Covered California (CC): The State's Health Insurance Market for People and Small Businesses

Annual CA IHS/Tribal Consultation Session
Pala Hotel and Casino
March 12, 2013

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Health Insurance Markets are Designed to Remedy Many Health Care Challenges

Challenges include, but are not limited to:

Unsustainable costs;

Inconsistent quality;

Lack of focus on wellness and health disparities; &

Millions without coverage.

Structure of Health Insurance Marketplaces

The marketplaces will provide a website where people & small businesses can compare health plans and enroll in a plan of their choice.

The website will let people know if they are eligible for Medicaid (Medi-Cal) and/or other government services, such as subsidies of premiums, and provide a way to enroll.

These functions also can be accessed via telephone through a call center operated by the marketplaces.

ACA Requirements for Health Insurance Marketplaces

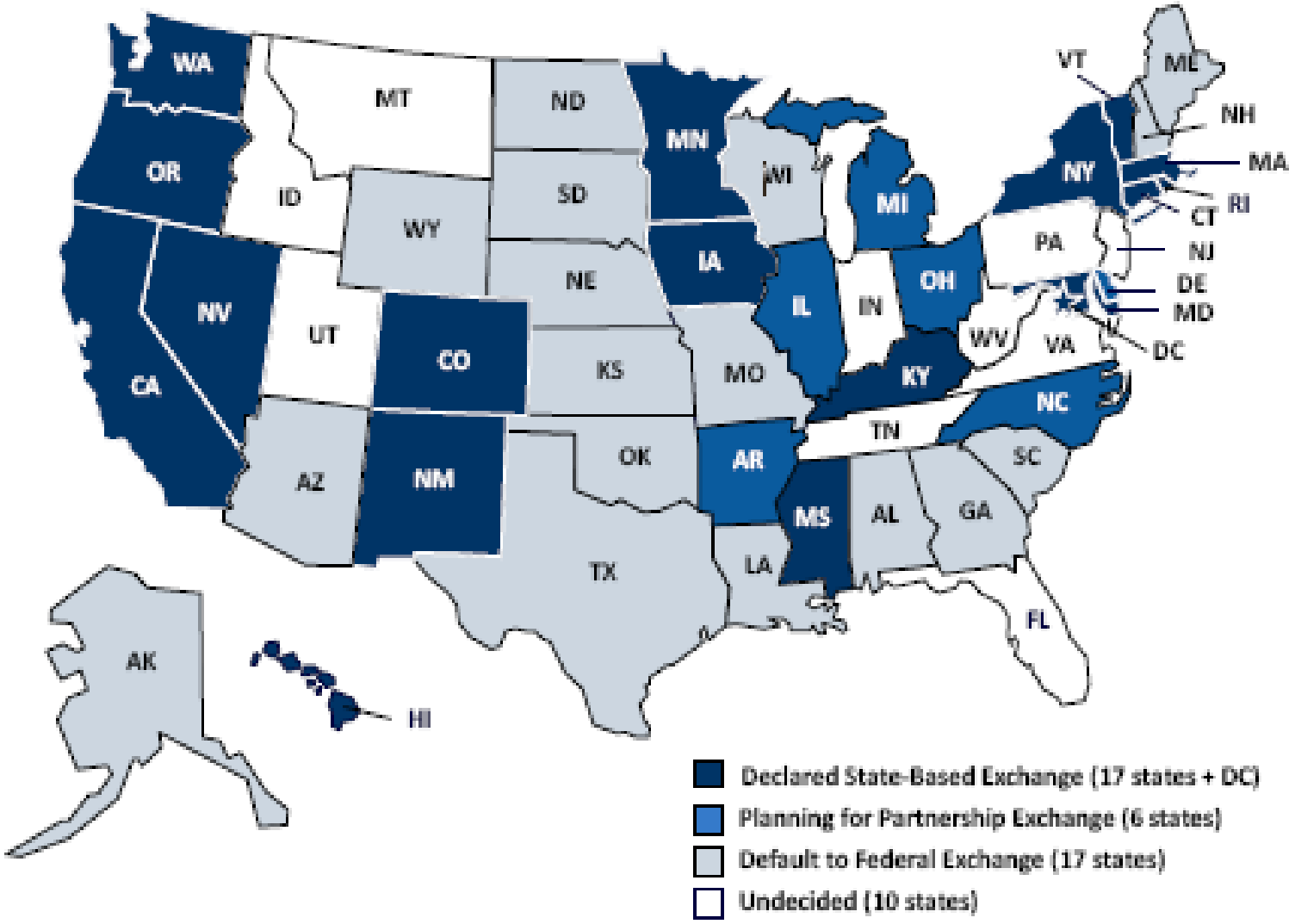
By 1/14, the ACA requires health insurance marketplaces to operate in States.

States are provided great authority and latitude in developing their marketplaces.

The federal government has provided funds for planning and until 2015 will provide funds for implementation and operating costs.

Covered California is the name of the health insurance marketplace for CA.

State Decisions For Creating Health Insurance Exchanges



As of November 29, 2012

SOURCE: Data compiled through review of state legislation and other exchange documents by the Kaiser Family Foundation

CA Legislature Established the CA Health Benefits Exchange (Covered California)

In 2010, California enacted ACA related health insurance market legislation, including:

AB 1602 (Perez) and SB 900 (Alquist/Steinberg)

CC is subject to a range of accountability processes, including reporting to the CA legislature and meeting all relevant OMB accounting requirements.

Covered California – Independent State Entity

Board Members:

Diana Dooley, Board Chair and Secretary of the California Health and Human Services Agency

Kim Belshé, Senior Policy Advisor of the Public Policy Institute of California

Paul Fearer, Senior Executive VP and Director of Human Resources of UnionBanCalCorporation

Robert Ross, M.D., President and CEO of The California Endowment

Susan Kennedy, Nationally-recognized policy consultant

Covered California Vision & Mission

The *Vision* of CC is to improve the health of all Californians by assuring their access to affordable, high quality care.

The *Mission* of CC is to increase the number of insured Californians, improve health care quality, lower costs, and reduce health disparities through an innovative, competitive marketplace that empowers consumers to choose the health plan and providers that give them the best value.

Covered California's Values

Consumer-focused: At the center of CC's efforts are the people it serves

Affordability: It will provide affordable Health insurance while assuring quality and access

Catalyst: CC will be a catalyst for change in California's health care system

Integrity: CC will earn the public's trust

Partnership: CC welcomes partnerships

Results: The impact of CC will be measured by its contributions to expanding coverage and access

The Functions of Covered California

Make coverage accessible

Simplify the process of obtaining coverage

Certify Health Plans

Maintain Consumer Access to Information

Perform Premium Reviews

Outreach and Exemption Functions

Covered California Coverage

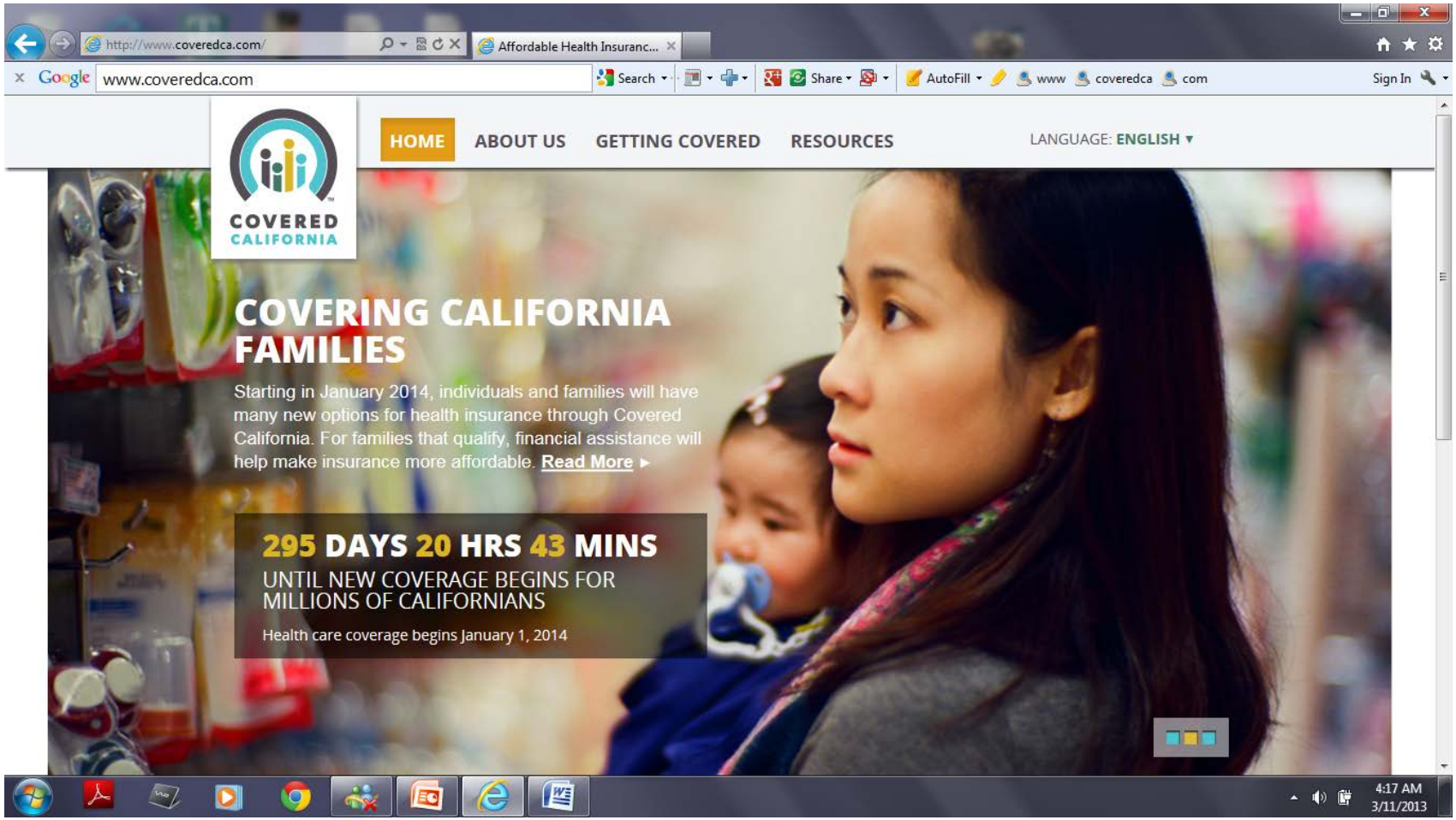
On 10/1/13, enrollment for new subsidized coverage will begin.

On 1/1/14, Californians will have access to the online CC portal to shop for health insurance coverage.

In 2019, millions of Californians will obtain health coverage.

Low-income people and families will be able to access federal subsidies to offset the cost of premiums, which will make health insurance affordable to millions for the first time.

Covered California Website: www.coveredca.com



California Plans and Benefits

The Board adopted principles to guide the selection & oversight of the plans and benefit designs.

These principles include:

- Promoting affordability
- Assuring access to quality care
- Facilitating informed choice of health plans
- Promoting wellness
- Reducing health disparities
- Working to reform the health care delivery system
- Operating with speed

Essential Health Benefits

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

CC Offers Coverage in Uniform Categories

Metal Tiers By Share of Cost

	SHARE OF COST PAID BY PLAN	SHARE OF COST PAID BY INDIVIDUAL/CONSUMER
BRONZE	60%	40%
SILVER	70%	30%
GOLD	80%	20%
PLATINUM	90%	10%

Insurance Market Reforms Under the ACA

Effective Sept. 23, 2010:

- Insurers can't set lifetime dollar limits on essential health benefits
- Insurers are not allowed to re-examine a customers' initial application to cancel
- Dependent children up to age 26 must be offered coverage under a parent's insurance plan.
- Insurers can't exclude children under the age of 19 from coverage due to a pre- existing medical condition.

Effective Jan. 1, 2011:

- Insurance companies must spend a specific % of premium dollars on medical care and quality improvement activities

Insurance Market Reforms Under the ACA (continued)

Effective Jan. 1, 2014:

- Low-income people will receive federal subsidies to help them buy insurance and cover their out-of-pocket costs.

- Insurance companies must offer the same premium to all applicants of the same age and geographical location.

- Insurance issuers must offer a comprehensive set of health benefits.

- Insurance issuers will no longer be allowed to select enrollees based on risk.

Insurance Market Reforms Under the ACA (continued)

- Large employers who do not provide affordable coverage will pay a fee if their employees receive premium tax credits to buy their own insurance in CC.

- Small businesses will be eligible for tax credits to offset the cost of credits up to 50 % of the cost of insurance if they meet 3 criteria.

- The ACA requires nearly all individuals to be enrolled in a health insurance plan.

A 29-year-old with asthma who earns $20K a year as a self-employed painter (179% of the federal poverty level)

Before the ACA

- unable to buy health insurance due to his medical condition
- asthma treated irregularly and ineffectively
- makes regular high-cost trips to the emergency room
- loses wages due to his intermittent inability to work

After the ACA

- buys health insurance for the first time
- obtains regular care from a physician for his asthma
- pays $89/month in premiums because the $280 monthly premium for insurance is offset by a federal subsidy of $191
- pays a maximum of $2,017/year in co-pays or deductibles due to provisions of the ACA that cap on out-of-pocket costs for individuals at his income level
- works without interruption and enjoys a better quality of life because his asthma is under control

CALIFORNIA RURAL INDIAN HEALTH BOARD, INC. SINCE 1969

A family of 4 with parents age 33 & 35, 1 of whom earns $35K a year as a window washer (152% of FPL)

Before the ACA

- attempted to buy coverage and found the monthly premium of $760 unaffordable
- learned that many of the policies offered did not include benefits they needed
- one family member continued to gain 20 pounds/year, leading to adult-onset diabetes
- began seeking acute care in the emergency room, with costs shifted to the government and others who have insurance

After the ACA

- bought coverage for the family for the 1st time
- pays a monthly premium of $119 due to a $640 subsidy offsetting the $760 monthly premium
- paid a maximum of $4,033 in copays and deductibles due to ACA provisions that cap out-of-pocket costs for families at their income level
- began getting regular medical care, learning of the dangers of diabetes and undertaking lifestyle changes to prevent the disease
- began weight loss program to improve health with support from Drs. and insurers
- improved overall health and avoided trips to the emergency room, reducing costs to the health care system

Tribal Consultation under the ACA

Section 1311(d)(6) of the ACA requires state health insurance marketplaces/exchanges to consult with stakeholders in the planning, establishment, and ongoing operation of exchanges.

The U.S. DHHS requires that each State that has 1 or more federally-recognized Tribes, located within the Exchange's region, engage in regular and meaningful consultation with Tribes on Exchange policies that have Tribal implications.

CC Consultation Policy Statement

California is committed to strengthening and sustaining effective government-to-government relationships between the State and the Tribes by identifying areas of mutual concern and working to develop partnerships and consensus.

CC recognizes and reaffirms this commitment and the inherent right of these Tribes to exercise sovereign authority over their members and territory.

CC Consultation Policy Statement (continued)

To establish and maintain a positive relationship, communication and consultation must occur on an ongoing basis so that Tribes have an opportunity to provide timely input on issues that may have a substantial direct effect on Tribes and Indian health organizations. A clear Tribal Consultation Policy will establish the foundation of the relationship between the CC and California's Indian Tribes, and ensure Tribes have access to CC leadership.

ACA – Health Insurance Marketplace/Exchange Indian Provisions

Cost-Sharing Exemption –AI/AN persons with incomes up to 300% of FPL ($33,510 for a single person and $69,150 for a family of four) exempted from marketplace cost-sharing.

Tribal Program Cost-Sharing Provisions –QHP cannot reduce payments to tribal programs or any other provider for AI/AN cost-sharing exemption.

Insurance Exemption –AI/AN people are exempt from health insurance penalties.

QHP Enrollment –AI/AN people can enroll monthly and change plans at least once a month.

Payer of Last Resort –Tribal and urban Indian health programs are payer of last resort for services to AI/AN people.

Other Provisions Impacting AI/AN Enrollment

Consultation –HBE on-going consultation with specific entities, including federally recognized tribes in their geographic area.

Premium Payments –Federal rules allow HBE to adopt provisions to allow Tribes and urban Indian health programs to pay premiums for AI/AN people.

Navigator Program –HBE required to pay grants to entities to serve as "Navigators, including Tribes, tribal programs and urban Indian health programs.

Essential Community Providers –QHPs required to contract with essential community providers, includes " …. *facility operated by a tribe or tribal organization under the ISDA or by an urban Indian organization receiving funds under title V of the IHCIA for the provision of primary health services*."

Essential Community Provider Contract Requirements –QHPs must include, ". . .*within the provider network. . . have a sufficient number of essential community providers. . .that serve predominately low-income, medically underserved individuals*." Definition of sufficient number left to the States to determine.

Indian Health Care Improvement Act Reauthorization

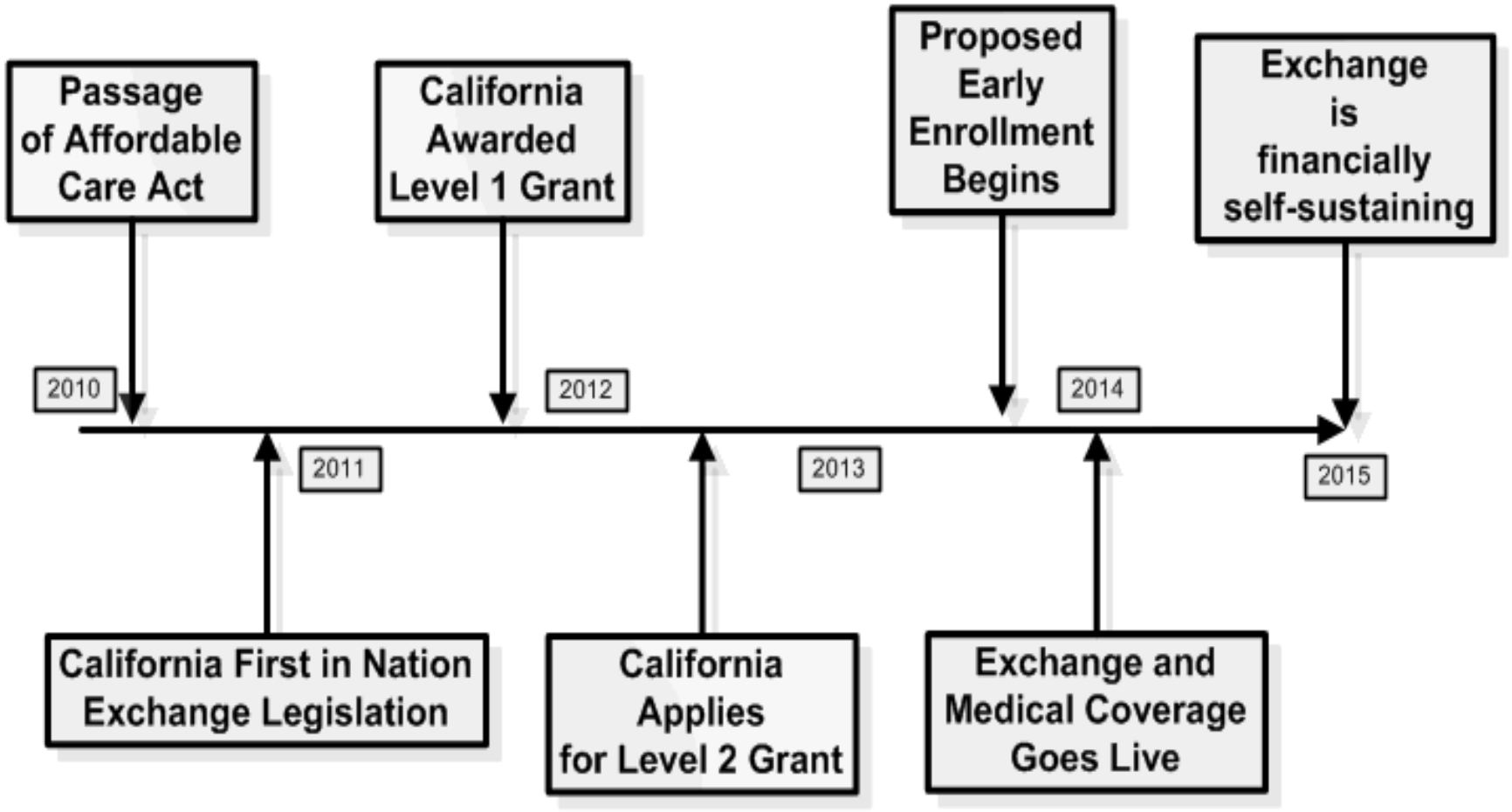
ACA further prompts goal of improving health care for the AI/AN population by permanently re-authorizing IHCIA. Includes set of provisions to assist tribal programs participating in federal programs, including the ACA HBE, intended to support tribal capacity to serve AI/AN people

Tribal and Urban Indian Program Licensing Requirements –Tribal programs must meet federal/state requirements, but do not need to be licensed.

Tribal Provider Licensing Requirements –Tribal program's professional staff can be licensed in another state.

Tribal Program Payments –Indian health providers have the right to recover from third party payers, including insurance companies up to the reasonable charges billed for providing health services or, if higher, the highest amount the insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries.

Timeline for Covered California



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