ISSUE
Winter
MARCH
2012

PracticePerspectives

The National Association of Social Workers

750 First Street NE
Suite 700
Washington, DC 20002-4241
SocialWorkers.org

Stacy Collins, MSW
Senior Practice Associate
scollins@naswdc.org

State Health Insurance Exchanges:

What Social Workers Need to Know

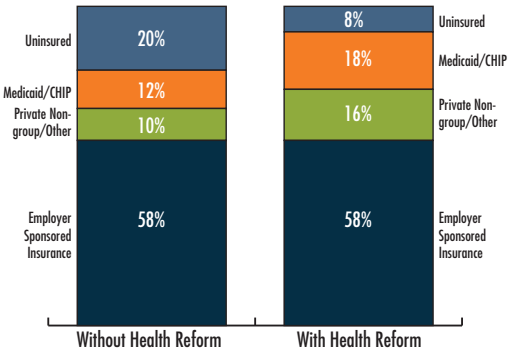
Background

Health insurance exchanges are a hallmark of the 2010 Patient Protection and Affordable Care Act (ACA). Exchanges are state-based health insurance marketplaces, where individuals and small businesses can purchase affordable health coverage. Designed to create a more organized and competitive system for buying health insurance, exchanges will offer a choice of different health plans, certify participating plans for compliance with federal requirements, and provide information to help consumers better understand their insurance options and make informed choices. Low-income individuals will receive federal subsidies to cover the cost of insurance purchased through the exchanges.

The impact of the exchanges for uninsured and low-income Americans cannot be overstated. When fully implemented in 2019, it is estimated that nearly 24 million non-elderly people will receive coverage through health insurance exchanges, either through individual purchasing or through their employers (Kaiser, 2011). As health reform implementation moves rapidly from the federal to the state level, there will be on-going opportunities for social workers to influence exchange development and operation, on behalf of the profession, as well as the vulnerable populations that will be served by the exchanges.

Estimated Health Insurance Coverage in 2019

Total Nonelderly Population = 282 million



(Source: Kaiser Family Foundation, 2011)

Building Exchanges

The ACA requires each state to have an exchange operating by January 1, 2014.[1] States can set up their own exchanges, form coalitions with other states to create regional exchanges, or opt to do nothing, in which case the federal government will set up an

The federal government has set broad guidelines for exchange governance and benefit design, but the details of these important exchange features will be determined largely by individual states (Collins, 2011).

exchange for the residents of that state. State health exchanges can be set up as government agencies or non-profit organizations. Examples of exchanges or exchange-like systems currently in operation include the Massachusetts and Utah health exchanges, the Federal Employees Health Benefits Plan, and Medicare Advantage (Medicare Part C). The ACA gives states significant latitude to develop their exchanges to meet the needs of their particular populations, employer communities, and insurance markets. The federal government has set broad guidelines for exchange governance and benefit design, but the details of these important exchange features will be determined largely by individual states (Collins, 2011).

Health Coverage Expansion Through the Exchanges and Medicaid

The ACA expands health coverage for low-income individuals in two ways. Beginning in 2014, all people with incomes up to 133% of the Federal Poverty Level (FPL) will be eligible for Medicaid. Those with incomes between 133% and 400% of the FPL will be eligible for sliding scale federal subsidies to purchase insurance on the exchanges. Small businesses will also have the option to purchase health coverage for their employees through the exchanges.[2] Undocumented immigrants, however, are prohibited from purchasing coverage in the exchanges. Taken together, when health reform is fully implemented, Medicaid and the state exchanges will ultimately bring 40 million new people into the U.S. health care system (CBO, 2011). It has been suggested that the Medicaid expansions and federal exchange subsidies are likely to reach more low-income households than any need-based program in American history (Dorn, 2011).

Income	Health Coverage Programs
185%–400% FPL	Exchange Subsides for Individuals & Families
133%–185% FPL	CHIP (Children's Health Insurance Program) Exchange Subsides for Adults
0%–133% FPL	Medicaid

Functions of an Exchange

Exchanges are designed to fulfill four major functions: create large risk pools with people of varying ages and health status; make insurance markets more transparent and facilitate consumer choice; manage competition among insurers (focusing on price and quality rather than on risk); and reduce administrative costs (Jost, 2010). Envisioned as "one stop shopping" for health coverage, exchanges will also be required to conduct eligibility determination for Medicaid and CHIP (the Children's Health Insurance Program), through seamless (i.e., "no wrong door") enrollment processes.

Exchange Governance

Exchanges must have a clearly defined governing board, overseen by the state. Most exchange governing boards will include representatives from state government, consumer groups, the health insurance industry, and small and large employers. The governing board must include at least one consumer representative. The ACA requires governing boards to consult with stakeholders during the development and operation of an exchange. Such stakeholders include health plan beneficiaries, representatives of small businesses and self-employed individuals, state Medicaid offices, and advocates for hard-to-reach populations (Weil, 2011). States may also choose to establish non-voting advisory boards, to allow further input from consumers, insurers and providers regarding exchange operations.

Benefits Offered Through Exchange Health Plans

Federal rules have set broad guidelines for the benefit packages that beneficiaries will receive—and the providers they may access—in the exchanges. All health plans offered through the exchanges must contract with "essential community providers," defined as primary care professionals who work with medically underserved populations. In addition, health plans must maintain a network that is sufficient in numbers and types of providers, including providers that specialize in mental health and substance abuse, to assure that services are accessible without unreasonable delay (DHHS, 2012).

The ACA lists ten benefit categories that must be provided by health plans offered in the state exchanges. These include ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care (DHHS, 2011). According to current federal guidelines, each state will determine its own package of essential benefits, modeled after a specific benchmark plan selected by the state (DHHS, 2011).

Challenges for Exchange Development

Virtually all states have received an exchange planning grant from the Centers for Medicare and Medicaid Services (CMS). While many states have already established an exchange—or have indicated their intent to establish one—others are proceeding slowly. One reason for the slow pace is concern about the March 2012 U.S. Supreme Court case, challenging the constitutionality of the ACA. Some states are reluctant to take any steps toward developing an exchange until the Supreme Court issues its decision. However, delaying implementation could prevent a state from meeting the federal timetable for exchange establishment (Kaiser, 2012). Another concern is the on-going primary care provider shortage, which will be exacerbated by the influx of new beneficiaries (Hoffman, 2011).

Roles for Social Workers in Exchange Development and Implementation

BE A VOICE FOR THE SOCIAL WORK PROFESSION AND VULNERABLE POPULATIONS, AS EXCHANGE DEVELOPMENT BEGINS IN YOUR STATE

Because most exchanges are in an early stage of development, the most important role advocates can play in the process is to become involved in setting up the exchange (Families USA, 2011). As a first step, assess your state's exchange development status. State health advocacy coalitions are often involved in this issue (consult the resources section for information on identifying your state coalition). Join your state coalition and become involved in its activities. Encourage your coalition to develop good working relationships with other exchange stakeholders, including state health care associations, medical societies, health care administrators, insurance commissioners, and state and local health departments. Follow the exchange development process closely in your state and take advantage of opportunities, such as public hearings and requests for comments, to provide input into the design of your state exchange.

Work with your state health coalition and other advocates to ensure adequate amount, duration, and scope of covered benefits, especially care coordination, mental health and substance abuse services, and reimbursement levels that recruit enough providers to furnish good access to care.

SUPPORT GOOD GOVERNANCE AND ACCOUNTABILITY IN YOUR STATE EXCHANGE

Work to ensure that your exchange governing board is representative of those it is meant to serve, by advocating for board representation for beneficiaries, as well as representatives of organizations that represent medically underserved communities and individuals with certain diseases or conditions. Advocate also for exchange board advisory groups that include individuals with disabilities and those who need culturally and linguistically appropriate services, to ensure that these vulnerable populations are being served appropriately by the exchange (Hayes, 2011). When appropriate, volunteer to serve on exchange advisory boards. When your exchange board is fully functioning, monitor its activities. Exchange governing boards will play a vital role in your state health care system, leading up to and after the full implementation of the ACA.

ADVOCATE FOR COMPREHENSIVE BENEFITS, INCLUDING SOCIAL WORK SERVICES, IN YOUR STATE'S ESSENTIAL HEALTH BENEFITS PACKAGE

Developing the essential health benefits (EHB) package, which will be offered by the exchange health plans, is a critically important task. Most states will offer opportunities for public input into the EHB process. Work with your state health coalition and other advocates to ensure adequate amount, duration, and scope of covered benefits, especially care coordination, mental health and substance abuse services, and reimbursement levels that recruit enough providers to furnish good access to care. Consult the NASW commentary on the EHB package for guidance (NASW, 2011).

SERVE AS A RESOURCE FOR IDENTIFYING HARD-TO-REACH POPULATIONS

Enrolling newly eligible people into Medicaid and the health exchanges will involve considerable public education and outreach. Participate in public education enrollment efforts within your state. Contact your health exchange leadership and offer your expertise in reaching medically underserved populations, especially those with severe mental illness and other vulnerable populations. If you work in an agency that serves people who receive public benefits, such as SNAP (Supplemental Nutrition Assistance Program), TANF (Temporary Assistance to Needy Families Program), WIC (Women, Infants and Children Program) and subsidized childcare, make sure your clientele is aware of the expanded health coverage available through the state exchange and Medicaid.

ADVOCATE FOR HORIZONTAL INTEGRATION OF HEALTH AND HUMAN SERVICE BENEFITS

Many who receive health coverage through the new exchange subsidies and Medicaid expansions will also qualify for human services programs that address other basic needs. If states allow unified applications for all health and human service programs, more eligible households would receive benefits (e.g., SNAP), which typically fail to reach many who qualify for help (Dorn, 2011). Encourage your state to adopt a unified application that allows individuals and families to apply for all needed benefits at one time.

Resources

Community Catalyst is a national non-profit advocacy organization working to build state-level consumer and community leadership in health reform. The organization maintains a database of state advocacy coalitions focused on health reform implementation issues, including exchange development: **www.communitycatalyst.org/states**

Families USA - Health Reform Central has produced a series of guides for state health advocates on implementing insurance exchanges: **www.familiesusa.org/health-reform-central/implementing-the-new-law**

Enroll America is a national non-profit organization working to ensure that all Americans are enrolled in and retain health coverage, especially those newly eligible through the ACA. Enroll America works with health coverage stakeholders—to advance accessible enrollment processes. The organization offers best practices for optimizing enrollment, provides guidance to states on adopting user-friendly enrollment policies, and raises awareness of enrollment options among the uninsured. **www.enrollamerica.org**

References

Collins, S.R. (2011). *HHS's Proposed Regulation for Health Insurance Exchanges: An Emphasis on State Flexibility, Part I*. The Commonwealth Fund Blog (New York: The Commonwealth Fund).

Congressional Budget Office. (2011). *Estimate of the Effects of the Insurance Coverage Provisions Contained in the Patient Protection and Affordable Care Act (Public Law 111-148) and the Health Care and Education Reconciliation Act of 2010 (P.L. 111-152)*. Washington, DC.

Department of Health and Human Services. (2011). *Essential Health Benefits: HHS Informational Bulletin*. Retrieved from www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

Department of Health and Human Services. (2012). Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule. *Federal Register*. Retrieved from: www.ofr.gov/OFRUpload/OFRData/2012-06125_PI.pdf

Dorn, S. (2011). *How Human Services Programs and Their Clients Can Benefit from National Health Reform Legislation*. Washington, DC: Urban Institute. Retrieved from www.urban.org/UploadedPDF/412446-National-Health-Reform-Legislation.pdf

Families USA. (2011*). Implementing Exchanges: Obtaining Exchange Funding and Achieving Consumer-Friendly Outcomes: A State "To Do" List*. Retrieved from http://familiesusa2.org/assets/pdfs/health-reform/Exchanges-Funding-and-Consumer-Friendly-Outcomes.pdf

Hayes, K.J. (2011). *Update: Health Insurance Exchanges: Qualified Health Plans, Reinsurance, Risk Corridors and Risk Adjustment*. Retrieved from www.HealthReformGPS.org

Hoffman, C., Damico, A. & Garfield, R. (2011). *Kaiser Family Foundation Research Brief: Insurance Coverage and Access to Care In Primary Care Shortage Areas*. Retrieved from www.kff.org/insurance/upload/8161.pdf

Jost, T.S. (2010*). Alliance for Health Reform Briefing: Health Insurance Exchanges: Policy Issues*. Retrieved from www.allhealth.org/index.asp

Kaiser Family Foundation. (2011). *The Uninsured: A Primer*. Retrieved from www.kff.org/uninsured/upload/7451-07.pdf

Kaiser Family Foundation. (2012). *Establishing Health Insurance Exchanges: A National Overview of State Efforts*. Retrieved from www.kff.org/healthreform/upload/8213-FS.pdf

National Association of Social Workers. (2011). *Recommendations on the Essential Health Benefits (EHB) Package*. Retrieved from www.socialworkers.org/practice/health/2011/Essential%20Health%20Benefits%20Package_NASW%20Commentary_10_26_11.pdf

Weil, A., Shafir, A. & Zemel, S. (2011). *National Academy for State Health Policy Briefing: Health Insurance Exchange Basics*. Retrieved from www.nashp.org/sites/default/files/health.insurance.exchange.basics.pdf

ENDNOTES

[1] As of January 2012, 18 states had established exchanges or had plans to do so; 22 were still studying their options; nine had no significant exchange development activity; and two have decided not to create exchanges. Source: Kaiser Family Foundation (Feb 2012). State Action Toward Creating Health Insurance Exchanges; Retrieved from http://statehealthfacts.kff.org/comparemaptable.jsp?ind=962&cat=17

[2] Until 2016, states have the option to define small businesses as either 1-50 employees or 1-100 FTE (full- time equivalent) employees, for the purposes of exchange enrollment. After 2016, all businesses with 100 or fewer FTE employees will be able to purchase insurance through the exchanges. In 2017, states can let in companies with more than 100 employees. Retrieved from www.nashp.org/sites/default/files/health.insurance.exchange.basics.pdf

Encourage your state to adopt a unified application that allows individuals and families to apply for all needed benefits at one time.

Center for Workforce Studies & Social Work Practice Recent Publications

Occupational Profiles: Available at http://workforce.socialworkers.org/studies/other.asp

- *Social Work Salaries by Gender*
- *Social Work Salaries by Race/Ethnicity*
- *Social Workers in Colleges and Universities*
- *Social Workers in Government Agencies*
- *Social Workers in Health Clinics & Outpatient Health Care Settings*
- *Social Workers in Hospice and Palliative Care*
- *Social Workers in Hospitals and Medical Centers*
- *Social Workers in Mental Health Clinics & Outpatient Facilities*
- *Social Workers in Private Practice*
- *Social Workers in Psychiatric Hospitals*
- *Social Workers in Schools*
- *Social Workers in Social Service Agencies*

Social Work Practice Perspectives: Available at www.socialworkers.org/practice/default.asp

- *2011 Medicare Changes for Clinical Social Workers*
- *Accountable Care Organizations (ACOs): Opportunities for the Social Work Profession*
- *Adolescent Depression and Suicide Risk: How Social Workers Can Make a Difference*
- *Advocating for Clinical Social Workers: Highlights of 2010*
- *Creativity and Aging*
- *Dangerous Rites of Passage: Trends in College Alcohol Consumption*
- *Domestic Violence and Human Trafficking: Double Jeopardy for Immigrant Women in the United States*
- *Domestic Violence and Women of Color: Complex Dynamics*
- *Engaging Young People in Their Transition Planning*
- *Healthy People 2020: Social Work Values in a Public Health Roadmap*
- *Opting Out of Medicare as a Clinical Social Worker*
- *Results of 2010 Psychotherapy Survey*
- *Support for Family Caregivers: The National Landscape and the Social Work Role*
- *Supporting the Child Welfare Workforce to Reduce Child Maltreatment*
- *The Medical Home Model: What Is It and How Do Social Workers Fit In?*

Leadership Ladders: Steps to a Great Career in Social Work Available at http://careers.socialworkers.org/professionaldev/default.asp

- *From the Front Line to the Corner Office*
- *Letting Your Voice be Heard*
- *Managing Stress*
- *Navigating Large Service Systems*
- *Opening a New Private Practice*
- *Outside the Lines: Maximizing the Flexibility of a Social Work Degree*
- *Presenting Your Work to Others*
- *Publishing as a Practitioner*
- *Risk Management in Clinical Practice*
- *Strengthening Your Writing Skills: An Essential Task for Every Social Worker*
- *The Tech-Savvy Social Worker: Prepared for the Challenges of 21st Century Practice*
- *The Value of Dual Degrees*

New Practice Standards
For a complete list of practice standards, visit www.socialworkers.org/practice/default.asp

- *NASW Standards for Social Work Practice with Family Caregivers of Older Adults (2010)*

NASW
National Association of Social Workers

750 First Street NE, Suite 700
Washington, DC 20002-4241
SocialWorkers.org