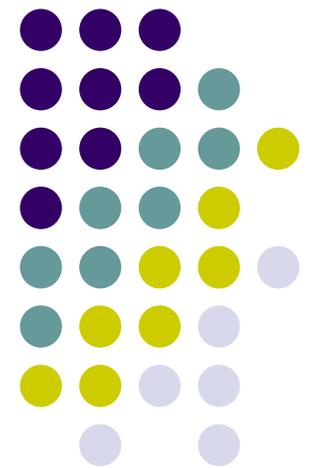


Health Insurance Exchange



Patient Protection and Affordable Care Act (PPACA)



On March 23, 2010, the President signed the Patient Protection and Affordable Care Act (PPACA) into law. Additionally, the President signed the Health and Education Reconciliation Act which made amendments to PPACA. Together, these two acts are referred to as the Affordable Care Act. Some of the most significant changes included the Affordable Care Act as outlined below.

Federal High Risk Pool: The Federal High Risk Pool was one of the first items implemented from the Affordable Care Act. The high-risk pool covers South Dakotans who are uninsurable due to pre-existing health conditions and who have been without health care coverage.

Insurance Changes: The Affordable Care Act required several insurance changes to take effect at the start of the plan year beginning on or after September 23, 2010.

Health Insurance Exchange: The Affordable Care Act requires each state to have a health insurance exchange in place by 2014.

What is an Exchange?



The federal Affordable Care Act contemplates an exchange to be a one-stop shopping place where people can purchase health insurance coverage.

Exchanges will allow individuals below certain income levels to obtain financial assistance in the form of tax subsidies and cost-sharing reductions that will make health insurance more affordable. When individuals apply for a plan through the exchange, they will also be screened for Medicaid and Children's Health Insurance Program (CHIP) eligibility.

Small businesses will also be able to purchase insurance for their employees through the exchanges.

Individuals and small businesses choosing to purchase a qualified plan through the exchange will be assisted by a navigator and provided information about the quality and cost of the health plans. Individuals and small businesses can enroll in a health plan via a Web Portal or a Phone Hotline.



Statutory Requirements

- Designed to be a one stop health insurance mall where....
 - Eligible individuals will purchase qualified health plans with the minimum essential benefits.
 - Individuals eligible for Medicaid and the South Dakota Children's Health Insurance Program (CHIP) will be enrolled through the exchange. This is in addition to current eligibility processes for Medicaid through the Department of Social Services (DSS).
 - Individuals 138% to 400% of Federal Poverty Level (FPL) (\$30,429-\$88,200 for a family of four) will receive premium subsidies and cost sharing assistance.
 - Small businesses will be allowed to purchase insurance for their employees.
 - Individuals can be certified exempt from the individual responsibility requirement.

Required Enrollment Assistance



- A web portal and 1-800 hotline will be provided to individuals and small businesses to assist them in purchasing insurance through the exchange.
 - Web portal will provide standardized quality and cost information about each health plan.
- Navigator programs to assist individuals in finding the exchange and purchasing insurance from the exchange.
- Provide a calculator to determine the actual cost of coverage after financial assistance.

Other Statutory Requirements



- Consultation with stakeholders including tribes.
- Publication of data on the Exchange's Administrative costs.
- Presentation of enrollee satisfaction survey results.
- Required to self sustaining by 2015.

Planning Grant



- First phase of funding to assist states in the initial phase for implementation
- \$1 million for planning - no state match required
- Grant period runs from October 1, 2010-September 30, 2011.
- If the state determines that a state-based exchange is feasible and financially sustainable, the state will use the planning grant funds to determine the needed governance structure, program intersection points, technical infrastructure, staffing, accounting and auditing procedures, and policies.

Planning Grant Continued



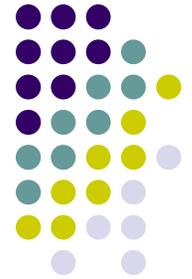
- The grant will be spent on the following categories:
 - Exchange Personnel
 - Background Research
 - Stakeholder Involvement



Exchange Personnel

- FTE's were allocated to this planning process for the following agencies:
 - Governor's Office
 - Department of Social Services
 - Division of Insurance
 - Bureau of Information and Telecommunications

Exchange Personnel



- Governor's Office
 - Kea Warne, Health Insurance Exchange Project Manager
- Department of Social Services
 - Teresa Bray, Health Care Exchange Project Manager
 - Beverly Wilson, Health Care Exchange General Specialist
 - Technical Specialist (to be hired)
- Department of Labor and Regulation
 - Randy Moses, Assistant Director, Division of Insurance
- Bureau of Information and Telecommunications
 - Martie Stulken, BIT Eligibility Systems Analyst
 - Marcia Graves, BIT Medicaid Systems Analyst
 - Karrie Geffre, BIT Financial Systems Analyst
 - Randy Johnson, BIT Insurance Systems Analyst
 - BIT has selected a vendor for project management and development of the web portal

Navigant Consulting



- Navigant Consulting (<http://www.navigant.com/>)
- Lend expertise & lead exchange technology discussions
- Identify content & business needs for web site
- Develop web portal options
- Participate in Task Force & Subcommittees
- Technical Project Management
- State staff participation
- Consultant staff
- Worked with Massachusetts on the assessment of its CommonwealthCare Program
- Worked with Pennsylvania with the design of its exchange
- Experience with TANF, SNAP and Medicaid edibility systems
- Experience working with commercial insurers and brokers



Background Research

- The grant will be used to plan for an exchange in South Dakota by evaluating a number of relevant areas to determine the feasibility of operating a state-based exchange.
- Research is a significant portion of the planning process. The state will complete background research, utilizing existing sources of information, as well as engage a vendor to conduct research on the general state of insurance and uninsured population in the state.
- Two surveys are currently being conducted to collect background research
 - Individual and Family Survey
 - Small Business Survey
- Both surveys will be completed by mid-July.

Individual and Family Survey



- 5 companies responded to our RFP to conduct research services for the exchange. 4 US companies and 1 Canadian Company.
 - Market Decisions, LLC out of Portland, Maine was selected to conduct the individual and family survey.
- This survey will:
 - Assess health insurance coverage and coverage characteristics.
 - Gather data on non-coverage and risks for loss of coverage.
 - Gather basic demographic data to allow analysis of health insurance coverage by population characteristics.
 - Gather data on potential eligibility for coverage through a potential exchange.
 - Assess residents' opinions regarding enrollment methods and preferences, and views of the individual mandate.

Small Business Survey



- The Department of Labor and Regulation is conducting the survey of small businesses with 2 to 50 employees to determine:
 - Number currently providing health insurance coverage
 - Number of employees enrolled
 - Of those that have not enrolled, how many indicated they have other health insurance or creditable coverage
 - Number currently offering family health insurance coverage
 - Number of family members enrolled

Stakeholder Involvement



- Representation has been sought and received from small businesses, insurance agents, insurance companies, health care providers, consumer advocates, state agencies, state legislators and Tribes.
- The Health Insurance Exchange Task Force will have several subgroups focusing on areas such as operations and financing an exchange, outreach and communication, and insurance plan and market organization.



Establishment Grant

- Second phase of Exchange implementation.
- Cover the costs of the planning and establishment of Exchanges through January, 2015.
- States apply for a Level I or II Establishment Grant
 - Level I – state can choose the core areas (one to eleven of the core areas) for which the funding would be used and provide specific milestones for accomplishing each one.
 - Level II – more detailed requirements which include:
 - Work plan must include all activities through the end of 2014
 - All eleven core areas must be part of the work plan
 - Legislative authority for the exchange must be established in the state
 - Governance structure must be established
 - Budget through the end of 2014
- Federal government will fund implementation until 2015 when exchange must be self-sustaining.

Establishment Grant Core Areas

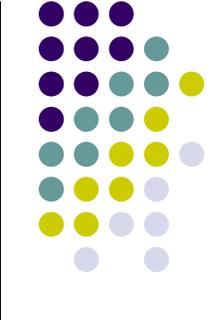


- Background Research
- Stakeholder Consultation
- Legislative and Regulatory Action
- Governance
- Program Integration
- Exchange IT Systems
- Financial Management
- Oversight and Program Integrity
- Health Insurance Market Reforms
- Providing Assistance to Individuals and Small Businesses, Coverage Appeals, and Complaints
- Business Operations of the Exchange



Key Timeline Dates

- Summer, 2011 - HHS releases regulations to states
- August 31, 2011 – Task Force develops a set of recommendations for an exchange
- December 30, 2011 – Deadline for state to submit application for Level I Establishment Grant
- January 1, 2012 – Establish the legal authority necessary to establish and operate an exchange
- June 29, 2012 – Deadline for state to submit application for Level II Establishment Grant
- December 31, 2012 – Development and initial testing for functionality of exchange must be completed
- January 1, 2013 – Submit Exchange to the Secretary of HHS for certification
- January 1, 2014 – Exchange becomes operational
- January 1, 2015 – Exchange becomes self-sustaining



?

Statutory Requirements for Health Plans



- Only qualified health plans with an essential health benefit package as defined by the Secretary of HHS can be sold in the exchange.
- The exchange will need to certify, decertify and recertify health plans as qualified health plans.
- Provision of an open enrollment period.

Essential Benefit Categories



- Ambulatory patient services
- Emergency Services
- Hospitalization
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health treatment
- Prescription Drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

Federal Principles Center for Consumer Information and Insurance Oversight (CCIIO)



- Promoting Efficiency
- Avoiding Adverse Selection
- Streamlined Access and Continuity of Care
- Public Accountability and Transparency
- Fiscal Accountability

Federal Guidance Organizational Form



Two Options

1. State Agency (Utah) or
2. Independent Public Authority (Massachusetts)

Either option must:

1. Be Publicly Accountable
2. Be Transparent
3. Have Technically Competent Leadership
4. Include Security Procedures/Privacy Standards

Federal Guidance Model Options



Active Purchaser (Market Regulator)

- Massachusetts
- Negotiates with insurers based upon benefits/premiums
- Limits participation of insurers
- Sets marketing standards

Open Marketplace (Market Facilitator)

- Utah
- Allows all qualified plans to participate
- Relies on market for competition

Federal Guidance Compliance Areas



- Network Adequacy
 - Sufficient number of providers in and out of network
 - Provider Directories
 - Availability of essential community providers

NAIC Exchange Model



Enabling legislation for American Health Benefit Exchange (individuals) and Small Business Health Options Program (SHOP)

- Bare bones model legislation
- Defines plans in/out (health benefits plans v. excepted benefits)
- Provides for general authority and duties of exchange entity



NAIC Exchange Model

- Sets for the certification process for qualified plans offered through exchange
- Authorizes exchange to charge assessments or user fees
- Allows exchange to promulgate rules



South Dakota Medicaid & the Health Care Exchange



May 19, 2011

What is Medicaid?

- Federal / State Partnership since 1965
- Federal government mandates certain healthcare coverage to certain categories of individuals and allows states to cover optional categories and services at their discretion
- Medicaid is governed by federal regulations and each state's approved Medicaid State Plan- essentially a contract with the federal government
- Medicaid is an entitlement program

What is CHIP?

- Children's Health Insurance Program
- Federal allocation is block grant
- Coverage limited to children with higher incomes than Medicaid levels, can't have insurance
- Runs as a "Medicaid look alike" program in our state- same services provided to children eligible through Medicaid or CHIP

Who is covered by Medicaid?

69 percent are children and 31 percent are adults

- Low income children, pregnant women, adults and families
 - very low income families (family of three \$9,552 annual income/52% FPL)
- Elderly or disabled
- Children in Foster Care

•Average monthly eligibility for FY10 in total 111,005

- Elderly – 6,957
- Disabled – 16,856
- Children of low-income families – 61,275
- Pregnant women (pregnancy only)– 2,829
- Low-income adults – 10,900
- Children’s Health Insurance Program – 12,188

•Total unduplicated for FY10= 139,666

Eligibility for Medicaid

- Current Medicaid eligibility depends on whether a person meets specific eligibility criteria, resources, and income limits
- States cannot cut current eligibility. The Patient Protection & Affordable Care Act (PPACA) includes a Maintenance of Effort (MOE) requirement. States must maintain all current eligibility standards until January 2014 and standards for children until October 2019.

Department of Social Services

2010 FEDERAL POVERTY GUIDELINES

Annual Amount at Various Percentage Levels

Family Size	100%	130%	133%	140%	150%	160%	200%
1	\$10,830	\$14,079	\$14,404	\$15,162	\$16,245	\$17,328	\$21,660
2	\$14,570	\$18,941	\$19,378	\$20,398	\$21,855	\$23,312	\$29,140
3	\$18,310	\$23,803	\$24,352	\$25,634	\$27,465	\$29,296	\$36,620
4	\$22,050	\$28,665	\$29,327	\$30,870	\$33,075	\$35,280	\$44,100
5	\$25,790	\$33,527	\$34,301	\$36,106	\$38,685	\$41,264	\$51,580
6	\$29,530	\$38,389	\$39,275	\$41,342	\$44,295	\$47,248	\$59,060
7	\$33,270	\$43,251	\$44,249	\$46,578	\$49,905	\$53,232	\$66,540
8	\$37,010	\$48,113	\$49,223	\$51,814	\$55,515	\$59,216	\$74,020
Each Additional approximately	\$3,740	\$4,862	\$4,974	\$5,236	\$5,610	\$5,984	\$7,480

Program Eligibility:

Medicaid (Pregnant Women)	133%
Medicaid	140%
CHIP Children's Health Insurance Program	200%

Services Covered by Medicaid - Required Services

Services federally required to be covered by Medicaid:

- Services to children through “Early, Periodic, Screening, Diagnosis and Treatment”, or EPSDT.
- Inpatient and outpatient hospital
- Physician services
- Nursing facility services for individuals age 21 or older
- Emergency dental services
- Emergency medical transportation
- Lab and X-Ray
- Skilled home health services
- FQHC/Rural Health Care Center Services
- For certain people eligible for Medicare- Medicaid must pay co-insurance/deductibles; buying them into Part A or B. Medicare Part D Clawback

Services Covered by Medicaid - Optional Services

- Physician assistants
- Psychologists and independent mental health practitioners
- Intermediate Care Facilities for the Mentally Retarded (ICF/MR)

Other Services for Adults

- Podiatry
- Prescription Drugs
- Optometry
- Chiropractic services
- Durable medical equipment
- Dental services
- Physical, occupational, speech therapy, audiology
- Prosthetic devices and eyeglasses
- Hospice care, nursing services
- Personal care services and home health aides

Medicaid Expenditures

- FY10 expenditures: \$850.2 million (DSS, DHS, DOC, DOE)
- FY12 budget: \$904.4 million (DSS, DHS, DOC, DOE)
- Services paid at Federal Medical Assistance Percentage or FMAP rate- FY12: 59.66% federal funds/40.34% general funds
- From FY09 to FY10, the national average growth in Medicaid expenditures was 8.8%; in SD, the growth was 7.6%.
- Compared to our neighboring states we spend the least amount per Medicaid enrollee.
 - South Dakota Medicaid spends 4% less than Iowa
 - South Dakota Medicaid spends 14% less than Wyoming
 - South Dakota Medicaid spends 22% less than Nebraska
 - South Dakota Medicaid spends 28% less than Montana
 - South Dakota Medicaid spends 47% less than North Dakota
 - South Dakota Medicaid spends 55% less than Minnesota

How Will Medicaid Change in 2014?

- Eligibility for Medicaid will expand to all people with incomes 138%FPL and below
 - Use of Modified Adjusted Gross Income (MAGI)- for Medicaid and all health subsidies provided through the exchange
 - No asset test for most eligibles
 - No categorical test
 - Several process requirements, i.e., single application, must accept electronic applications
 - Need to determine enrollment process through the Exchange- business process and technology considerations

How Will Medicaid Change in 2014?

- Expect 54,100 more people to be eligible for Medicaid
 - Biggest group impacted will be childless adults
 - Estimated 49,600 “newly eligible”, plus 4500 currently eligible but not enrolled
 - FY2014 estimate: 19,000 eligibles
 - FY2015 estimate: 44,000 eligibles

How Will Medicaid Change in 2014?

- All qualified health plans offered through the exchange must provide an “essential benefits package”
- New eligibles for Medicaid must be provided “benchmark” or “benchmark equivalent” coverage
 - “Essential benefits package” plus certain additional services
 - Can extend benchmark coverage to some currently eligible populations, but others are exempt from benchmarking- i.e., elderly and disabled

How Will Medicaid Change in 2014?

Graduated federal participation in costs for services for new eligibles:

2014-2016: 100% federal funds

2017: 95% federal funds

2018: 94% federal funds

2019: 93% federal funds

2020: 90% federal funds

How Will Medicaid Change in 2014?

- Total state cost estimate 2014-2019, without factoring in changes for essential benefit plan or development of new eligibility system: \$99.7 million
 - FY2014 estimate: \$3.9 million in state funds-administrative costs (50/50) and costs for people currently eligible but not enrolled (FMAP)
 - FY2015 estimate: \$10.3 million in state funds-administrative costs and costs for people currently eligible but not enrolled

How Will Medicaid Change in 2014?

- Current planning activities
 - Eligibility system assessment
 - Business process assessment
 - Monitoring federal guidance, especially on income verification processes, essential benefit package definitions



South Dakota Department of Social Services



Thank you!