



HUMAN SERVICES  
DEPARTMENT

**NEW MEXICO**

**HEALTH INSURANCE EXCHANGE**

**Legislative Work Group**

## Legislative Work Group

### AGENDA

Tuesday, October 2, 2012, 9:00 – 11:00 a.m.

PERA Building , 1120 Paseo de Peralta

Time	Action	Owner
9:00	Welcome and Introductions	Milton Sanchez, Deputy Director, Office of Health Care Reform, Staff, and Leavitt Partners
9:10	Introduction to Primer	Milton Sanchez, Staff, and Leavitt Partners
9:30	Introductory Presentation	Milton Sanchez
10:00	BREAK	
10:15	Discussion of questions; assignments; establish procedures	Milton Sanchez, Staff, and Leavitt Partners
10:45	Wrap-Up	Milton Sanchez, Staff, and Leavitt Partners
11:00	Location for Next Meeting	Work Group

# Advisory Task Force Work Groups

- HSD's NM HIX Advisory Task Force is leading a Work Group process to assist in the development of the Exchange with stakeholder input.
- Work groups are:
  - Essential Health Benefits (EHB)
  - Outreach, Education, Adoption, Enrollment
  - Legislative
  - Exchange Market Regulation
  - Program Integration
  - Native American
  - Financial Sustainability
  - Employer Participation

# PRIMER

- This document provides an overview of activities for the New Mexico Health Insurance Exchange, as well as issues for which the Advisory Task Force requests guidance.

# Questions

- A. Certification/decertification and other carrier participation requirements
  - 1. Should carriers be required to participate in both the individual and small group markets?
  - 2. Should carriers participating in the exchange be required to offer plans at more than the two levels of coverage required by federal law (i.e., Silver and Gold)?
  - 3. Should health plans inside the exchange be subject to enhanced regulation on rate review or reporting requirements?
  - 4. What criteria, such as relative quality and price of benefits, should be used to rate plans available through the exchange?
  - 5. Does a qualified health plan need to be available to everyone statewide, or can it be offered to only those in one region of the state?
- B. Where should regulatory oversight responsibility be housed?
- C. Financial Sustainability/Operating Costs
  - 1. Should exchange-related assessments be imposed? If so, against whom (consumers, insurance carriers, providers, employers, hospitals, etc.)?
  - 2. What other ways could be used to fund operating costs?

# Agency Vision

New Mexico's Exchange will:

- Be Free Market, Consumer Friendly, State-Based
- Increase Efficiency in Health Insurance Market
- Greater Transparency on Cost and Quality of Health Care
- Begin with efforts in the small-group market
- Improve Health care Outcomes
- Focus on competition and choice
- Increase Value for Health care Dollars

# Three Options are Available for Exchanges under PPACA

## 1. State-Based Exchange (SBE)

State operates all activities, but can use federal services such as:

- Premium tax credit & cost sharing determinations
- Risk adjustment program
- Reinsurance program

## 2. State-Federal Partnership Exchange (Partnership)

State operates activities for:

- Plan Management
- Consumer Assistance

## 3. Federally-Facilitated Exchange (FFE)

- Health & Human Services operates all activities
- State operates plan management on its behalf.

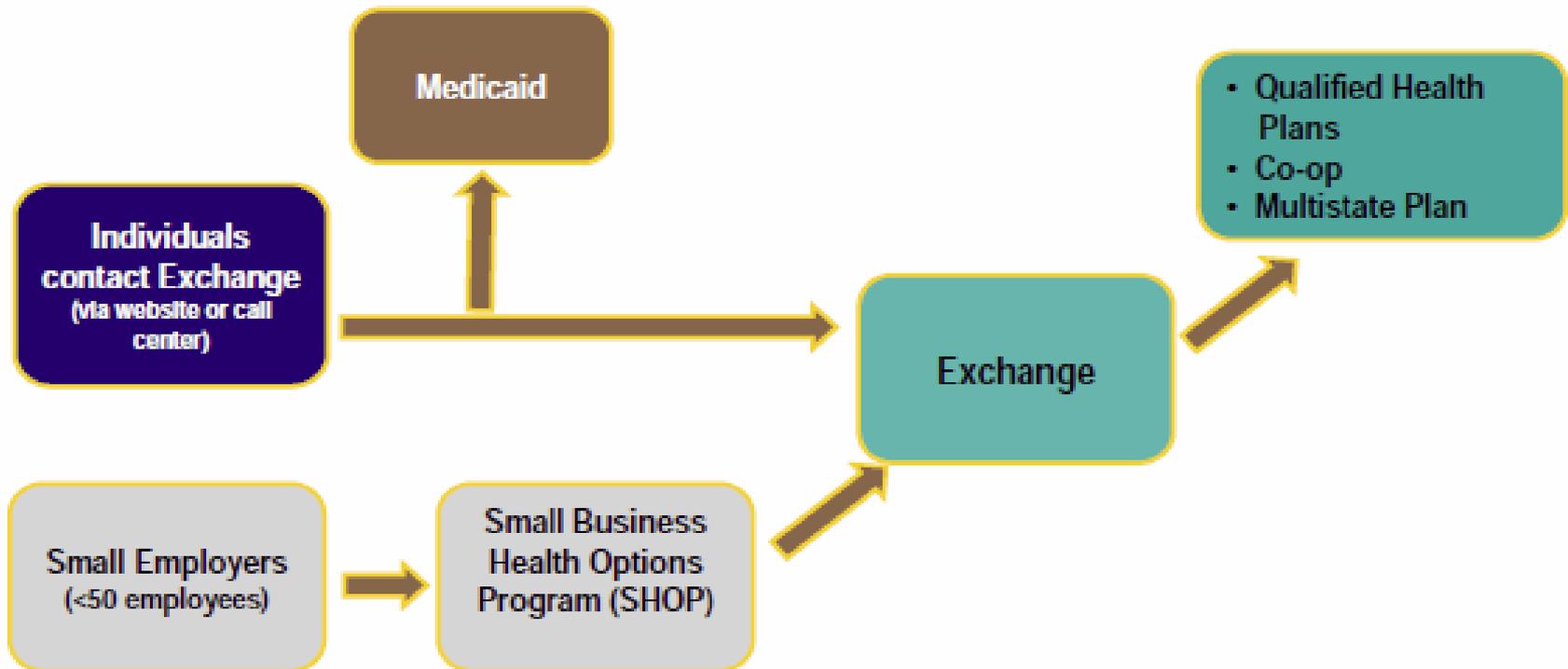
# Who Will the Exchange Serve?

- Individuals who meet certain criteria, including no access to other affordable insurance
  - Individuals who meet specified income guidelines will be eligible for federal insurance premium assistance (tax credits) when they purchase a QHP through the Exchange
- Small business employers  
(with up to 50 full-time employees)
  - Small employers that meet certain criteria will become eligible for a tax credit if they join or contract with the Exchange

# How Will the Exchange Help?

- Bring availability of multiple private health plans to one place.
- Allow for easy comparison of similar products.
- Make health plans ultimately responsible for the quality of their products.
- Provide a streamlined application process
- Present a standardized way to compare health plans
- Offer standard essential benefits on all health plans
- Hold Qualified Health Plans to specific requirements
- Make data regarding provider quality and complaints and health plan rating information available to all consumers, to aid in the decision-making process
- Provide consumer assistance programs

# How will the Exchange work?



# Additional Help from the Exchange

A toll-free telephone number will be available to provide:

- General health insurance coverage information
- Assistance with eligibility and enrollment, including application intake and questions
- Information about Tax credit premiums, cost sharing, enrollment cards, provider network, and billing
- Appeals and grievance guidance
- SHOP questions – from employers and employees
- Case updates (income changes, insurance status changes, address changes)
- A website with FAQs and an email assistance link

# What Are Essential Health Benefits?

ACA requires health insurance plans sold to individuals and small employers to provide a minimum package of services in 10 categories called Essential Health Benefits (EHBs). EHBs are to be applied both inside and outside Exchanges. They are:

- Ambulatory patient services
- Emergency services
- Hospitalizations
- Maternity and newborn care
- Mental health and substance use disorder services, including behavioral health
- 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

## Summary of Benefit Cost Differences And Recommendations

### Summary of Benefit Cost Differences

The table below shows a summary of the expected relative cost differences between the benchmark options. It can be seen that all the plans are close in value (± 1.0%) except for two of the FEHBP plans, which include dental benefits for adults.

Benefit Category	SO	State FF		FEHBP			HMO
	Lowcase Classic (Default)	BCBS PPO	Free	BCBS High	BCBS Standard	GDHA Standard	Lowcase Premier 2008
1.a. Chiropractic	0.0%	0.0%	0.0%	-0.2%	0.0%	-0.2%	0.0%
1.h. Home health	0.0%	0.0%	0.1%	-0.0%	-0.2%	-0.2%	0.0%
1.j. Genetic testing	0.0%	0.0%	0.0%	0.0%	0.0%	-0.1%	0.0%
1.l. Infertility	0.0%	-0.8%	0.0%	0.0%	0.0%	-0.0%	0.0%
1.o. Dental	0.0%	0.0%	0.0%	8.7%	8.7%	0.0%	0.0%
1.r. Acupuncture	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%
4.d. Home births	0.0%	0.0%	0.0%	-0.1%	-0.1%	0.0%	0.0%
5.a. Residential reh	0.0%	1.1%	1.1%	0.0%	0.0%	0.0%	0.0%
7.a. PT, OT, ST	0.0%	0.0%	0.0%	-0.2%	-0.8%	-0.4%	0.0%
7.b. Massage therapy	0.0%	0.2%	0.2%	0.0%	0.0%	0.0%	0.0%
7.a.2. Orthotics	0.0%	0.0%	0.0%	0.1%	0.1%	0.1%	0.0%
7.g. Skilled nursing	0.0%	0.0%	0.0%	-0.2%	-0.2%	-0.1%	0.0%
10.h. Hearing aids	0.0%	-0.1%	-0.1%	0.0%	0.0%	-0.2%	0.0%
Combined	0.0%	0.7%	1.0%	7.6%	7.6%	-1.4%	0.0%

### Recommendations

Our recommendations for the New Mexico Essential Health Benefits benchmark plan are as follows:

1. Adopt the Lowcase Classic PPO as the Essential Health Benefits benchmark plan. Our reasons for this recommendation are as follows:
  - There were few differences between this and the other benchmark plan options.
  - Supplementing this benefit package was not necessary in any of the benefit categories other than habilitative benefits and pediatric dental and vision, which was also true in most of the other plans.
2. Habilitative services would be offered at parity with rehabilitative services. A plan covering services such as PT, OT, and ST for rehabilitation would also cover those services in similar scope, amount, and duration for habilitation. Our reasons for this recommendation are as follows:
  - The benchmark option plans do not generally cover habilitative services, so one of the federal options must be chosen.
  - This approach will provide for consistency between carriers, while other federal approach would not.
3. Pediatric dental and vision coverage would be offered at the NM S-GHP level of benefits. Our reasons for this recommendation are as follows:
  - The benchmark option plans do not generally cover pediatric dental and vision services, so one of the federal options must be chosen.
  - This approach will make it easier for children to move back and forth between the GHP plan and the commercial market, while other federal option will not.

DRAFT

# Who Is Eligible for Premium Tax Credits?

Individuals who purchase insurance through the Exchange and whose income is 100% - 400% of the federal poverty level (but not eligible for Medicaid) may be eligible for a tax credit to help pay the cost of coverage.

Individuals eligible for the tax credit cannot have access to employer-sponsored insurance

Exception: if an employee's required premium contribution for the employer's insurance exceeds 9.5% of the employee's income it is considered unaffordable, and the employee is therefore eligible for a premium tax credit

# Premium Limits for Consumers

- The premium assistance subsidy reduces the amount that an individual or family pays for health insurance coverage by providing a tax credit. These subsidies are only available through the Exchange. Subsidies are determined on a sliding scale, based on income, so that individuals at the lower end of the income scale get the most help. The subsidy is based on the premium for a benchmark plan (the second lowest cost silver plan available in an Exchange). An individual or family who wants a more expensive or higher tier plan (i.e., gold or platinum) must pay the difference.

# Premium Assistance Subsidies

Size of Family	Federal Poverty Level	Annual 100% FPL 2% of income	133% FPL 2% of income	150 FPL 4.0% of income	200% FPL 6.3% of income	300% FPL 9.5% of income	400% FPL 9.5% of income
1	\$11,170	\$19	\$25	\$55	\$114	\$259	\$345
2	\$15,130	\$26	\$34	\$75	\$154	\$349	\$466
3	\$19,090	\$32	\$42	\$94	\$195	\$440	\$587
4	\$23,050	\$38	\$51	\$115	\$235	\$531	\$708

# Cost-sharing Assistance Subsidies

## Out-of-Pocket Spending Limits for Consumers Based on Income

Income	Out-of-Pocket Limit
100 - 200% FPL	\$1,983/individual; \$3,967/family
200 - 300% FPL	\$2,975/individual; \$5,950/family
300 - 400% FPL	\$3,967/individual; \$7,933/family
Above 400% FPL	\$5,950/individual; \$11,500/family

# What is a “SHOP”?

ACA requires states to create a Small Business Health Options Programs (SHOP) if the state chooses to build a Health Insurance Exchange

- ACA requires a SHOP to help small employers (those with 2 to 50 employees, adjusting in 2017 to include employers with up to 100 employees) access affordable insurance for their employees
- ACA allows states to combine SHOP with the individual Exchange. Under PPACA, states will assist small employers in enrolling their employees in private health insurance plans
- Plans offered on the SHOP must comply with all QHP regulations and requirements
- Premiums will vary only by geography, age of the insured, and tobacco use
- Employers can choose to offer coverage from multiple insurers, just like larger companies and government employee plans, but get a single bill and write a single check
- SHOP Exchanges can also allow employers to select only a single plan to offer employees

# How Will Small Employers Benefit from SHOP?

Starting in 2014, small employers purchasing coverage through a SHOP might be eligible for a tax credit of up to 50 percent of their premium payments if they:

- Have 25 or fewer employees
- Pay employees an average annual wage of less than \$50,000
- Offer all full-time employees coverage
- Pay at least 50 percent of the premium cost

The credit is available for two years (non-profit employers meeting the eligibility criteria can receive credit for 35 percent of their premium payments).

# Tax Credit for Eligible Small Companies

- During Phase I, the credit is worth up to 35% of a company's health insurance costs (25% for non-profits).
- During Phase II, the credit is worth up to 50% of a company's health insurance costs (35% for non-profits).
- To be eligible for the credit:
  - The company must employ less than 25 full-time equivalent employees (FTEs) during the tax year
  - Must pay average annual wages below \$50,000.
  - The employer must pay at least 50% of an employee's qualified health insurance through a qualified contribution arrangement to receive the credit.
  - For tax-paying companies, the credit is claimed on the company's annual income tax return as a general business credit. If the company does not owe any income taxes in the current tax year, the credit can be carried back 1 year or carried forward up to 20 years.

**Table 1. Small Business Tax Credit as a Percent (Maximum of 35%) of Employer Contribution to Premiums, For-Profit Firms in 2010-2013 and Nonprofit Firms in 2014+**

Firm size	Average wage					
	Up to \$25,000	\$30,000	\$35,000	\$40,000	\$45,000	\$50,000
Up to 10	35%	28%	21%	14%	7%	0%
11	33%	26%	19%	12%	5%	0%
12	30%	23%	16%	9%	2%	0%
13	28%	21%	14%	7%	0%	0%
14	26%	19%	12%	5%	0%	0%
15	23%	16%	9%	2%	0%	0%
16	21%	14%	7%	0%	0%	0%
17	19%	12%	5%	0%	0%	0%
18	16%	9%	2%	0%	0%	0%
19	14%	7%	0%	0%	0%	0%
20	12%	5%	0%	0%	0%	0%
21	9%	2%	0%	0%	0%	0%
22	7%	0%	0%	0%	0%	0%
23	5%	0%	0%	0%	0%	0%
24	2%	0%	0%	0%	0%	0%
25	0%	0%	0%	0%	0%	0%

# What is a Navigator?

Navigators are “assisters” required by ACA to:

- Conduct public education activities to raise awareness of QHPs available through the Exchange
- Distribute fair, impartial information about enrollment in QHPs, the availability of premium tax credits, and cost-sharing assistance through the Exchange
- Facilitate enrollment in QHPs
- Provide referrals to consumer assistance programs or any other appropriate State agencies to Exchange enrollees with grievances, complaints, or questions regarding their Qualified Health Plan, their coverage, or a determination made under such plan or coverage
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the populations being served by the Exchange

# How will Brokers and Agents Be Affected by the Exchange?

ACA does not affect New Mexico's role in licensing agents and brokers

Exchanges may permit agents and brokers to:

- Enroll individuals, employers or employees in a QHP in the individual or small group market through the Exchange
- Assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for Qualified Health Plans

# Can Agents and Brokers Be Navigators?

Agents and brokers can be Navigators providing they:

- Meet Navigator training requirements
- Meet the minimum duties required by the federal and state rules
- Meet any Conflicts of Interest standards developed by the Exchange
- Receive no compensation from health insurers

# ACA Timelines

- October 1, 2012 – Submit Benchmark
- January 2013 – CMS will certify the Exchange has the ability to operate
- October 2013 – The Exchange begins enrollment
- January 2014 – The Exchange becomes fully operational
- January 2015 – The Exchange becomes financially self-sustaining