

ONE HUNDRED TWELFTH CONGRESS
Congress of the United States
House of Representatives
COMMITTEE ON ENERGY AND COMMERCE
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December 11, 2012

MEMORANDUM

To: Committee on Energy and Commerce Democratic Members and Staff

Fr: Committee on Energy and Commerce Democratic Staff

Re: Hearing on “State of Uncertainty: Implementation of PPACA’s Exchanges and Medicaid Expansion”

On Thursday, December 13, 2012, at 10:00 a.m. in room 2123 Rayburn House Office Building, the Subcommittee on Health will hold a hearing entitled, “State of Uncertainty: Implementation of PPACA’s Exchanges and Medicaid Expansion.”

I. WITNESS LIST

Gary Cohen, J.D.

Director

Center for Consumer Information and Insurance Oversight (CCIIO)
Centers for Medicare & Medicaid Services (CMS)
U.S. Department of Health and Human Services

Cindy Mann, J.D.

CMS Deputy Administrator/Director
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U.S. Department of Health and Human Services

Mr. Bruce D. Greenstein

Secretary

Department of Health and Hospitals
State of Louisiana

Mr. Dennis G. Smith
Secretary
Department for Health Services
State of Wisconsin

Gary D. Alexander, J.D.
Secretary
Department of Public Welfare
Commonwealth of Pennsylvania

Joshua M. Sharfstein, M.D.
Secretary
Department of Health and Mental Hygiene
State of Maryland

Andrew Allison, Ph.D.
Director
Division of Medical Services, Department of Human Services
State of Arkansas

II. HEALTH INSURANCE EXCHANGES

The Affordable Care Act (ACA)¹ establishes new insurance market consumer protections pertaining to the individual and small group health insurance markets. These provisions only allow premiums to vary based on age, tobacco use, family size, and geography. Insurance companies will no longer be allowed to raise premiums based on any other factors—including pre-existing conditions, gender, and health status. The provisions a minimum level of coverage and prohibit current insurance company abuses like rescissions of benefits when someone gets sick.²

In addition to these consumer protections, the ACA creates transparent and competitive marketplaces for quality insurance to be offered called Exchanges. 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 for individuals and small employers.

Section 1311 of ACA requires the Secretary of the Department of Health and Human Services (HHS) within one year of enactment, to award grants to states to plan and establish Exchanges. By January 1, 2014, each state must have an Exchange to facilitate access to qualified health

¹ The ACA is comprised of two public laws, P.L. 111-148 and P.L. 111-152.

² Department of Health and Human Services, *Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review*, 77 Fed. Reg. 227 (Nov. 26, 2012) (proposed rule).

plans. The grants are provided through January 1, 2015 to states making progress in establishing an Exchange, implementing ACA's private health insurance market reforms, and meeting other benchmarks. Exchanges will have to be self-sustaining starting in 2015.³

Historically, the individual and small group health insurance markets have suffered from adverse selection and high administrative costs, resulting in low value for consumers. Exchanges will allow individuals and small businesses to benefit from the pooling of risk, market leverage, and economies of scale that large businesses currently enjoy.

Beginning with an open enrollment period in 2013, Exchanges will help individuals and small employers shop for, select, and enroll in high-quality, affordable private health plans that fit their needs at competitive prices. 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.

The functions of an Exchange include determining eligibility and providing for enrollment in Qualified Health Plans (QHP), Medicaid and the Children's Health Insurance Program and premium tax credits cost sharing subsidies. It will ensure that all plans operating in the Exchange and Small Business Health Options Program (SHOP) are certified as qualified health plans, and provide financial management and consumer support.

On December 10, 2012, the Secretary announced that six states—Colorado, Connecticut, Massachusetts, Maryland, Oregon, and Washington—have made enough progress setting up their state-based Exchanges to have their plans conditionally approved. These Exchanges are on track to open October 2013.⁴ The Secretary sent a letter to the governors of these six states which can be found here: <http://cciio.cms.gov/resources/files/gov-letter-faqs-12-10-2012.pdf>. CMS also released a document answering frequently asked questions regarding Exchanges and market reforms which can be found here: <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>.

A. Models for Exchanges

A state-based Exchange is one in which the state establishes and runs the new insurance marketplace. The state can receive grants for these purposes through 2015 after which the Exchange will have to be self sufficient in operation using options such as user fees or other means of sustaining the Exchange. States are required to notify HHS by December 14, 2012 of their intent to have a state-based Exchange. A state may move to this type of Exchange in the future as well even if they do not start with one in 2014.⁵

³ Section 1311 of the ACA.

⁴ Healthcare.gov, *Progress Continues in Setting up health Insurance Marketplaces* (Dec. 10, 2012) (online at <http://www.healthcare.gov/blog/2012/12/marketplaces121012.html>).

⁵ The Henry J. Kaiser Family Foundation, *Establishing Health Insurance Exchanges: An Overview of State Efforts* (online at <http://www.kff.org/healthreform/upload/8213-2.pdf>) (Nov 2012).

A state partnership Exchange is one in which the state can select to operate certain functions of an Exchange while working with HHS to implement the remaining functions. For example, a state can handle only the management of plans or consumer outreach and assistance. A state partnership Exchange can also be an option for a state that wants to transition more slowly to a full state-based Exchange.⁶ A number of states have expressed interested in such an Exchange and they have until February 15, 2012 to express their intent to operate this type of Exchange.⁷

If a state does not elect to have a state-based or partnership Exchange beginning in 2014, HHS will operate a federally facilitated Exchange in the state to ensure consumers access to quality affordable healthcare and premium tax credits. Regardless of the type of Exchange operating in a state, states still have control over a number of decisions that effect the full insurance market such as whether they merge their individual and small group markets and what benchmark plan they choose for their marketplace.⁸

An Exchange may operate in multiple states, if each state agrees to the operation of the Exchange and if the Secretary approves. A state may have more than one Exchange ("subsidiary Exchanges") if each serves a geographically distinct area and the area served is adequately large.⁹

Small businesses with up to 100 employees will also have access to Exchanges through state-based Small Business Health Options Program (SHOP) Exchanges. SHOP will provide small business employers the opportunity to offer their employees a variety of affordable Qualified Health Plans (QHPs), each with different benefits and premiums. Eligible small businesses can use the small business tax credits to purchase this coverage in the SHOP Exchange. Starting in 2017, states can extend SHOP participation to businesses with more than 100 employees.¹⁰

B. Funding for Exchanges

In 2010, HHS awarded over \$54 million in Exchange Planning grants to 49 states and the District of Columbia along with four territories. These grants were to be used for a number of important planning activities, including research of their insurance markets, efforts to obtain the legislative authority to create Exchanges, and steps to establish the governing structures of Exchanges. In 2011, seven states received more than \$249 million in Early Innovator grants to develop model IT systems to operate the functions of the Exchange.¹¹ Thus far, 34 states and the

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ Healthcare.gov, *Affordable Insurance Exchanges: States Are Leading the Way* (online at <http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011d.html>) (accessed Dec. 5, 2012).

¹⁰ Healthcare.gov, *Affordable Insurance Exchanges: Choices, Competition and Clout for States* (online at <http://www.healthcare.gov/news/factsheets/2011/07/exchanges07112011a.html>) (accessed Dec. 6, 2012).

¹¹ Healthcare.gov, *Creating a New Competitive Marketplace: Affordable Insurance Exchanges* (online at

District of Columbia have received more than \$856 million in Establishment grants based on each state's needs and planned expenditures.¹²

C. Final Exchange Rules

On March 12, 2012, HHS published a final rule on Exchanges, which is the product of two years of collaboration with states, small businesses, consumers, and insurers. HHS released two Notices of Proposed Rulemaking (NPRMs) on July 15, 2011, and August 17, 2011, and the final rule combines the policies from both. The final rule offers a framework for establishment and operation of Exchanges; certification and standards of qualified health plans; determination of eligibility and enrollment; coordination with Medicaid, CHIP, and the Basic Health Program (BHP); and SHOP. A fact sheet on the Exchange final rule can be found here: <http://www.healthcare.gov/news/factsheets/2011/07/Exchanges07112011a.html>, and the final rule can be found here: <http://www.healthcare.gov/news/factsheets/2011/07/Exchanges07112011a.html>.

III. PROPOSED AND FINAL RULES FOR ACA PROVISIONS

A. Essential Health Benefits/Actuarial Value Proposed Rule

On November 20, 2012, HHS published a proposed rule provides a framework for standards related to “essential health benefits” (EHB) and the determination of actuarial value (AV) for plans in the individual and small group market, both inside and outside of Exchanges. These regulations build on guidance that was released December of 2011. In developing these guidelines, HHS worked extensively with states, small businesses, consumers, and insurance companies. As of November 20, they received over 11,000 public comments; final comments are due December 22, 2012. The rule provides states with ample flexibility to develop their definition of EHB, and recommends a timeline for how and when insurers who plan to offer health plans in a Federal or State Exchange can become accredited. A fact sheet summarizing the proposal can be found here: <http://www.healthcare.gov/news/factsheets/2012/11/ehb11202012a.html>, and the entire proposed rule can be found here: <http://www.gpo.gov/fdsys/pkg/FR-2012-11-26/pdf/2012-28362.pdf>.

D. Update on the Federally-Facilitated Exchange (FFE)

The Centers for Medicare & Medicaid Services (CMS) is working to build Exchanges in every state (including D.C.). All Exchanges will begin open enrollment in October 2013. A Federally-Facilitated Exchange (FFE) will exist in states that have opted, temporarily or permanently, not to build their own Exchange. CMS will ensure that an FFE be adaptable to meet each state's needs. Guidance on FFE was released on May 16, 2012, and can be found here:

<http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html>) (accessed Dec. 5, 2012).

¹²U.S. Department of Health and Human Services, *News Release: More states work to implement health care law* (online at <http://www.hhs.gov/news/press/2012pres/05/20120516a.html>) (May 16, 2011).

<http://cciio.cms.gov/resources/files/ffe-guidance-05-16-2012.pdf>, and more information on building and implementing an FFE can be found here:
<http://cciio.cms.gov/resources/files/Files2/FFE%20Progress%20fact%20sheet.pdf>.

E. Multi-State Plan Proposed Rule

On November 30, 2012, the U.S. Office of the Personnel and Management (OPM) released proposed standards for the Multi-State Plan Program (MSPP) pursuant to section 1334 of the ACA. The MSPP promotes competition in the marketplace, and ensures more plan options for consumers. Beginning in 2014, insurers can contract with OPM to provide at least two multi-state plans (MSPs) in each Exchange. At least one of the plans must be issued by a non-profit entity. Health insurers who want to participate in the MSPP must apply to OPM. These MSPs will compete on a level playing field with other insurers in the state and will have to meet any health benefit mandates the other plans are required to meet. A fact sheet on the MSPP proposal can be found here: <http://www.opm.gov/insure/mspp/index.asp>, and the proposed rule can be found here: http://www.ofr.gov/OFRUpload/OFRData/2012-29118_PI.pdf.

F. Insurance Market Reforms Proposed Rule

CMS recently published a proposed rule to implement several of the ACA's most important consumer protections that protect Americans from the worst insurance company practices. Provisions of the proposed rule include guaranteed availability and renewability of coverage, fair health insurance premiums, single statewide risk pool, and catastrophic plans. These rules create a fair marketplace where persons are not discriminated against for pre-existing conditions, their gender and more. A fact sheet on these provisions can be found here: <http://www.healthcare.gov/news/factsheets/2012/11/market-reforms11202012a.html>, and the proposed rule can be found here: http://www.ofr.gov/OFRUpload/OFRData/2012-28428_PI.pdf.

G. Benefit and Payment Parameters for 2014

On December 7, 2012, CMS released a proposed rule providing further detail on the implementation standards for Exchanges, states, and insurers related to several ACA policies including reinsurance, risk adjustment, risk corridors programs, advance payments of the premium tax credit, and cost-sharing reductions. The purpose of these rules is to protect consumers from the abuses of insurers, and to stabilize premiums in the individual and small insurance markets, and in the Exchange. A fact sheet on this proposal can be found here: <http://cciio.cms.gov/resources/factsheets/draft-2014-payment-notice.html>, and the proposed rule can be found here: <http://www.gpo.gov/fdsys/pkg/FR-2012-12-07/pdf/2012-29184.pdf>.

III. MEDICAID EXPANSION

The ACA contains several major provisions to improve Medicaid and the Children's Health Insurance Program (CHIP) and expand coverage to millions of low-income Americans.

A. Medicaid and CHIP Eligibility and Enrollment

Currently, low-income adults who are not offered health insurance through their job, and are not eligible for Medicaid, have very few, if any, affordable options for coverage. The ACA fills this gap in coverage by expanding access to Medicaid and CHIP. Effective January 2014, Medicaid eligibility will be streamlined to include individuals between ages 19 and 65 with income levels below 133 percent of the federal poverty level (FPL). For the first time in most states, adults who are childless and do not have disabilities will be eligible for coverage at the state's option. On March 16, 2012, CMS released its final rule on Medicaid and CHIP eligibility and enrollment to help states implement the new expansion provisions. A fact sheet on the final rule can be found here:

<http://www.medicaid.gov/AffordableCareAct/Provisions/Downloads/MedicaidCHIP-Eligibility-Final-Rule-Fact-Sheet-Final-3-16-12.pdf>, and the final rule can be found here:

<http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/FR-2012-03-23.pdf>.

The ACA creates new and improved rules and systems for Medicaid eligibility, enrollment, and renewal processes based on successful state efforts already in place. Financial eligibility will rely on a single standard called “Modified Adjusted Gross Income” (MAGI). Eligibility categories will be simplified into four main groups—adults, children, parents, pregnant women. Individuals living with disabilities or in need of long-term services and supports can enroll in an existing category. The eligibility verification procedures will be modernized to rely primarily on electronic data through a federal data services “Hub” that works with state exchanges.¹³

Medicaid and Chip eligibility and enrollment will be seamlessly coordinated with the newly created Exchanges. States will have the flexibility to use two different methods to determine Medicaid-eligibility in Exchanges: the Exchange can make the determination using the state's rules; or the Exchange can make a preliminary assessment and rely on state Medicaid and CHIP agencies to make the final decision.

B. The Supreme Court

The Supreme Court decision in *National Federation of Independent Business (NFIB) v. Sebelius* on July 16, 2012, upheld the 2014 ACA Medicaid expansion for all individuals up to 133% FPL. However, the Court concluded that federal Medicaid funds from the existing program could not be withheld if a state elects not to expand their program to childless adults to 133% FPL, effectively making the expansion voluntary.¹⁴ Thus far, 17 states including D.C. have committed to the expansion, and 9 states have said they will be opting out.¹⁵

¹³ Department of Health and Human Services, *Medicaid Program; Eligibility Changes Under the Affordable Care Act of 2010*, 77 FR 57 (final rule; interim final rule) (online at <http://www.gpo.gov/fdsys/pkg/FR-2012-03-23/pdf/FR-2012-03-23.pdf>).

¹⁴ *National Federation of Independent Businesses (NFIB) v. Sebelius*, 567 U.S. _____ (2012).

¹⁵ *Medicaid expansion scorecard: 17 states say yes, 9 say no*, Washington Post (Dec, 7, 2012).

The decision did not affect the other Medicaid provisions in the ACA. So for example, the ACA's maintenance of effort (MOE) provisions, which require states to maintain existing Medicaid coverage for adults until 2014 and for children until September 2019, is unchanged. The increase in payments for primary care services delivered in the Medicaid program up to the level of Medicare payments is unchanged.

C. Financing

Beginning in January 2014, the ACA will provide new federal matching rates—100 percent federal funding for newly eligible individuals for CY 2014-2016, and this rate will gradually be reduced to 90 percent in 2020 where it will remain. States that have already expanded to all or part of the “expansion population” will receive a higher matching rate for that population starting in 2014 that increases to 90 percent by 2020.¹⁶

D. Factors to Consider for States

The Medicaid expansion is fiscally beneficial for states, as it will have modest costs and likely small net budget gains. The federal government will fund the large majority of increased Medicaid costs to states. According to Kaiser Family Foundation (KFF), if all states were to agree to the expansion, state Medicaid spending would increase by \$76 billion over CY 2013-2022—an increase of less than 3% for states—while federal Medicaid spending would increase by \$952 billion—a 26% increase. The incremental cost to states, over CY 2013-2022, is \$8 billion, which is a 0.3% increase over what would be spent under the ACA policies without the Medicaid expansion.¹⁷

In addition, states could see a variety of other benefits. For example, they could benefit from increased economic activity, lower costs from state-based insurance programs, or lower costs for state-based mental health or substance use programs because these services will now be covered by the Medicaid program for a population that currently does not have access to Medicaid and has to rely on exclusively on state and privately funded programs. It is estimated that if all states choose to expand they will save a total of \$10 billion over CY 2013-2022, and savings are likely to be greater due to other state fiscal gains.¹⁸

If all states agreed to adopt the expansion, an additional 21.3 million individuals could gain coverage by 2022. Combined with the other ACA provisions, the expansion would reduce the number of uninsured Americans by 48%. States with higher uninsured rates would reduce the number of uninsured individuals by up to 55%. By reducing the number of uninsured people,

¹⁶ Medicaid.gov, *Financing*, (online at <http://www.medicaid.gov/AffordableCareAct/Provisions/Financing.html>) (accessed Dec. 6, 2012).

¹⁷ J. Holahan et al, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, The Henry J. Kaiser Family Foundation: Kaiser Commission on Medicaid and the Uninsured (Nov 2012).

¹⁸ *Id.*

states will save substantial amounts on uncompensated care for people who cannot afford insurance.¹⁹

States that opt out of the expansion are leaving people below 100% of the FPL with few options. Effective 2014, individuals with incomes between 100-400% FPL will be eligible for tax credits and cost sharing subsidies to help them afford coverage in the Exchanges. The ACA assumes that individuals up to 133% FPL would be eligible for Medicaid, but the Supreme Court decision changed that by making the expansion voluntary. Individuals below 100% FPL in states that chose not to initiate the expansion will not be eligible for tax subsidies and may not be eligible for Medicaid.²⁰

On December 10, 2012, CMS released a document answering frequently asked questions regarding Medicaid which can be found here: <http://cciio.cms.gov/resources/files/exchanges-faqs-12-10-2012.pdf>.

IV. PROFILES OF THE FIVE STATES TESTIFYING

- **Arkansas.** Arkansas has received three federal grants totaling \$27.2 million, and will set up a state partnership Exchange. Arkansas has committed to participate in the Medicaid Expansion.
- **Louisiana.** Louisiana received \$998, 416 in federal funds, but in March 2011 announced that it would return the money. A FFE will operate in Louisiana. Louisiana will not participate in the Medicaid expansion.
- **Maryland.** Maryland has received three federal grants totaling \$157.2 million. HHS has conditionally approved its plan to establish a state-based Exchange, indicating that it is on track to launch October 2013. Maryland has committed to participate in the Medicaid expansion.
- **Pennsylvania.** Pennsylvania has received \$34.8 million in federal grants. The type of Exchange that will operate is undecided. Pennsylvania has not decided whether it will participate in the Medicaid expansion.
- **Wisconsin.** Wisconsin received two federal grants totally \$38.7 million, but in January 2012 announced that it would return the money. A FEE will operate in Wisconsin. Wisconsin has not decided whether it will participate in the Medicaid expansion.

¹⁹ *Id.*

²⁰ Center on Budget and Policy Priorities, *Statement of Robert Greenstein, President: Court Decision Will Allow Health Reform to Bring Major Benefits to the Nation, Especially If States Do Their Job* (June 28, 2012) (online at <http://www.cbpp.org/cms/?fa=view&id=3796>).