What you need to know about Insurance Exchanges?
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Today’s presenter

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New Jersey
Pennsylvania
Connecticut
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Agenda

1. What is an Insurance Exchange?
2. What happens if states decline to create their own Exchange?
3. What are the different benefit levels and what are their features?
4. How will Exchanges benefit employers and consumers?
5. What tax subsidies will be available for Exchange-participating employers?
6. Questions?
State Actions to Implement Health Insurance Exchanges

Updated December 2011

Health Insurance Exchanges are, for most states, new entities that will function as a marketplace for buyers of health insurance, giving them choices for health coverage.

They will offer a variety of certified health plans and provide information and educational services to help consumers understand their options.

The 2010 Affordable Care Act (ACA) gives states the option to:

- Establish one or more state or regional exchanges
- Partner with the federal government to run the exchange
- To merge with other state exchanges
- If a state chooses not to create an exchange, the federal government will set up the exchange(s) in the state

Massachusetts and Utah passed laws prior to the enactment of the Affordable Care Act in March 2010.
HHS Goal:
“A new transparent and competitive insurance marketplace where individuals and small businesses can buy affordable and qualified health benefit plans.

Exchanges will offer you a choice of health plans that meet certain benefits and cost standards.”*The law establishes two different exchanges,

• The American Health Benefit Exchange (individuals and self-employed exchange)
• The Small Business Health Options Program (SHOP) exchange (small groups).

The three main stages of the process of purchasing individual health insurance: The Research Stage, the Shopping Stage and the Purchase Stage.

**Note:** During this uniform application process, income questions will be asked to see if you are qualified for free, or a reduction in cost, of purchasing a qualified health plan through the Exchange.
States still have a great deal of flexibility in designing their own “Exchanges”

- Under the new rules, marketplaces will have to post information online about price and quality, offer specific standardized plans and set an open enrollment period.
- Insurers will be allowed to hold seats on exchange oversight boards and states will not be required to negotiate with plans on price or benefit offerings.
- The deadline is 1/1/13 for states to show they will have an Exchange up and running by 1/1/14. Some flexibility – states showing progress will be granted “conditional approval.”
- States leaders should take the flexibility that they have been granted and design a strong, negotiating exchange on behalf of consumers.

How will Exchanges benefit employers and consumers?

- The development of these Exchanges will allow Americans to find comprehensive and affordable health coverage on a statewide or regional basis.
- “By increasing competition between insurance companies and allowing individuals and small businesses to band together to purchase insurance, Exchanges will lower costs.”
- Insurers will no longer be able to use a person’s health status to determine eligibility, benefits or premiums.
- Exchanges will create a health insurance marketplace that will allow employers and consumers to choose from several plans offering high quality benefits giving them the tools they need to make comparisons against benefits, pricing and quality.

HHS has allocated and distributed $185M to 13 states. HHS will decide by January 2013 if a state is in compliance

- States will first have to decide whether to design and implement an exchange.
- States are required to notify HHS by January 1, 2013 if they will set up their own exchange.
- If they do not, HHS will set up an exchange for the state (Sec. 1321(c)). Regardless of whether the state or HHS designs the state’s exchange, it will begin operation on January 1, 2014.
- 13 states enacted Exchanges in 2010. (see next slide)
- 19 states did not pass an Exchange in 2011. (see next slide)
- California is the only state to establish an Exchange in 2010.
<table>
<thead>
<tr>
<th>Enacted Exchange Established in 2010 or 2011 --13 States</th>
<th>Did not Pass in 2011***-- 19 States</th>
<th>Pending--5 States + D.C.</th>
</tr>
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*Indicates that it is a 2011-2012 carry over state and the bill may be reintroduced in the 2012 legislative session.
** California is the only state to pass exchange establishment in 2010.
State run “Exchanges” will create online, one stop shopping for consumers, employers and brokers

- Exchanges will make purchasing health insurance easier by providing eligible consumers and businesses with tools to compare benefits, pricing and quality in order to make the best choice for themselves, their families or their employees.
- If a state chooses to operate an exchange, it must also establish a Small Business Health Options Program (SHOP).

State “Exchanges” will be available initially to consumers & small businesses

- The state role is to create an Exchange for individuals and small businesses and provide oversight of health plans with regard to the new insurance market regulations, consumer protections, rate reviews, solvency, reserve fund requirements, premium taxes and to define rating areas.

Fewer than 50 Employees:
Businesses with fewer than 50 employees are exempt from penalties faced by larger employers that do not offer coverage. The penalties for larger employers (50 or more employees) do not go into effect until 2014.

Fewer than 100 Employees:
Small businesses with fewer than 100 employees will be able to purchase coverage through Small Business Health Options Program (SHOP) Exchanges beginning in 2014. These state-based exchanges are intended to allow employers to shop for qualified coverage and more easily compare prices and benefits. In 2017, states will have the option to allow businesses with more than 100 employees to purchase coverage through the SHOP Exchanges.
Initial open enrollment for both SHOP (Small Business Health Options Program) and IFP (Individual Family Plans) available in 2014

- If a state chooses to operate an exchange, it must establish a Small Business Health Options program (SHOP).
- SHOP will assist qualified employers by facilitating enrollment of qualified employees into Qualified Health Plans (QHPs).
- SHOP determines eligibility for both employers and employees, using a single employer application form and a single employee application form, before permitting purchase of QHP coverage.

- **SHOPs must also transmit enrollment information to QHPs.**
  - Notify employees of the effective date of coverage
  - Administer payments
  - Terminate non-compliant employers
  - Receive and maintain enrollment and participation records
  - Reconcile information at least monthly
  - Notify the employer if an employee terminates coverage

- **The exchange must provide for the following:**
  - Initial open enrollment period
  - Annual open enrollment period
  - Special enrollment period
SHOP program expanded to employers with more than 100 employees in 2017

• In 2017, states will have the option to allow businesses with more than 100 employees to purchase coverage through the SHOP exchanges.

Private “Exchanges” already exist – E.g. CaliforniaChoice

• CaliforniaChoice has been operating for 15 years and serves more than 150,000 members and more than 10,000 small employers with 2 to 50 employees.
• Two state exchanges exist in Massachusetts, serving the individual and family plans as well as the small group markets with 220,000 members.
• Utah has a state exchange serving the small group market with 2,200 members.
What happens if a state does not implement the Exchanges required by PPACA?

• If a state chooses not to establish an Exchange or implement the new insurance rules according to the standards set forth in the new law, then the federal government will step in and perform those functions.

• According to the Henry J. Kaiser Foundation, starting in 2014, all families with incomes up to 133% of the federal poverty level (about $29,000 for a family of four in 2009) will be eligible for Medicaid, with the majority of the additional cost paid by the federal government. The expansion in eligibility will be a required component of every state Medicaid program. States are not required to have Medicaid programs, though all states currently do, in large part, because the federal government pays the majority of the costs.
“Exchanges” will feature benefit levels…including Bronze, Silver, Gold & Platinum

<table>
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<tr>
<th>Benefit Category</th>
<th>Description</th>
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| Bronze           | • Minimum creditable coverage  
                   • Provides essential health benefits  
                   • Covers 60% of the benefit costs of the plan  
                   • Cost–sharing may not exceed HSA current law limit in 2014 (currently $6,050 individual/$12,100 family for 2012) |
| Silver           | • Provides essential health benefits  
                   • Covers 70% of the benefit costs of the plan  
                   • Cost–sharing may not exceed HSA current law limit in 2014 |
| Gold             | • Provides essential health benefits  
                   • Covers 80% of the benefit costs of the plan  
                   • Cost–sharing may not exceed HSA current law limit in 2014 |
| Platinum         | • Provides essential health benefits  
                   • Covers 90% of the benefit costs of the plan  
                   • Cost–sharing may not exceed HSA current law limit in 2014 |

*Source: Kaiser Family Foundation, Summary of New Health Reform – Last Modified March 26, 2010*
Entire approach to “Exchanges” will alter the delivery of employer provided Healthcare from Defined Benefit to Defined Contribution much like pension Reform in the USA after 1978

• Defined benefits, which are the most common approach, provides employees with guaranteed coverage for a certain, predetermined set of benefits, whether they use that coverage often or not at all.
• Defined contributions is where the employer’s contribution is predetermined, and the employee chooses how to spend that set amount.
• With a defined contribution approach, an employer sets a monthly fixed dollar allowance for employees.
• The employees use this money to go to an online insurance store to purchase insurance.
What types of subsidies does PPACA provide to people buying health insurance?

- New eligibility rules enacted under PPACA extend coverage in Medicaid to most people with incomes under 133% of poverty.
- For people with somewhat higher incomes (up to 400% of poverty), PPACA provides tax credits that reduce premium costs.
- People with incomes up to 250% of poverty also are eligible for reduced cost sharing (e.g., coverage with lower deductibles and copayments) paid for by the federal government. The premium tax credits and cost-sharing assistance will begin in 2014.

Who is eligible for premium tax credits?

- Citizens and legal residents in families with incomes between 133% and 400% of poverty who purchase coverage through a health insurance exchange* are eligible for a tax credit to reduce the cost of coverage.
- People eligible for public coverage and people offered coverage through an employer are not eligible for premium tax credits unless the employer plan does not have an actuarial value of at least 60%* or unless the person’s share of the premium for employer-sponsored insurance exceeds 9.5% of income.
- People who meet these thresholds for unaffordable employer-sponsored insurance are eligible to enroll in a health insurance exchange and may receive tax credits to reduce the cost of coverage purchased through the exchange.

What is the amount of the tax credit provided to people?

• The amount of the tax credit that a person can receive is based on the premium for the second lowest cost silver plan* in the exchange and area where the person is eligible to purchase coverage. A silver plan is a plan that provides the essential benefits for and has an actuarial value of 70%. (In PPACA, a 70% actuarial value means that on average the plan pays 70% of the cost of covered benefits for a standard population of enrollees.)

Note: *The Federal Poverty Level (FPL) was $10,830 for an individual and $22,050 for a family of four through early 2010. For more information, please see the Department of Health and Human Services Poverty Guidelines, available at [http://aspe.hhs.gov/poverty/](http://aspe.hhs.gov/poverty/).
What is the amount of the tax credit provided to people? Continued

The amount of the tax credit varies with income such that the premium that a person would have to pay for the second lowest cost silver plan would not exceed a specified percentage of their income (adjusted for family size), as follows:

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Premium as a Percent of Income</th>
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<tbody>
<tr>
<td>Up to 133% of FPL</td>
<td>2% of income</td>
</tr>
<tr>
<td>133–150% FPL</td>
<td>3–4% of income</td>
</tr>
<tr>
<td>150–200% FPL</td>
<td>4–6.3% of income</td>
</tr>
<tr>
<td>200–250% FPL</td>
<td>6.3 – 8.05% of income</td>
</tr>
<tr>
<td>250–300% FPL</td>
<td>8.05 – 9.5% of income</td>
</tr>
<tr>
<td>300–400% FPL</td>
<td>9.5% of income</td>
</tr>
</tbody>
</table>

Note: The Federal Poverty Level (FPL) was $10,830 for an individual and $22,050 for a family of four through early 2010. For more information, please see the Department of Health and Human Services Poverty Guidelines, available at [http://aspe.hhs.gov/poverty/](http://aspe.hhs.gov/poverty/)
A person who wants to purchase a plan that is more expensive would have to pay the full difference between the cost of the second lowest cost silver plan and the plan that they wish to purchase.

An example shows how the premium tax credits work. Assume:

- Pat is 45 years old and has an income in 2014 that is 250% of poverty (about $28,735)
- The cost of the second lowest cost silver plan in the exchange in Pat’s area is projected to be about $5,733
- Under PPACA, Pat would not be required to pay more than 8.05% of income, or $2,313, to enroll in the second lowest cost silver plan.

The tax credit available to Pat would be $3,420 ($5,733 premium minus the $2,313 limit on what Pat must pay).

Because health insurance premiums have typically grown more rapidly than income, PPACA adjusts the percent of premium that people are required to pay to reflect the excess of the premium growth over the rate of income growth. Beginning in 2019, if aggregate premiums and cost-sharing subsidies exceed 0.54% of GDP, the premium percentages would be further adjusted to reflect the excess of premium growth over CPI.

During this process, it is important to recognize that the majority of Americans have never purchased health insurance on their own. Normally, people obtain insurance through an employer (usually choosing from a limited number of plans) or they receive publicly subsidized coverage from Medicaid or Medicare. Under the “Exchange” approach, there will be tens of millions of new “customers” that will be responsible for purchasing health insurance, many of whom will be doing this for the first time.
Questions

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