



ALASKA'S HEALTH BENEFITS EXCHANGE

Enrollment Projections, Federal Subsidies, Economic Implications and Design Questions

EXECUTIVE SUMMARY, MAY 2011

OVERVIEW

Federal health reform is designed to increase health insurance coverage for Americans through expanded eligibility for Medicaid, new regulated marketplaces for purchasing insurance and a requirement for individuals to have insurance coverage. Federal subsidies will offset costs for households with incomes up to 400 percent of Federal Poverty Level (FPL), which this year is \$111,760 for a family of four in Alaska. This executive summary and its accompanying white paper reviews the exchange provisions in the Affordable Care Act (ACA), estimates exchange enrollment and the value of federal subsidies in Alaska, provides a preliminary estimate of the economic impacts and asks key questions about the design of the exchange. The forthcoming white paper also will review progress and decision-making on health exchanges in selected states.

WHAT IS A HEALTH BENEFITS EXCHANGE?

Under the ACA, each state must open a health benefits marketplace no later than Jan. 1, 2014. States may establish a separate exchange for small business customers or incorporate them into the main exchange. If states cannot show they are on track by 2013, then the federal government will take over planning and operation. The U.S. Department of Health and Human Services (HHS) defines a health exchange: ¹ "An exchange is a mechanism for organizing the health insurance marketplace to help consumers and small businesses shop for coverage in a way that permits easy comparison of available plan options based on price, benefits and services, and quality. By pooling people together, reducing transaction costs, and increasing transparency, exchanges create more efficient and competitive markets ... Exchanges will assist eligible individuals to receive premium tax credits or coverage through other federal or state health care programs. By providing one-stop shopping, exchanges will make purchasing health insurance easier and more understandable."

HOW MANY ALASKANS ARE EXPECTED TO ENROLL IN THE EXCHANGE?

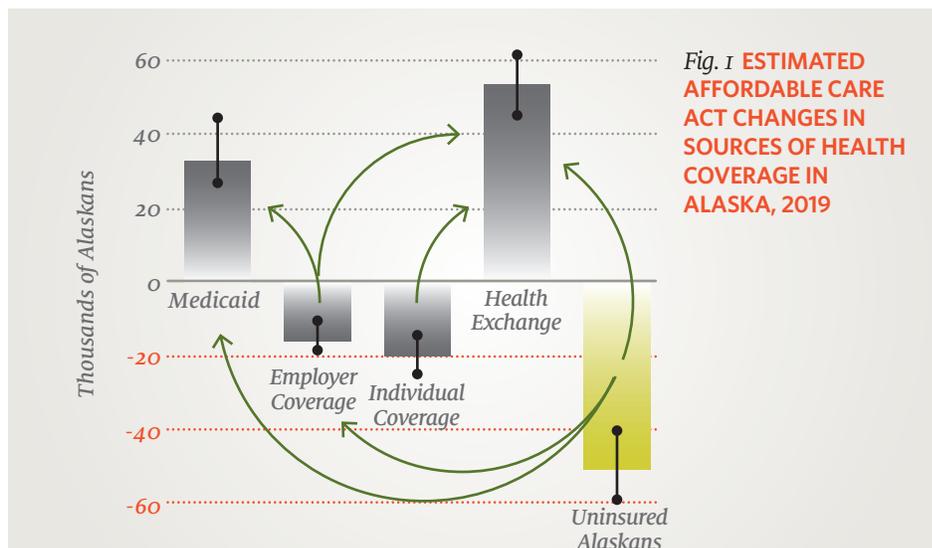
Estimates range from 40,000 to 120,000 enrollees by 2019, depending on which analysis is used to make our projections.² Factoring in many variables, a reasonable mid-range estimate for the number of enrollees in the new health insurance exchange is 40,000 to 60,000 Alaskans. (Figure 1).

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*If a state cannot show it is
developing a viable exchange
by 2013, then the **FEDERAL
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OPERATIONS.***
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PARTNERS: Alaska State Hospital and Nursing Home Association, Denali Commission, Alaska Mental Health Trust Authority, Mat-Su Health Foundation, Rasmuson Foundation, Alaska Primary Care Association, AARP Alaska, Alaska Behavioral Health Association

WRITTEN BY: Bruce Scandling, Health Reform Program Officer for the Alaska State Hospital and Nursing Home Association.
Data and analysis provided by Mark A. Foster & Associates (MAFA).

Most uninsured Alaskans who gain coverage under ACA will DO SO IN THE EXCHANGE OR THROUGH EXPANDED MEDICAID.



WHAT ARE THE FEDERAL PREMIUM SUBSIDIES AND COST-SHARING PROVISIONS?

To make health insurance more affordable, the ACA offers sliding-scale premium subsidies and other federal cost support to families and individuals. This support is based on household income and the cost of the plan purchased in the health exchange. *(It is important to note that, under ACA, federal premium subsidies and cost support are available only for health insurance plans purchased in the exchange.)* Four basic levels of “metallic” insurance plans must be offered in the exchange – Bronze, Silver, Gold and Platinum. Each has a different actuarial value – the percentage of medical expenses paid by the insurance policy vs. how much the policyholder pays. The least expensive Bronze level has an actuarial value of 60 percent, while the Platinum plan’s actuarial value is 90 percent and would be the most expensive to purchase. The Silver level, with an actuarial value of 70 percent, often is considered as the median coverage available in the exchange.

A mid-range estimate of enrollees in the new health insurance exchange is 40,000 TO 60,000 ALASKANS.

HOW MUCH WILL THIS FEDERAL SUPPORT PAY TOWARDS THE COST OF HEALTH INSURANCE SOLD IN THE EXCHANGE?

Under these mechanisms, we expect federal premium support and cost-sharing to pay 80 percent of the cost of an average health insurance policy for an Alaska family of four with household income between 138 and 150 percent of poverty (\$38,560 to \$41,910 in today’s dollars). For a family of four with income at 350 to 400 percent of poverty (*this year, \$97,790 to \$111,760*), federal premium and cost support will cover about 40 percent of the cost of an average policy (*Figure 2*). For single coverage in Alaska, the percentages are roughly comparable. Averages for family plan: We estimate the average federal support of those who are eligible and enroll for family coverage in the exchange to be roughly \$22,500 on a total cost of health insurance coverage of \$30,900 per year for a Silver plan. Averages for single plan: Average federal support of those who are eligible and enroll for single coverage in a Silver plan is estimated at roughly \$8,600 on a total cost of health insurance coverage of \$12,200 per year.

Federal subsidies will help offset costs for households with incomes up to

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 - THIS YEAR \$111,760 FOR AN ALASKA FAMILY OF FOUR.

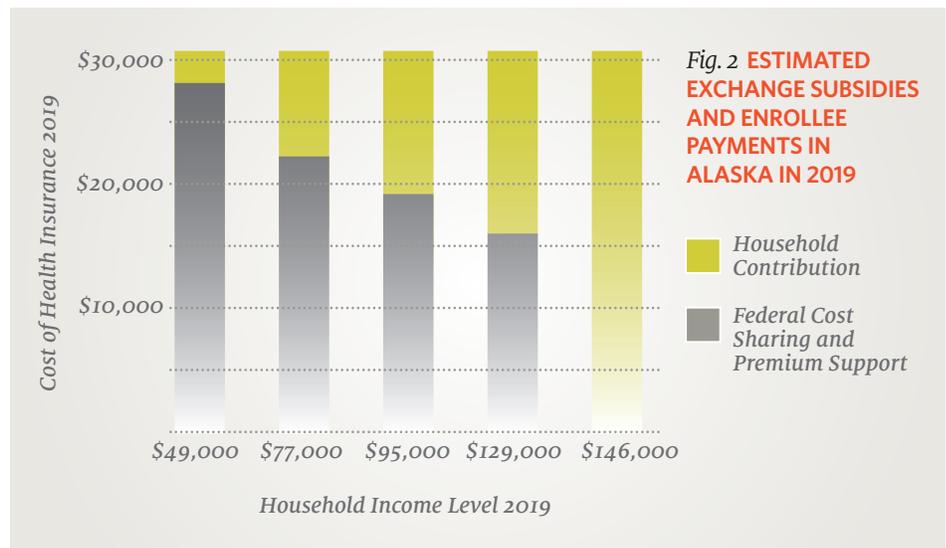


Fig. 2 ESTIMATED EXCHANGE SUBSIDIES AND ENROLLEE PAYMENTS IN ALASKA IN 2019

WHAT ARE THE ECONOMIC IMPLICATIONS OF FEDERAL SUPPORT FOR INSURANCE PURCHASED IN THE EXCHANGE?

Our analysis suggests the combination of higher federal subsidies and cost support for Alaska (*federal poverty guidelines are 25 percent higher in Alaska*) and the high cost of health insurance and health care here may result in about 80 percent of enrollees in the health exchange being eligible for and participating in federal support. The new insurance exchange may generate \$240 million to \$360 million in federal support for health insurance in the Alaska economy in 2019.

WHAT ARE THE BASIC RESPONSIBILITIES OF THE HEALTH EXCHANGE?

The exchange has the critical responsibility to certify or decertify “qualified health plans” – basically, to decide which plans can be offered. To be certified plans must meet certain minimum requirements and include strategies to lower costs and improve health outcomes. Among its many other required responsibilities, the exchange must:

- Assign a price and a quality rating to each health insurance plan;
- Maintain a website offering information to current and prospective enrollees;
- Determine for applicants whether they are eligible for Medicaid or the Children’s Health Insurance Program and direct them to enrollment information;
- Provide an electronic calculator for Alaskans to determine the actual cost of coverage under each health plan, defining and taking into account their eligibility for premium tax credits and cost-sharing reductions;
- Certify those individuals who are exempt from the individual responsibility mandate to obtain health insurance (*the most notable exemptions are for religious beliefs or if an applicant cannot find a qualified health plan costing less than 8 percent of his or her income*);
- Require health plans to describe their costs and benefits in a brief, simple standardized format;

For a low-income Alaska family, federal subsidies will

pay about **80 PERCENT OF THE COST OF AN AVERAGE HEALTH INSURANCE**

POLICY. For a higher-earning family, **SUBSIDIES WILL**

COVER ABOUT 40 PERCENT.

THE EXCHANGE MAY
GENERATE \$240 MILLION
TO \$360 MILLION in the
Alaska economy through
federal support for health
insurance.

- Establish a navigator program that provides grants to entities assisting consumers with education and enrollment (*there is ongoing debate about whether insurance agents and brokers can be navigators, but it is clear other entities can be – such as fishing organizations, chambers of commerce, unions and non-profit consumer advocacy groups*);
- Create open enrollment periods to purchase health insurance in the exchange;
- Consult with stakeholders, including tribes, about the functions of the exchange; (*While the ACA specifically mentions consumers, enrollment experts, small businesses, the state Medicaid agency and advocates for hard-to-reach populations, other stakeholders such as health care providers need to be at the planning table*)
- Consider past premium increases and review justifications for new premium increases requested by health insurers; and
- Publicly disclose health plan data, including claims handling policies, financial disclosures, enrollment and disenrollment data, claims denials, rating practices, cost sharing and other information.

IS STATE LEGISLATION REQUIRED TO FORM AN ALASKA EXCHANGE, OR CAN IT BE DONE THROUGH REGULATION?

The answer in part depends on whether sufficient oversight of the insurance market is already allowed by Alaska law; that may best be determined by a legal analysis from the state Department of Law or the Legislature. Guidance from federal HHS includes this broad language (*emphasis added*): “In defining the authority and duties of an exchange, states in authorizing legislation or *other governing documents* should incorporate, by reference or explicit provisions, the federally-required exchange functions and oversight responsibilities.” Alaska has only had statutory authority to review proposed rates for “Hospital or Medical Service Corporations” – the only qualifier under that definition is Premera Blue Cross Blue Shield. According to a recent analysis by the Kaiser Family Foundation³ Alaska law has not given express “prior approval” authority to the state Division of Insurance, but as a practical matter the insurer has not implemented a new rate until it has been reviewed and approved. All other insurance carriers have not been required by Alaska law to file their rates, but that will change with recent legislation. As of May 2011, House Bill 164 had passed the Legislature and was awaiting transmittal to the Governor for signature. Still, it remains to be seen whether this change and other existing statutory authority is sufficient to create an Alaska Health Benefits Exchange that meets the basic requirements of the ACA – or if further state legislation is necessary.

SHOULD THE EXCHANGE BE A NEGOTIATOR OR SIMPLE CLEARINGHOUSE?

States must decide whether their exchanges will operate much like large employers in an “active purchaser” role to use market leverage and competition to negotiate with insurers, or as a simple clearinghouse open to all qualified insurance plans. As described by the Robert Wood Johnson Foundation State

The exchange has the critical
RESPONSIBILITY TO CERTIFY
OR DECERTIFY “QUALIFIED
HEALTH PLANS” OFFERED
in the new marketplace.

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The ACA requires each exchange to offer two national health plans from private insurers, but IT IS UNCERTAIN WHETHER THEY WILL OFFER ADEQUATE REIMBURSEMENT TO ALASKA HEALTH PROVIDERS.

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Health Access Data Assistance Center,⁴ the role of the exchange can have a significant impact on premium prices, consumer choice and participation by insurers: “A state can limit the exchange to the role of market organizer, serving as an impartial information source that lists and compares all qualified health plans. Alternatively, a state can make the exchange an active purchaser, by using a bidding process, by applying restrictive certification and reporting requirements, and by negotiating with plans to identify and select high performers. ... If a state serves as a market organizer, acting as a clearinghouse for qualified health plans, this would maximize plan choices for consumers. On the other hand, if a state serves as an active purchaser, determining which plans qualify for exchange status, the state might have greater potential to influence health care costs and quality. However, this could reduce consumer choice if plans choose not to participate in the exchange or if the exchange drops plans.” This decision will be especially important in Alaska, where reimbursements from private insurers to health care providers are typically above government payers such as Medicaid and Medicare. The exchange must balance a level of regulation that offers consumers competition and choice without imposing excessive regulatory overhead and increasing costs and potentially driving away major private insurers. In addition, the ACA requires each state exchange to offer two national health plans provided by private insurers. It is uncertain whether national health plans will provide adequate reimbursement to Alaska health care providers to ensure beneficiary access or whether they will be more like Medicare in Alaska – where reimbursements are below both private and public insurance providers and beneficiary access to primary care has become problematic.

WHAT ARE OTHER CONSIDERATIONS IN DEVELOPING A STATE HEALTH BENEFITS EXCHANGE?

The National Conference of State Legislatures says state planners and policymakers should consider these basic questions as they move forward in developing the exchange:

- Will it be administered by a government agency or a nonprofit organization?
- Regardless of who administers the exchange, the government will be involved with policy decisions related to the exchange. Which agencies will be involved in those policy decisions?
- Does the state have the capacity to establish, run and sustain an exchange? Does it have the needed expertise or does it need to contract out?
- Will it be statewide, regional or merged with other states? Will the state have several exchanges or just one?
- What legislation and regulations will be needed to create, implement and administer the exchange? Will legislation be required to make future changes to the exchange?
- Does the state have the data needed to complete an analysis on exchanges and to create policy? If not, the state needs to determine the data needed and the agency responsible for collecting that data.

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- How will the state make the exchange “interoperable” with the Medicaid program, as required by federal law? (*The ACA requires state exchanges to screen enrollees for eligibility in health and human services programs requiring a transfer of data for verification and screening. States will need to evaluate their existing systems to determine if an upgrade or replacement is required. Legislators must consider the cost of these system changes, not only for the purchase of new technology, but also to determine the personnel required to carry out these changes.*)

ABOUT THIS REPORT

This is one in a series of papers prepared for and funded by an ongoing project entitled, *AK Health Reform: Assessing Federal, State and Market Changes in the Next Decade*. The goal of the project is to provide factual research, data and analysis regarding the state of health care in Alaska. More information is available at: www.akhealthreform.org.

¹ Initial Guidance to States on Exchanges,” HHS.gov: http://www.hhs.gov/ociio/regulations/guidance_to_states_on_exchanges.html

² These assumptions are explained in the accompanying white paper. They are based on projections by the Congressional Budget Office, the Centers for Medicare and Medicaid Services and RAND Corp. of changes in insurance coverage market share applied to the Alaska addressable market.

³ “Rate Review: Spotlight on State Efforts to Make Health Insurance More Affordable,” Kaiser Family Foundation, December 2010: <http://www.kff.org/healthreform/upload/8122.pdf>

⁴ “Health Insurance Exchanges: Implementation and Data Considerations for States and Existing Models for Comparison,” October 2010. <http://www.rwjf.org/files/research/70588.pdf>