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Economic Affairs Interim Committee

62nd Montana Legislature

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as of June 1, 2011

House Joint Resolution No. 33

* * * Draft Study Plan Regarding Health Insurance Exchanges * * *

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for the Economic Affairs Interim Committee

Introduction

As mid-2011 rolls around, provisions of the Patient Protection and Affordable Care Act (PPACA) are in court as well as under review by Congress both in terms of repeal and as negotiating fodder for budget reductions, which means that specific provisions may be overturned or changed. With that potential for change, the Economic Affairs Interim Committee may choose to emphasize flexibility in addressing issues related to health insurance exchanges as outlined in the House Joint Resolution (HJR) No. 33 study.

Further, by deciding not to implement any of the legislation providing for a state health insurance exchange (HB 124 or HB 620) and instead passing SB 228 to prohibit creation of a health insurance exchange under PPACA, a bill vetoed by the governor, the 62nd Legislature issued a strong indication of concern about PPACA and its directives. However, the 62nd Legislature did also pass this HJR 33 study of a health insurance exchange. That study ranked third in a post-session poll of what legislators would like studied over the interim.

With concerns about PPACA in mind as well as a recognition of the complex nature of health insurance exchanges and the slow evolution of related federal guidance, the Economic Affairs Interim Committee may choose to emphasize certain priorities in the HJR 33 study with less attention on other study aspects outlined in HJR 33. In addition, numerous advocates of health insurance exchanges predict that Montana will be unable to initiate an exchange in time to meet current federal timelines. That means the prospect for a federal exchange is high in Montana. But that does not mean -- if Montanans want more state control over a marketplace for health insurance -- that a locally responsive health insurance exchange is an impossibility. Further, the interim process gives legislators an opportunity to comment, take public comment, and otherwise seek to influence activities, such as executive orders, that may be contemplated during that time.

Logistics

At the first meeting of the Economic Affairs Interim Committee members may want to consider whether the full committee, a subcommittee, or a stakeholder working group is to be the primary actor. If the full committee is involved, then the matrix provided on pages 11-13 of the draft work plan would apply solely to the committee. If a subcommittee is involved, the HJR 33 matrix would apply to the subcommittee, and the committee's meeting times would be reduced by 25%

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at all two-day meetings. If a stakeholder working group is involved, the committee could decide on which involvement level is preferred and which priorities it wants the stakeholder group to address. Stakeholder presentations then would be made on the prioritized issues, and the full committee would consider making recommendations. Stakeholder involvement would also be expected for committee or subcommittee activities but the discussions and recommendations would be solely by committee or subcommittee members.

Priorities

In setting priorities, the committee has been asked to fill out comments and whether issues listed in HJR 33 are high, medium, or low priorities for study (see page 17 of the committee's draft work plan). Also helpful would be an indication from the committee of whether the direction of the study should be aimed at a state, a regional, or a federal exchange:

- If the choice is a state exchange, then what components of HB 124 or HB 620 are the most important to study first?
- If the choice is a regional exchange, then what type of interstate compact makes the most sense to committee members? (The interstate health compact in HB 526 sought to exclude federal control, which is one approach. Another approach is to implement the federal law regionally, for which there is no template as of yet.)
- If the choice is the federal exchange, does the state want to seek a role through an advisory or statutory committee or does the state want to focus solely on the impact to the state's health insurance plan and have no ties to a federal exchange?

Timelines and Activities to Date

On or before January 1, 2013, the Department of Health and Human Services is to decide whether a state will have a state-based health insurance exchange operational by Jan. 1, 2014. To date, the following states have enacted some form of legislation regarding a health insurance exchange:

California (has an independent public exchange governed by a politically appointed board)
Maryland (establishes an exchange as a public corporation)
Massachusetts (exchange as an independent state agency already operational)
Mississippi (a study committee is to report to the 2011 legislature and is dissolved in 2013)
North Dakota (insurance commissioner and Department of Human Services directed to establish an exchange to ensure federal government of operational capacity by Jan. 1, 2014)
Utah (electronic exchange operating out of Governor's office for small businesses)
Virginia (specific recommendations due Oct. 1, 2011)
Washington (establishes public-private partnership distinct from state, with political appointees)
West Virginia (established as a governmental entity)
Wyoming (study to make recommendations for the 2012 legislative session).[1]

Maryland, along with five other states, received early innovator grants from the federal government to develop and test health information technology that can be used in an exchange.

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[1]The list is primarily from a May 10, 2011, summary from the National Association of Insurance Commissioners, which also included Montana because of HJR 33 but did not include Massachusetts and Utah.

The other states are Kansas, New York, Oregon, Oklahoma, and Wisconsin. Rhode Island, Vermont, and Connecticut share in a multi-state grant project directed by the University of Massachusetts Medical School. Some of the early innovator states and states with studies related to a health insurance exchange also are among the 26 states that have joined the lawsuit(s) against PPACA (including Kansas, Virginia, Wisconsin, and Wyoming.)

The early innovator grant recipients have promised to make their technology transferrable to other states. A January 2011 report available from the State Auditor's Office (colloquially known as CSI, which stands for the Commissioner of Securities and Insurance) indicated that the electronic portion of the exchange is only one part of the equation. The remainder includes figuring out some of the other factors mentioned in HJR 33, including: roles of insurance producers and agents, current state mandates if they are not included in the list of essential benefits being developed by the federal government, and how to handle eligibility determinations for Medicaid (to redirect applicants on an exchange who may be eligible for Medicaid subsidies instead of the subsidies associated with an exchange) as well as how to direct employer contributions so that an employee with more than one job (common in Montana) can aggregate contributions to buy health insurance on an exchange. The issues related to insurance agents and direct contributions were part of HB 124 and HB 620. How to handle state mandates on any type of exchange, including a federal exchange, will depend on the scope of the essential benefits that the federal government is to determine later this year.

Montana's activities to date have included stakeholder meetings held by the State Auditor's Office and legislation proposed by that office (HB 124) as well as by Rep. Tom Berry (HB 620). Given Montana's biennial legislature, there are concerns that regardless of the actions of an interim committee under HJR 33 there is no time to achieve implementation by January 1, 2014, as required under federal guidance on PPACA. If a state is unable to meet that deadline, PPACA says that a federal exchange will be made available for the state.

Although the Montana State Auditor's Office has not directly taken into account the technology that may be forthcoming from the early innovator grants, there is the expectation that any technology would have to be adapted to Montana circumstances. From that perspective, the following timeline available on the State Auditor's website shows the technological portions of a health insurance exchange:

January to July 2011 - Develop information technology requirements for a state-based exchange
October 2011 - Release requests for proposals for the electronic aspects of the exchange
January 2012 - Launch informational website
May 2012 - Launch exchange prototype
June to December 2012 - Test and improve exchange design; add functions as they are developed
March 2013 - Deliver final product
March 2013 to September 2013 - Test and remediate
October 2013 - Go Live.

Two months are necessary for enrollment in a policy offered on the exchange, so various timelines related to the exchanges indicate an October initiation date.

HJR 33 Study Areas and Options

The Economic Affairs Committee's work plan lists in Appendix B the components that HJR 33 is to study. These include an evaluation of:

- the scope of service to be offered by an exchange;
- whether an exchange can facilitate the sale of health insurance across state lines;
- whether an exchange can be used, with a waiver and premium assistance, to help serve the state's Medicaid population;
- differences between what the federally determined contributions and plan criteria include versus what the state may feel are appropriate, including how to address state mandates that may not be included among the federal "essential benefits";
- ways to aggregate premiums from multiple employers of an employee buying insurance on the exchange;
- how an exchange will interact with insurance producers;
- what steps may be needed to neutralize the costs of state employees at various salary levels if the state no longer provides insurance, using the exchange as backstop; and
- what costs or savings might accrue to the state for discontinuing state employee or legislator health insurance.

In carrying out the study, the Economic Affairs Interim Committee is expected to make recommendations regarding whether the state should proceed with a state exchange or a regional exchange and incorporate participation by nonvoting stakeholders. Presumably this recommendation will be made approximately in March or May, which gives time for the committee to review any legislation that might be requested. Throughout the study, the committee also may request fiscal impact assessments from the Legislative Fiscal Division.

Brief explanations of the components are below:

- ***Scope of service***

  Health insurance exchanges may operate in a variety of ways. Some -- like Utah's version -- emphasize Internet access but offer defined contribution options and a risk adjuster board. (Utah will have to update to meet all the requirements posed by PPACA, including serving individuals.) Others, like Massachusetts, are intended to function through nonprofit or quasi-governmental organizations that both oversee access to web-based insurance and provide assistance in navigation.

- ***Sale of insurance across state lines***

  Not part of the PPACA, the sale of insurance across state lines has been promoted by advocates as a way of introducing competition within the health insurance market. One question that might be explored is whether a federal or a regional exchange will introduce competition among insurers in ways that destabilize the local insurance market or that improve competition.

  A federal exchange and all state-based exchanges will have at least two nationally operating insurance companies to participate. The federal government will negotiate contracts and determine which companies participate (using negotiations similar to the federal government employee coverage.). What that would mean in Montana is that two large companies, such as United Healthcare, Aetna, or Cigna, would provide access to a broader range of policies here than they currently do.

  Another aspect of competition, not specifically related to sales of insurance across state

lines, deals with risk adjustment. This term refers to finding ways to protect insurers from being burdened by the riskiest cases. Currently insurers try to avoid such risks through underwriting and denying or delaying coverage in the individual market in particular for certain preexisting conditions. Now because of PPACA people with preexisting conditions must receive coverage as of January 1, 2014 (for children the preexisting condition exclusion already is in effect), if PPACA is not overturned in court.

- **Role of an exchange for the state's Medicaid population**

  The Medicaid population includes many people who move in and out of Medicaid in a year and who may be eligible for either Medicaid or low-income subsidies under a health insurance exchange. One goal proposed for exchanges is to offer a seamless "no wrong door" approach to provides a way for a person to determine eligibility for either Medicaid, Healthy Montana Kids, or insurance purchased on the health insurance exchange. Another idea for unifying an exchange with a Medicaid program is to obtain a waiver that would allow Medicaid-eligible persons to obtain insurance through a health insurance exchange, which means that the benefits covered and the subsidies would fall under different criteria than they currently do. Potential changes by Congress to Medicaid may either encourage or discourage an insurance exchange tie-in with Medicaid.

- **Contributions and plan criteria/Montana mandates**

  PPACA provides general descriptions of different categories of plans but federal guidance has not yet been written that specifies what types of employer contributions might be necessary and what services must be made available. Similarly, states do not know if their mandated coverage is among the must-provide services or if the states will be responsible for paying for the state-mandated services. The federal government is expected to develop the list of essential benefits no earlier than this fall.

- **Aggregation of premiums in case of multiple employers for one employee**

  In both HB 124 and HB 620 there were provisions for employers to establish a defined contribution. The committee may want to examine the approach to determine workability and equity. (For example, what would happen if an employee with two employers received a contribution from only one of the employers? Would the contribution be sufficient to pay for a premium even if the employee's aggregated income was not eligible for a subsidy?)

- **Interaction with insurance producers**

  Health insurance producers and agents typically get paid for helping customers find insurance and servicing those accounts. They might get commissions. If an insurance exchange provides the matchups between insurance policies and customers, then what is the role of insurance producers and agents? Among the discussions currently under way are whether to include producer or agent commissions within or outside the medical loss ratio that PPACA requires to be at 80% for individual or small employer group insurers and 85% for large employer group insurers. Utah has developed a flat fee, while Massachusetts provides a role for producers and agents in the small group market to help develop Section 125 plans and provide other services to small employers.

- **Role of exchange for state employee/legislator health insurance, including costs/savings**

  There are at least two approaches the committee may want to consider: whether to no longer provide a state health insurance plan or to use the health insurance exchange as its own marketplace in a way that increases the volume of people served on the exchange and accordingly both pools the health insurance risk among more people and allows health care provider rates to correspond to a larger pool.

  Employers that provide health insurance benefits long have done so to give them a competitive edge in hiring and retaining employees. As more employers weigh the costs of health insurance coverage and shift some of those costs to employees or drop health insurance benefits completely, the issue of offering benefits, and how, is relevant to the HJR 33 discussions. Similarly, the state health plan, which currently is grandfathered and not required to meet all of the PPACA requirements, may not retain that status far into the future, which means that a review of the state pay plan situation also may be relevant.

Summary

There are many activities related to health insurance coverage, sales, and state health insurance law that are affected by PPACA but do not specifically depend on implementation of any type of health insurance exchange. A review of these activities is valid simply for legislators to decide what issues may need further exploring. Legislators also may want to consider the nuts and bolts of implementing an exchange, including the regulatory provisions, costs, and how Insure Montana would operate if an exchange or marketplace provides similar subsidies through the federal government that small businesses now may access through Insure Montana.

Worth emphasizing is that none of the activities being contemplated under HJR 33 involve the mandatory coverage component of PPACA. As such the prohibitions of SB 125 do not apply (against the state administering the PPACA requirement for individuals to buy health insurance). Also worth noting is that, while the U.S. Supreme Court may eventually decide on the constitutionality of PPACA, the process may well take most of this interim before a decision is made. Health insurance components raised in HJR 33 may be studied without being a waste of time, regardless of the U.S. Supreme Court's final decision.