# *The Federal Patient Protection & Affordable Care Act: Medicaid Eligibility and Exchanges*

Presentation to the
Legislative Health and Human Services Committee

Carolyn Ingram, Director, Medical Assistance Division, HSD
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# Today's discussion – Patient Protection and Affordable Care Act (PPACA): Medicaid & Exchanges

- PPACA and Health Insurance Exchanges
  - Goals, Enrollment, Eligibility
  - Key functions of the Exchange and Federal Statutory Requirements
  - Compliance & Penalties
  - Challenges
- Medicaid Eligibility and the Exchange
- IT Solutions
- PPACA and Next Steps for Overall Implementation in NM

# The Goal of the Health Insurance Exchange is to shift the marketplace

- Passage of the Patient Protection and Affordable Care Act mandates establishment of the exchange
- Market Reform Policy—shift the market from competition based on avoiding risk into competition based on price and quality
- Screens health care purchasers to help them determine the best insurance products available for them

Currently only Massachusetts and Utah have state-based insurance exchanges

# Key functions of the Exchange

- Maintain an on-line portal where consumers can obtain standardized information on insurance products
- Make comparison shopping for insurance easy (like Orbitz or Insurance.com)
- Centralize enrollment and screen individuals for Medicaid and link to Medicaid system for enrollment
- Provide customer service and call center
- Transition between commercial and government programs
- Determine eligibility for and administer subsidies
- Provide electronic calculator to determine the cost of coverage after tax and cost sharing
- Enroll individuals and businesses into plans through standardized electronic forms
- Maintain customer confidentiality
- Enforce consumer protections
- Promotes competition

# Enrollment and eligibility issues in the Exchange

## Enrollment Functions

- New Mexico already conducts some functions of an Exchange within the
  - Human Services Department's *Insure NM!* Call Center
  - New Mexico Health Insurance Alliance
  - Public Regulation Commission's Division of Insurance
  - New Mexico Medical Insurance Pool (NMMIP)

## Integrated Eligibility

- Single application form for Medicaid/SCHIP and Exchange subsidies
- Available online, in person, by phone, on paper

Sort plans by Benefits Package

**You've Selected:**

Benefits Package
- [x] YAP
- [x] Bronze
- [x] Silver
- [x] Gold

**Narrow Your Plans by:**

**Monthly Cost**
- Less than $300 (40)
- $301 - $400 (19)
- $401 - $500 (2)
- Greater than $500 (1)

**Annual Deductible**
- None (12)
- $250 - $500 (16)
- $500 - $1,000 (6)
- $1,000 - $2,000 (6)
- $2,000 - $4,000 (22)

**Insurance Carrier**
- Carrier A (11 Plans)
- Carrier B (7 Plans)
- Carrier C (11 Plans)
- Carrier D (11 Plans)
- Carrier E (11 Plans)

Show Plans. Then choose up to 3 to compare. Click **Continue** at bottom.

| | $ Monthly Cost | Annual Deductible | Annual Out of Pocket Max. | Doctor Visit | Generic Rx | Emergency Room | Hospital Stay |
|---|---|---|---|---|---|---|---|
| **YAP Low no Rx** Benefits Package<br>5 plans available<br>Show Plans \| About YAP Low no Rx | as low as **$136** | STANDARD BENEFITS FOR ALL YAP LOW WITHOUT Rx PLANS | | | | | |
| | | $2,000 | $5,000 | $25 copay | Not applicable | $250 copay | annual deductible, then 20% co-insurance |
| **YAP Low with Rx** Benefits Package<br>5 plans available<br>Show Plans \| About YAP Low with Rx | as low as **$163** | STANDARD BENEFITS FOR ALL YAP LOW WITH Rx PLANS | | | | | |
| | | $2,000 | $5,000 | $25 copay | $15 copay | $250 copay | annual deductible, then 20% co-insurance |
| **YAP High no Rx** Benefits Package<br>5 plans available<br>Show Plans \| About YAP High no Rx | as low as **$168** | STANDARD BENEFITS FOR ALL YAP HIGH WITHOUT Rx PLANS | | | | | |
| | | $250 | $5,000 | $25 copay | Not applicable | $250 copay | annual deductible, then 30% co-insurance |
| **YAP High with Rx** Benefits Package<br>5 plans available<br>Show Plans \| About YAP High with Rx | as low as **$191** | STANDARD BENEFITS FOR ALL YAP HIGH WITH Rx PLANS | | | | | |
| | | $250 | $5,000 | $25 copay | $15 copay | $250 copay | annual deductible, then 30% co-insurance |
| **Bronze Low** Benefits Package<br>6 plans available<br>Show Plans \| About Bronze Low | as low as **$219** | STANDARD BENEFITS FOR ALL BRONZE LOW PLANS | | | | | |
| | | $2,000 (ind.) $4,000 (fam.) | $5,000 (ind.) $10,000 (fam.) | annual deductible, then $25 copay | annual deductible, then $15 copay | annual deductible, then $100 copay | annual deductible, then 20% co-insurance |
| **Bronze Medium** Benefits Package<br>6 plans available<br>Show Plans \| About Bronze Medium | as low as **$224** | STANDARD BENEFITS FOR ALL BRONZE MEDIUM PLANS | | | | | |
| | | $2,000 (ind.) $4,000 (fam.) | $5,000 (ind.) $10,000 (fam.) | $30 copay | $10 copay | annual deductible, then $150 copay | annual deductible, then $500 copay |
| **Bronze High** Benefits Package<br>6 plans available<br>Show Plans \| About Bronze High | as low as **$229** | STANDARD BENEFITS FOR ALL BRONZE HIGH PLANS | | | | | |
| | | $250 (ind.) $500 (fam.) | $5,000 (ind.) $10,000 (fam.) | $25 copay | $15 copay | $150 copay | annual deductible, then 35% co-insurance |
| **Silver Low** Benefits Package<br>6 plans available<br>Show Plans \| About Silver Low | as low as **$272** | STANDARD BENEFITS FOR ALL SILVER LOW PLANS | | | | | |
| | | $1,000 (ind.) $2,000 (fam.) | $2,000 (ind.) $4,000 (fam.) | $20 copay | $15 copay | annual deductible, then $100 copay | annual deductible, then no copay |
| **Silver Medium** Benefits Package<br>6 plans available<br>Show Plans \| About Silver Medium | as low as **$288** | STANDARD BENEFITS FOR ALL SILVER MEDIUM PLANS | | | | | |
| | | $500 (ind.) $1,000 (fam.) | $2,000 (ind.) $4,000 (fam.) | $20 copay | $15 copay | $100 copay | annual deductible, then no copay |
| **Silver High** Benefits Package<br>6 plans available<br>Show Plans \| About Silver High | as low as **$311** | STANDARD BENEFITS FOR ALL SILVER HIGH PLANS | | | | | |
| | | None | $2,000 (ind.) $4,000 (fam.) | $25 copay | $15 copay | $100 copay | $500 copay |
| **Gold** Benefits Package<br>6 plans available<br>Show Plans \| About Gold | as low as **$380** | STANDARD BENEFITS FOR ALL GOLD PLANS | | | | | |
| | | None | None | $20 copay | $15 copay | $75 copay | $150 copay |

# Federal statutory requirements for the Exchange

- States must establish a Health Insurance Exchange by 2014 or allow the federal government to establish one for the state
  - State must be ready to stand-up an exchange by January, 2013
- There will be 2 types of Exchanges
  - American Health Benefit Exchange, or Health Exchange
  - Small Business Health Options Program, or SHOP Exchange
  - States can choose to establish a single Exchange serving both individuals and small businesses, or offer options through separate entities
- States can operate the Exchange directly, contract with a nonprofit entity, enter into agreements with other states to jointly provide an exchange, or allow the federal government to run the Exchange for the state
- States may form regional Exchanges or allow more than one Exchange to operate in a state as long as each Exchange serves a distinct geographic area
- Plans must meet certain qualifications to be sold on the exchange
  - Those plans can sell policies at the same price outside of the Exchange

# Exchange - Role in tracking compliance and penalties

- Individuals must acquire health care coverage or pay a tax penalty
- Some people are exempt from the individual mandate including:
  - Tribal members
  - Individuals with low incomes who are not required to file taxes
  - Members of certain religions that are exempted for religious reasons
  - Incarcerated individuals
  - Undocumented immigrants
  - Those without coverage for less than three months
  - People who do not have an affordable offer of coverage, either through the Exchange or through their employer

# There will be IT challenges to a successful Exchange

- To be successful the exchange must be able to screen, link and enroll people into products including public assistance and subsidies
- IT Solutions:

  Health Benefit Exchange applications will require:

  - Pricing Engines to quickly allow construction of coverage/premium options for target populations
  - Comparison Engines to enable consumers to compare plan options, premiums, deductibles and copayments and make informed decisions
  - Links between the public and private entities
- It must be easy to use and customer friendly
- States must decide which model to implement quickly due to tight timelines

# HCR IT implications for HSD

- Medicaid Interface with the Exchange
  - People will move between programs; eligibility must be integrated
  - The Health Insurance Exchange and the Medicaid eligibility system must be able to interface with each other. States will be required to:
    - Create a single, streamlined application for persons applying (Medicaid, SCHIP, subsidies, commercial)
    - Enable individuals to apply or renew Medicaid coverage through a web site with electronic signature; and
    - Apply for Medicaid, SCHIP, or the Exchange through a state-run web site by Jan. 1, 2014
      - States must be able to stand up an exchange by January, 2013
- Individuals will be screened for Medicaid before purchasing insurance through the Exchange
- HSD Technology Issues

- ISD2 Replacement
- HIPAA 5010
- ICD10
- AVS

# Current State of Eligibility for Medical Assistance Programs

- Medicaid - 541,000 enrolled and growing
  - Medical Assistance for Women, Children, and Families
  - Foster Care/Adoption
  - SSI/Institutional/Waiver/WDI/BCC
  - Emergency Medical Services for Aliens
  - Medicare Savings Program
  - SCHIP
  - Insure New Mexico
    - State Coverage Insurance (SCI)
    - Premium Assistance for Kids (PAK)
    - Premium Assistance for Maternity (PAM)
- Uninsured = 450,000 (361,000 Adults; 89,000 Children)

*According to the U.S. House Committee on Commerce and Energy, in New Mexico, the health care reform bill will extend coverage to 273,000 New Mexicans*

# Health reform standardizes most Medicaid eligibility

- Establish minimum eligibility threshold: 133% FPL
  - Apply a standard 5% income disregard (effective income threshold of 138% FPL)
- Adopt Modified Adjusted Gross Income (MAGI) as basis for:
  - Determining income for non-exempt groups
  - Any other purpose for which income determination is required (e.g. premiums and cost-sharing)
  - Eliminate all asset tests and income disregards for eligibility determinations using MAGI
- Threshold income using MAGI cannot be less than effective level that applied on date of enactment

# Medicaid: State eligibility responsibilities

- Assure coverage during transition to MAGI by establishing an equivalent income test
  - Secretary may waive PPACA requirements to protect beneficiaries
- Be able to determine and track "newly eligible" individuals and those who are eligible under criteria in effect at passage for purposes of:
  - Applying differential FMAP
  - New annual reporting requirements on Medicaid enrollment, disaggregated by multiple population groups

# Exemptions from use of MAGI

- Eligible w/o income determination (e.g. foster care, SSI)
- 65 and older
- Blind or disabled
- Medically needy
- Qualified Medicare Beneficiaries
- Eligible for Part D subsidies
- Eligible for LTC services
- Eligible through an Express Lane option
- Enrollees who would lose coverage solely on the basis of applying MAGI
  - Grandfathered coverage until the later of 3/31/14 or next eligibility redetermination date

# Basic Health Program may be an option for New Mexico

- States may create "Basic Health Program" for uninsured with income from 133-200% FPL
  - Option in lieu of individuals receiving premium subsidies for coverage in the Exchange
  - Individuals with incomes between 133-200% FPL in states creating Basic Health Plans will not be eligible for subsidies in the Exchange

- To establish the Plan, State receives 95% of federal premium and cost-sharing subsidy funds that would have been paid through Exchange

SCI is the foundation for the Basic Health Option

# Basic Health Program State Option

- States using option must
  - Have competitive process to enter into contracts with one or more standard plans
  - Provide at least federally-determined "essential health benefits"
  - Ensure eligible individuals do not pay more than they would have paid in the Exchange
- Preference given to plans that manage care, use performance measures, and demonstrate innovation (e.g. prevention incentives, disease management)

These requirements can be met with the SCI program

# Questions for the Exchange need to be addressed

## Exchange

1. Does NM Want One or Two Exchanges?
2. Which Model below should we choose?

| Exchange Operated by the Feds | Exchange operated by a non-profit agency | Exchange operated within a state agency | Join in a Regional Exchange with other States | Create regional exchanges within NM |
|---|---|---|---|---|

3. What legislation is needed to create the Exchange?
4. Determine functions within the Exchange and relationship to Medicaid

Medicaid ⟷ Exchange

5. How will Medicaid eligibility be determined?
6. Who will determine eligibility for the tax subsidies?
7. How will consumer education and protection be coordinated?
8. How will individuals move between the Exchange and Medicaid without loss of health care coverage?
9. How will individuals maintain some consistency in health care benefits when they move back and forth from the Exchange to Medicaid?

# PPACA and next steps—Overall implementation in New Mexico

- See Health Care Reform Leadership Team's Strategic Plan, ***Implementing Federal Health Care Reform—A Roadmap for New Mexico***, at

http://www.hsd.state.nm.us/pdf/hcr/NM%20Federal%20Health%20Care%20Reform%20Strategic%20Plan%207-12-10%20FINAL.pdf

- Further Information Available at

http://www.hsd.state.nm.us/includes/nhcrlao.htm

- Or Contact

RubyAnn.Esquibel@state.nm.us