Affordable Care Act Update and the Federally Facilitated Exchange

Presented by

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The CSI's Goal in Health Insurance Reform

The CSI is working to make sure Montanans have a voice in the future of the state's insurance market.

- Consumer protection is our top priority
- We believe Montanans are best suited to determine how our insurance is regulated
- We continue to work through the NAIC to preserve state regulatory authority

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2014 Reforms

- No pre-existing condition exclusions
- Guaranteed issue for all major medical health insurance markets
- Rating rules/Adjusted Community Rating
  - No health status rating
  - 3:1 maximum age rating
  - 1.5:1 tobacco use
- Single risk pools in individual and small group markets
- Individual responsibility requirement
- Employer responsibilities
  - Doesn't apply to small employers (<50)
- Risk adjustment, reinsurance, risk corridors to transition market to rating changes

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Uniform Explanation of Coverage Documents and Standardized Definitions

- A summary of benefits and coverage explanation must be provided to all potential policyholders and enrollees.
- The summary must contain the following:
  - Definitions, description of coverage, cost sharing, and exclusions
  - A “coverage facts label” that illustrates coverage under common benefits scenarios
  - A statement indicating that the minimum actuarial value meets the requirements of the individual mandate
  - A contact number for the insurer

*This information must be provided in prescribed format --the number of pages is restricted.

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Internal Claims Appeals Process

All individual and group health plans must follow the USDOL claims regulations, as modified by the ACA. Plans must:

- Treat a rescission of coverage as an adverse benefit determination
- Notify a claimant of a benefit determination involving urgent care not later than 72 hours after the receipt of the claim
- Allow the claimant to review the claim file and present evidence and testimony

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Internal Claims Appeals Process, cont.

- Provide a claimant with new or additional evidence relied upon
- Independence and impartiality must be guaranteed
- Notice of adverse benefit determination must include information sufficient to identify the claim involved
- Provide information regarding how to initiate internal appeals and external review processes
- Disclose the contact information for the office of health insurance consumer assistance, which will assist individuals with the internal appeals and external review processes *[IN MONTANA: THE CSI]
- A plan's internal appeals process will be deemed exhausted if a plan fails to adhere to substantive legal requirements

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External Review of Claim Denial After Internal Appeal

- In Montana this process has been known as "independent medical review."
- Federal rules applies to claims denied for reasons involving medical judgment or as a result of a rescission decision
- Strict timelines vary for "standard," "expedited," or "experimental or investigational treatment" claims

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External Review of Claim Denial After Internal Appeal, cont.

- Request for external review must be made within four months following internal appeal decision
- External review must be done by an "independent review organization" [IRO]
- IRO's must be chosen using a random selection process that is fair and impartial
- External review decisions are binding on both the health plan and the claimant
- As of Jan. 1, 2012, the federal process is in effect in Montana (state law failed to meet minimum standards)

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Rate Increases: Disclosure and Review Requirements

- On May 18, 2011, CMS issued the interim final rules.
- On July 1, 2011, Montana received notice from CCIIO indicating that "Montana does not meet the criteria for an Effective Rate Review Program."
- Beginning September 1, 2011, CMS will review rate increases that are subject to review and proposed for use in Montana that are filed or effective on or after September, 2011.

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Rate Increases: Disclosure and Review Requirements, Cont.

The Interim Final Rules provide as follows:

- Health insurance rate increases in the individual and small employer group health insurance market above a specified percentage (10% until 9/1/2012) will be reviewed to determine whether they are justified
- Does not apply to the large group market (employers over 50) or to grandfathered or self-funded health plans.
- After 9/1/2012, HHS will set different percentage thresholds by state that more accurately reflect the particular cost trends in each state.

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Rate Increases: Disclosure and Review Requirements, Cont.

- HHS will review rate increases that are more than the applicable state-specific threshold to determine if the rate is excessive, unjustified or unfairly discriminatory.
- HHS cannot actually block the use of a rate increase that is determined to be "unreasonable."
- However, the finding will be published on various state and federal websites and companies that persist in using "unreasonable" rates may be barred from selling insurance in the exchange.

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Premium Rate Review in Montana

- Montana is one of only three states that lack any form of health insurance rate review authority
- Other lines of insurance (home, auto, etc.) are required to submit rates to the CSI for review before they take effect
- Health insurers are not currently required to submit information about premium increases to the CSI
- Legislation to give the CSI authority to review and negotiate rates with insurance companies failed
- The CSI plans to bring legislation in 2013 to create effective rate review authority for Montana

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Adjusted Community Rating

- In 2014, adjusted community rating applies to the individual and small employer group markets
- Issuers may not vary rates for individuals or small groups based on health status or claims history
- Issuers may vary rates based on:
  - Age (3:1 maximum)
  - Tobacco (1:5:1 maximum)
  - Geographic rating area
  - Whether coverage is for an individual or a family
- This provision does not apply to non-grandfathered, fully insured health plans.

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Benefits of Reform to Small Business

- Beginning in 2014, small businesses can receive tax credits for two years worth up to 50% of an employer's contribution to employee plan (35% for tax exempt small businesses) if they purchase coverage through the **Small Business Health Option Program** (SHOP) Exchange.
  - Beginning in 2014, new health insurance exchanges are open to small businesses with up to 100 employees (or up to 50, at the option of the state until 2016).
  - These exchanges will enable small firms to compare and shop for health insurance more easily.

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The Federally Facilitated Health Insurance Exchange

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Regulatory Sharing Arrangement

- There are five core functions that must be performed by any exchange: consumer assistance, plan management, eligibility, enrollment and financial management.

- The Center for Consumer Information & Insurance Oversight (CCIIO) has identified two areas where states may use their existing regulatory authority to streamline certain exchange functions within the operation of the federally-facilitated exchange:
  - Plan Management
  - Selected consumer assistance functions

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Regulatory Sharing Arrangement, cont.

- Coordinating necessary functions of the federally facilitated exchange with existing regulatory activities will streamline the process for health plan issuers and consumers and save time and money.
- This coordination will help to preserve the state regulation of health insurance:
  - has the potential to save taxpayer dollars and keep premiums lower;
  - builds on the existing strengths and expertise of the states; and
  - avoids regulatory conflict and frustration for health insurers and consumers.

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Plan Management

- Plan management functions include:
  - plan selection
  - collection and analysis of plan rate and benefit package information
  - ongoing issuer account management
  - plan monitoring, oversight, data collection and analysis for quality

- It is possible that CCIIO will allow the state insurance department to perform some of these functions, even if they are not able to perform all of them.

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Consumer Assistance

- Consumer assistance functions that a state department of insurance may perform are as follows:
  - In-person assistance (consumer complaints)
  - Navigator management
  - Outreach and education

- HHS will handle:
  - Call center operations
  - Website management
  - Written correspondence with consumers to support eligibility and enrollment

Potential Timeline for QHP Certification

- Many states are beginning Issuer review/ approval in 2012 for state-based exchanges
- January 1, 2013, HHS will announce which states have state-based exchanges that are “certified” as meeting ACA requirements by HHS
- Qualified Health Plans should be certified by third quarter 2013 so that the websites can be populated with that information
- Open enrollment for exchange health plans begins October 1, 2013 for an January 1 , 2014 issue date

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Transition to State-Based Exchange

- A state that does not have an approved or conditionally approved exchange plan and operational readiness assessment by January 1, 2013 may seek approval to operate a state-based exchange after 2014
- The state's exchange plan must be approved prior to January 1 of the year before the first coverage sold through the exchange would be effective.
- States must work with HHS to develop a transition plan.
- State must still build its own exchange technology and infrastructure – taking over federal infrastructure is not possible
- No grant funding will be available for start-up costs after January 1, 2014

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Essential Health Benefit Requirements

- ACA requires EHB to include the 10 named categories and be equal in scope of benefits to that provided under a "typical" employer plan.
- The state must "defray the cost" of any benefits required by state law to be covered by qualified health plans beyond the EHB.
- The benchmark determination focuses on benefits, not cost sharing. Cost sharing features are determined by the "metal level" described in the ACA—the actuarial value limits associated with bronze (60%), silver (70%), gold (80%) and platinum (90%) plans.
- The CCIIO bulletin on essential health benefits issued on December 16, 2011 states that HHS proposes that EHB be defined by a benchmark plan selected by each state.

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Essential Health Benefit Categories

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

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Essential Health Benefit Benchmarks

- The bulletin identifies four benchmark plans that states may choose (only one) from:
  - The largest plan by enrollment in any of the three largest small group insurance products in the state's small group market (based on enrollment from the first quarter of 2012);
  - Any of the largest three state employee health benefit plans by enrollment;
  - Any of the largest three national FEHBP plan options by enrollment; or
  - The largest insured commercial non-Medicaid HMO operating in the state.

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Essential Health Benefit Benchmarks, cont.

- The state must make this choice by the 3rd quarter of 2012 for coverage issued in 2014.

- If the state does not make the benchmark decision by the 3rd quarter of 2012, the federal "default" benchmark for that state will be the largest plan by enrollment in the largest product in the state's small group market.

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Essential Health Benefit Benchmarks, cont.

- States may choose their benchmark plan in a way that minimizes the likelihood that it would have to defray the cost of state benefit requirements that may go beyond the EHB categories.

- For instance, the largest small group health plan by enrollment would necessarily contain all the state required benefits that existed before the first quarter of 2012. Therefore, those benefits become part of the EHB benchmark and their cost would not be “defrayed.”

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Essential Health Benefit Benchmarks, cont.

- State benefit requirements adopted after 2011 that go beyond the EHB benchmark may involve a cost to the state.

- HHS intends to assess the benchmark process for the year 2016 and beyond based on evaluation and feedback.

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Issues with Establishing the Benchmark

- If a benchmark plan is missing a category of benefits other than habilitative services or pediatric oral and vision care, the state must supplement the missing categories using the benefits from other benchmark options, i.e. other small employer group benchmark plans.

- Or, in a “default” benchmark option state, any missing categories may be supplemented by looking to the largest FEHBP plan by enrollment in that state.

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Issues with Establishing the Benchmark, cont.

- Mental health and chemical dependency coverage must be included in the EHB benchmark plan and full parity with physical illness generally will apply to all small employer group and individual coverage issued.

- Health plans in the individual and small employer group markets must offer benefits that are “substantially equal” to the benchmark plan and modified as necessary to reflect the 10 coverage categories.

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Decision-making in the Federally Facilitated Insurance Exchange

- Montana will not make policy decisions on how to structure, implement, or improve the exchange
- Montana will not determine what health plans can be sold in the exchange
- Montana will not establish certification requirements for QHPs
- Montana will not manage outreach to enroll Montanans in the exchange
- Montana will not decide what the long-term funding mechanism will be for the exchange – including how and which users will be assessed

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Decision-making in the Federally Facilitated Insurance Exchange, cont.

- Montana will not make decisions about marketing and promoting the exchange
- Montana will not decide which issuers will be allowed to sell in the exchange
- Montana will not decide how health plans will be accredited and rated for quality inside the exchange
- Montana will not be able to guarantee a level playing field as it will not have sole authority over products sold inside and outside the exchange

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Regulatory Hurdles in Montana

- Montana does not appear to have an effective law for network adequacy in PPO plans.
  - A state-law solution for PPO network adequacy that applies equally both in an out of the exchange may be necessary
- Montana's insurance commissioner does not have comprehensive rate review authority for health insurance.
  - State rate review authority is needed for health insurance so that rates both inside and outside the exchange can be effectively monitored
  - All rates used inside the exchange must be reviewed, not just rates that exceed the threshold
  - Preliminary justification must be posted for all rates used inside the exchange

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Regulatory Hurdles in Montana, cont.

- The potential for instability in the health insurance market in Montana may increase if the commissioner has no role in qualified health plan (QHP) certification.
  - Products sold both in and outside the exchange in the small employer group and individual market should be equally regulated.

- Failure to achieve equal regulation would be a missed opportunity for Montanans.
  - Equal regulation, both inside and outside the exchange may be necessary to avoid adverse selection issues.

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