

HEALTH REFORM BRIEF

A Health Insurance Exchange in Kansas? Decisions and Deadlines Ahead for State Leaders



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While legal challenges to the Affordable Care Act make the law's prospects uncertain, the Legislature will decide whether to build a state-based exchange where many Kansans could purchase insurance starting in 2014.

Online readers can select the words underlined in blue to get more in-depth information.

INTRODUCTION

Health insurance exchanges — state-based organized marketplaces where people and small businesses can compare and buy health insurance — are a centerpiece of the federal health reform law known as the [Affordable Care Act](#) (ACA). While aspects of the ACA face political opposition and legal challenges, including a lawsuit filed by Kansas and 25 other states, planning for the state's exchange continues.

In August, Governor Sam Brownback returned a \$31.5 million federal grant intended to help launch the Kansas health insurance exchange, citing concerns about the federal budget situation and strings attached to the early innovator grant. Despite that decision, work groups that had been planning for the exchange continue to meet and explore options to set up a state-based exchange. If Kansas fails to create an exchange and the ACA withstands the legal challenges, the federal government will establish one in the state.

A Kansas exchange will affect how many of the state's 2.85 million residents obtain health insurance, particularly people who do not have insurance through an employer and must purchase policies for themselves as required by the individual mandate. This part of the health reform law — a primary point of contention in lawsuits

challenging the ACA — requires nearly all Americans to have health insurance or [pay a penalty](#) starting in 2014.

The online exchange also will help identify people with incomes below a certain level and offer them federal financial assistance, depending on their income level and whether they have other health insurance coverage options. Kansans who are eligible for Medicaid or the Children's Health Insurance Program (CHIP) will use the exchange to enroll in those programs.

This brief summarizes the ACA requirements for a health insurance exchange, as well as the options that will be available through the exchange, and explores how the exchange may affect health insurance in Kansas.

WHAT IS IN THE LAW?

According to the ACA, state health insurance exchanges should, among other things:

- Determine eligibility for Medicaid, CHIP or premium tax credits and cost-sharing subsidies for private insurance coverage.
- Provide information about each plan, including cost, in a standard format.
- Certify that insurance plans meet required standards.
- Apply a quality rating system to health plans.

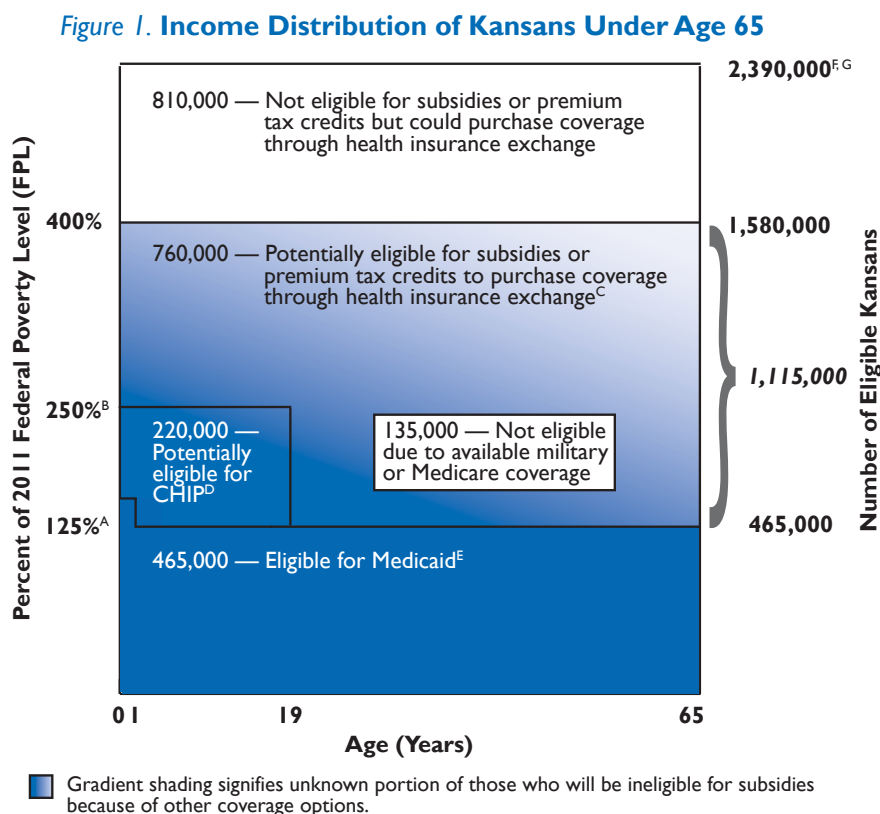
Although the ACA provides an outline for establishing exchanges, it gives states the option to determine many of the details. The deadline for having the exchange ready to enroll people is October 1, 2013, and it must be fully operational by January 1, 2014. To meet those deadlines, the Kansas Legislature will have to pass authorizing legislation. But opposition to the health reform law in the Legislature and from the Brownback administration makes it uncertain whether Kansas will establish an ACA-compliant exchange. If the federal government establishes and operates the state's exchange, it will be based on federally determined guidelines rather than Kansas-specific rules.

KANSAS IMPACT

The ACA requires the online exchange to evaluate all consumers for eligibility for medical assistance

programs through a standard “one front door” approach. The exchange will use information about each person’s income and other coverage options to determine eligibility for Medicaid, CHIP or federal assistance through premium tax credits and cost-sharing subsidies. Of the approximately 355,000 Kansans who are uninsured, nearly 90 percent could meet income guidelines that would qualify them for [Medicaid](#), CHIP or federal assistance.

Kansans will qualify for federal assistance if they have incomes between 133 and 400 percent of the [Federal Poverty Level](#) — from \$29,726 to \$89,400 for a family of four — and don’t have access to other coverage such as [Medicare](#), Medicaid, military benefits or affordable employer plans. Figure 1 shows the number of people who may be eligible for federal assistance through the exchange.



Notes:

- Estimates based on Current Population Survey (CPS) data. CPS has pre-built partitions; the partition closest to 133 percent FPL is 125 percent.
- Estimates based on CPS data. CPS has pre-built partitions; the partition closest to 238 percent FPL is 250 percent.
- Eligibility for subsidies is tied to the lack of other affordable coverage options such as an employer plan.
- A monthly premium between \$20 and \$75 applies to families with incomes between 150 percent and 238 percent FPL.
- Estimates represent eligibility based on income but do not capture eligibility due to disability or other criteria.
- More than 355,000 Kansans are over 65 and eligible for Medicare, making them unlikely to use the exchange.
- Estimates are based on CPS data, which may vary from actual counts due to sampling methodology and other factors. For example, the CPS extrapolated Kansas population is 2.75 million, while the 2010 Census returned a count of 2.85 million.

Premium tax credits will reduce the cost of health insurance purchased through the exchange. For example, a family just above the income eligibility level for Medicaid will get a tax credit limiting their share of the health insurance premium costs to 3 percent of annual income. The tax credit decreases for higher-income brackets, permitting up to 9.5 percent of annual income to be spent on premiums. Table 1 provides estimates of the maximum family share of premiums by income level.

The other type of federal assistance — cost-sharing subsidies — may be available to Kansans who are eligible for premium tax credits and meet additional requirements related to how much they spend for health insurance coverage. The ACA does not limit the amount of federal spending on premium tax credits or cost-sharing subsidies, so the potential costs for this financial assistance could be quite high. According to a Kaiser Family Foundation report, average annual premiums for employment-based health insurance in 2011 were \$15,073 for family coverage.

The 810,000 Kansans at the highest income level will not receive federal

assistance toward health insurance costs but could choose to purchase coverage through the exchange.

Plans in the Exchange

The health reform law requires that health insurance plans, with few exceptions:

- [Guarantee coverage](#) to all who apply, including people with [pre-existing conditions](#).
- Cover government-defined [essential health benefits](#).
- Eliminate co-pays and deductibles for many [preventive services](#).
- Cover dependents up to age 26.

In addition, each plan in the state exchange must be certified as a [qualified health plan](#) (QHP), which means it also must meet certain marketing requirements, ensure [sufficient choice of providers](#), include “[essential community providers](#)” and follow [quality improvement strategies](#).

Any plan offered in an exchange, as well as some sold outside exchanges, must fit into one of four coverage tiers. The four tiers — labeled bronze, silver, gold and platinum — represent different levels of coverage, ranging from the most basic (bronze) to the most comprehensive (platinum). The standard used to determine the four tiers is known as “[actuarial value](#),” which is a measurement of how much coverage the plan provides.

The exchange will rate plans based on price and quality using a system that the federal government will develop. Consumers can use the rating system to evaluate plans before they enroll. Kansas has the option to build upon the rating system to provide more information to exchange users about the plans.

Small Businesses

The ACA requires states to have an exchange where small businesses can purchase coverage for their employees. It can be integrated with the exchange for individuals or set up as a separate exchange.

States initially are permitted to limit the exchange to small businesses with 50 or fewer employees. In 2016, the ACA opens the exchange to businesses with up to 100 employees. In 2009, more than 70 percent of Kansas private businesses had 50 or fewer employees. This group collectively accounts for 223,000 employees and dependents with employment-based insurance. More than 75 percent of private businesses had 100 or fewer employees, accounting for 298,000 Kansans with employment-based coverage.

Businesses with 25 or fewer employees may qualify for a [tax credit](#) if they offer coverage to their employees.

Time for Decisions

By January 1, 2013, Kansas and other states must demonstrate their readiness to operate a state-based

Table 1. Estimated Share of Premiums by Family Income Level

Federal Poverty Level	Annual Income ^A	Limit on Percent of Income Spent on Premiums ^B	Maximum Annual Out-of-Pocket Premium Cost ^C
Less than 133%	Less than \$29,726	Medicaid, no cost to beneficiary ^D	Medicaid, no cost to beneficiary
133% to 150%	\$29,726 to \$33,525	3.0% to 4.0%	\$892 to \$1,341
150% to 200%	\$33,525 to \$44,700	4.0% to 6.3%	\$1,341 to \$2,816
200% to 250%	\$44,700 to \$55,875	6.3% to 8.05%	\$2,816 to \$4,498
250% to 300%	\$55,875 to \$67,050	8.05% to 9.5%	\$4,498 to \$6,370
300% to 400%	\$67,050 to \$89,400	9.5%	\$6,370 to \$8,493
Above 400%	Above \$89,400	No premium limit	No premium limit

Notes:

A. Based on 2011 Federal Poverty Level for a family of four.

B. Limit on percent of income spent on premiums is determined on a sliding scale based on income.

C. Maximum share of total premium cost for a family of four choosing the silver-tier plan with the second-lowest cost.

D. Lawfully present non-citizens are not eligible for Medicaid but are eligible for premium tax credits and cost-sharing subsidies.

Table 2. Elements of an Exchange

If the Legislature decides to create an exchange rather than leave development and operation of the exchange to the federal government, state officials will have to make several decisions that will affect the experience of Kansas residents, businesses, insurance companies, insurance agents and others. While designing the exchange, state officials must decide:

- Whether the exchange will be overseen by a government agency, quasi-governmental agency or a nonprofit organization.
- Who will be on the exchange governance board. Members could include a balance of industry representatives, consumers, health policy officials and other stakeholders.
- How to finance the exchange. This could be done through a per-user monthly fee, tax revenue, assessments on insurance companies and health care providers, or some other means.
- Which sizes of small businesses are allowed to buy insurance in the exchange. Options include either a 50- or 100-employee maximum between now and 2016.
- If or how the exchange will reimburse insurance agents.
- Whether to regulate the number of insurance companies and plans in the exchange. Fewer plans could streamline selection and help ensure quality, while a large variety of plans would provide more choices but also may overwhelm consumers.
- How the exchange will interact with the state Medicaid and CHIP programs.



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The Kansas Health Institute is an independent, nonprofit health policy and research organization based in Topeka, Kansas.

Established in 1995 with a multiyear grant from the Kansas Health Foundation, the Kansas Health Institute conducts research and policy analysis on issues that affect the health of Kansans.

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exchange by the start of 2014. If a state cannot demonstrate that it will be ready to operate an exchange by 2014, the federal government will operate the exchange in the state. Details about how a federally run state exchange would operate, interact with state systems and be financed are unclear.

Kansas was among seven recipients of federal grant money in February 2011 to develop insurance exchanges as “early innovators,” but the Brownback administration returned the \$31.5 million grant in August. Oklahoma refused its \$54

million grant, choosing instead to use state and private funds to build its exchange.

In January 2011, Kansas Insurance Commissioner Sandy Praeger formed eight [work groups](#) to create the state’s exchange. Recommendations from the work groups, which continue to meet, are reviewed by a steering committee with almost 50 members, composed of the work group leaders, Praeger, individuals from the Brownback administration, legislators and other stakeholders, including the insurance industry and consumer groups. These recommendations will be used to develop proposals that may be presented during the 2012 legislative session (Table 2).

WHAT’S NEXT

With less than two years before the state must demonstrate its readiness to operate an exchange, the size and complexity of the task are daunting. Policymakers will have to balance the need to pass legislation and have the exchange operational by January 1, 2014, with the public opinion divide about health reform. The Obama administration and officials from Kansas and 25 other states have asked the Supreme Court to rule on the legal challenge to the ACA during its upcoming term, making it likely that a court decision will come in 2012.

More Information

This publication is the third in a series of briefs about the impact of health reform in Kansas. It is based on work done by LeAnn Bell, Pharm.D. Other contributions were made by Suzanne Cleveland, J.D.; Susie Fagan; Jim McLean; Cathy McNorton and Robert F. St. Peter, M.D. This document and the other briefs in the series are available online at [www.khi.org](#).

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