2014:

4. Insurance Plans:
 - No pre-existing condition exclusions—all persons
 - No annual limits
 - Rating restrictions (no health factor, age 3:1)
 - Guaranteed issue
 - Approved clinical trials covered
 - Essential benefit plan
 - Benefit tiers (bronze, silver, gold, platinum)
5. CO-OPs (consumer operated and oriented plan program)
6. Medicaid expansion to 133% FPL

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INSURANCE PROVISIONS—TIMELINE

Effective 2013–16:

Standardized operating rules for:

- Eligibility verification and claims status (2013)
- EFT, payment, and remittance (2014)
- Encounter data, enrollment, premium payment, and referral certification and authorization (2016)

Effective in 2011:

Medical loss ratio limits/rebates

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INSURANCE PROVISIONS—TIMELINE

Effective in 2010:

1. Small employer tax credits
2. New federal review of health plan rates
3. State grants for office of consumer assistance

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INSURANCE PROVISIONS—TIMELINE

Effective 6 months after enactment:

1. No pre-existing condition exclusions for children
2. Limited use of annual limits
3. Restriction on lifetime limits (essential benefits)
4. No waiting period > 90 days
5. No rescissions (except fraud, etc.)
6. Dependent Coverage to age 26 (regardless of marital status)

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INSURANCE PROVISIONS—TIMELINE

Effective 6 months after enactment:

7. No copays and deductibles for preventive care—new plans
8. No prior authorization required for emergency services
9. No eligibility discrimination by salary
10. Effective appeals (internal/external)
11. Internet portal to facilitate individual and small employer shopping

Note: Items 7–11 do not apply to grandfathered plans. Items 1 and 2 do not apply to grandfathered nongroup plans.

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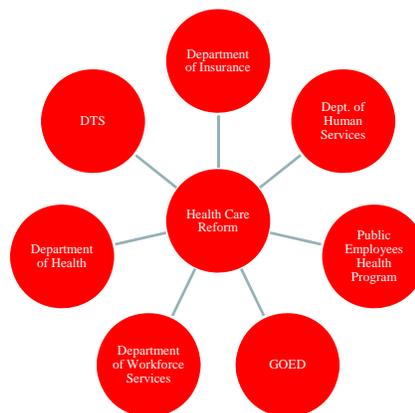
INSURANCE PROVISIONS—TIMELINE

Effective 90 days after enactment:

1. High risk pool (temporary)
2. Reinsurance for retirees, 55–64 (temporary)

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Agencies Impacted



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Implications for the State of Utah

- Costs new rules and regulations
- Changes to Medicaid and state/federal match rates
- State agencies
- Potential statutory changes
- Indirect costs/savings

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Medicaid Changes

1. New reimbursement for drugs (2011)
2. Limits to eligibility changes (2011)
3. 133% (138%) Federal Poverty Level income level eligibility (2014)
4. No asset test (2014)

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New Reimbursement for Drugs

- Currently - Drugs reimbursed at lowest of 3 calculated scenarios (\$25M GF)
- Change 2011
 - Federal calculated scenario to be based on 175% of Average Manufacturer's Price (new reporting system)

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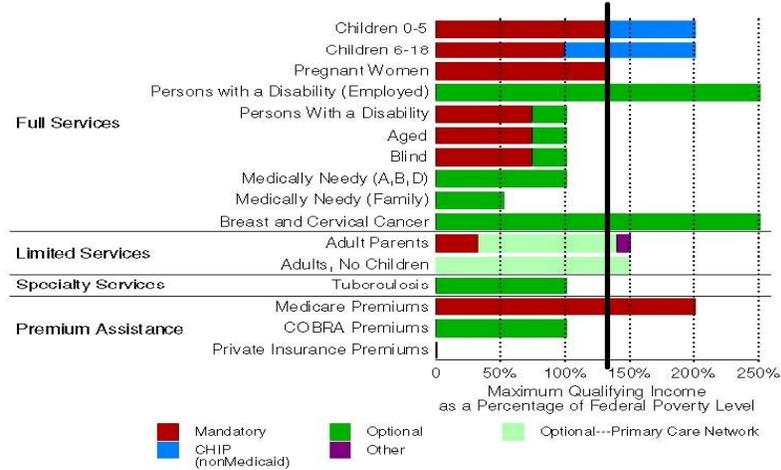
Limits to Eligibility Changes

- Currently - As part of federal stimulus can not change eligibility until January 1, 2011
- Change 2011
 - Limited changes to eligibility if prove financial hardship to federal government
 - Primary Care Network 150% FPL to 133% FPL
 - Breast and Cervical Cancer 250% FPL to 133% FPL
 - Utah's Premium Partnership for Health Insurance 150% FPL to 133% FPL
 - Total General Fund about \$10M for these 3 programs

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133% (138%) Eligibility Level

Figure 7: Mandatory vs. Optional Coverage of Major Groups
By Qualifying Income Level (Utah) 138%



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No Asset Test

Currently

- Income level
- And
- Cash
- Car equity
- Other liquid assets

Change 2014

- Income level
- And (that's it)

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Should Utah's exchange be one model under the federal health exchange?

Utah facilitates the exchange through private market place partners, has a defined contribution market for employees, aggregates premiums from multiple sources, and offers comparative shopping for individuals and small employers

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Should Utah run a high risk pool or let the federal government run it?

Requirements:

The Secretary shall establish a temporary high risk pool program directly or through contracts with the states or non-profit entities. States may not decrease current high risk pool funding.

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Continued

The state can:

1. operate a new high risk pool alongside the current state pool;
2. build upon other existing coverage programs designed to cover high risk individuals;
3. contract with a current HIPAA carrier of last resort or other carrier to provide subsidized coverage for high risk individuals; or
4. do nothing and let HHS carry out the state's coverage program.

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What is the state's role in regulating insurance plans, how do we keep the state relevant?

- Existing state statutes must be changed to implement federal requirements for insurance plans such as dependent coverage, pre-existing conditions, premium rate reviews, appeals process.
- How do we keep as much control at the state level so consumers and insurers are working with the state rather than a federal agency?

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What are the rules of engagement?

1. Do we engage in the federal rule making process?
2. Do we pursue grant money available to the states?
3. Who decides the rules of engagement and how?

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Legislative Oversight

1. HB 67, "Health System Amendments". Requires executive branch reporting to the Legislature.
2. Executive Appropriations. Provides oversight for federal grants and for Medicaid plan changes.
3. Coordination with Executive Branch. Lieutenant Governor Greg Bell and John T. Nielsen have been asked by the governor to coordinate the executive branch's response to the federal health care reform.

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How do we prepare for the changes
to Medicaid eligibility?

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Questions?

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