Considering a Health Insurance Exchange in Montana
Draft Report for House Joint Resolution # 33
By Pat Murdo, Legislative Research Analyst

Overview

The House Joint Resolution No. 33 study of health insurance exchanges has been a political hot potato from day one. The HJR 33 study listed a series of considerations regarding Montana and participation in the health insurance exchanges required by the Patient Protection and Affordable Care Act to be operating in every state (either by the state or by the federal government) by Jan. 1, 2014.[1] These exchanges are intended to be online markets where people can compare and buy health insurance policies as well as determine their eligibility for federal subsidies to help buy health insurance. Federal tax credits and cost-sharing reductions are available only through the exchanges. For the most part, the outline of information requested in HJR 33 ended up being shelved while members of the Economic Affairs Interim Committee (to which Legislative Council assigned the study) and the rest of the nation waited to learn whether the U.S. Supreme Court would uphold the Affordable Care Act.

Initial considerations--As the Economic Affairs Interim Committee began the study of HJR 33--the third-highest ranked (out of 13) studies for the 2011-2012 interim--three political facts[2] were obvious:

1. The 2011 Legislature had defeated legislation that would have created a role for Montana in implementing parts of the federally enacted Affordable Care Act,[3] including creation of a state-based

---

[1]The Patient Protection and Affordable Care Act will be termed the Affordable Care Act in this report.

[2]Not included here is mention of Legislative Referendum 122, created by Senate Bill No. 418, which puts to a vote in November 2012 the Montana electorate's feeling about whether the state or federal government can mandate health insurance coverage or impose a penalty or tax if a person declines to purchase health insurance. While the vote may inform the 2013 Legislature of Montanans' attitude toward the Affordable Care Act and the health insurance exchanges created by it, the Supremacy Clause and the U.S. Supreme Court's ruling upholding the ability of Congress to tax those citizens who are required to buy insurance but who do not do so mean the referendum does not affect the federal government's implementation of the Affordable Care Act. Under 2-1-501, MCA, enacted under SB 125 in the 2011 session, state employees are not allowed to implement the individual mandate of the Affordable Care Act. The statute has no affect on federal employee actions on the mandate.

[3]Three bills from the State Auditor's Office to provide more state authority in implementing portions of the Affordable Care Act were HB 105 granting the state's insurance commissioner authority to review and approve health insurance premiums, HB 124 creating a state-run health insurance exchange, and HB 129 creating a state-level external review process for health insurance.

Outline For HJR 33 Report

Overview — 2011 session actions, interim reviews, U.S. court case

Sections

I) Committee activities

II) Committee Policy Recommendations (none at this time)

III) Background information

A) issues regarding health care reforms

i) coverage
ii) health care costs
iii) costs to government/taxpayers
iv) access to care

B) information gathered for the Affordable Care Act and health insurance exchanges

i) health insurance coverage in Montana;
ii) status of health insurers in Montana - by premium in small group and individual markets, by medical loss ratio, and regarding rate review (by federal officials and the State Auditor's Office with Leif Associates as actuarial contractors);
iii) status of Montana Comprehensive Health Association and the federal high risk pool (Montana Affordable Care Plan);
iv) subsidies paid to employers to help buy health insurance, under Insure Montana and under the Affordable Care Act *and costs to businesses for not providing adequate coverage*;
v) status of the health co-operative that has received federal funding under the Affordable Care Act to provide a health plan alternative;
vi) other data gathered related to health insurance exchanges
vii) other??

C) what a federally facilitated exchange would look like

D)information related to ways to address health care efficiencies and access

i) health care provider status in Montana and shortages plus options for expanding access
ii) use of the Board of Medical Examiners and the Board of Nursing licensing and renewal process to improve data gathering needed by DPHHS and as a way of decreasing the amount of time spent by physicians and others in responding to the same questions by various credentialing organizations.
iii) network adequacy for managed care insurers - having a hospital, primary care provider, and pharmacy within a 30-mile radius of enrollee
iv) other??

IV. What to expect in the near future

Appendix A — Common terms and how they are used/referenced in the Affordable Care Act

Appendix B — Questions for legislative consideration

health insurance exchange.

2. The 2011 Legislature had passed a bill (SB 228) that would have prohibited a state role in creation of a health insurance exchange; the governor vetoed that bill.
3. There was nearly 100% certainty as the interim began in mid-2011 that the U.S. Supreme Court would have a role in determining the fate of the Affordable Care Act. The Supreme Court's June 28, 2012, ruling upheld the Affordable Care Act except for a Medicaid expansion-related penalty. By then, the Economic Affairs Committee had one meeting left in the 2011-2012 interim.

Post-Supreme Court ruling considerations--In late August 2011 the Economic Affairs Committee heard from federal officials that the state would have a federally facilitated exchange when all health insurance exchanges are to start operating on Jan. 1, 2014. That expectation sets the tone for the remainder of 2012 as far as Montana's activities related to a health insurance exchange. What remains unknown until election day Nov. 6, 2012, especially for the 37 states that have not yet definitively said they would create a state-run health insurance exchange, is what party will control the House, the Senate, or the White House and whether there are sufficient votes in Congress to overturn the Affordable Care Act, as suggested by some members of Congress and congressional candidates, at least to the degree that health insurance exchanges and mandates to buy health insurance are no longer federal law.

Taking into consideration that November's elections will be two months after the Economic Affairs Interim Committee finishes its work, this report is presented to provide background information on those parts of the Affordable Care Act, which remains law unless repealed, that affect health insurance exchanges. The following dates are sufficiently important to put into the overview and will be explained in more detail in the report.

- **Sept. 30, 2012.** At this time all states are to let the federal government know which health insurance plan in their state is to be used as the essential health benefit plan for a health insurance exchange. Four choices are available to each state (to be discussed later in the report), but the federal default benchmark plan (if a state

fails to make a choice) is the plan that serves the largest number of policyholders in the small group market, based on enrollment data collected in the first quarter of 2012. As of mid-2012, that federal default benchmark plan in Montana is the Blue Dimensions plan of Blue Cross Blue Shield of Montana.

- **Nov. 16, 2012.** The federal government has asked each state to file a declaration letter and a Blueprint that reviews the degree of readiness and preparation for states to run a state-based exchange or partner with the federal government on an exchange. Even if a state, like Montana, is expecting to have a federally facilitated exchange, federal officials are encouraging the state to say whether it will perform regulatory functions in "partnership" with the federally facilitated exchange and whether it will continue to make Medicaid eligibility decisions.
- **January 2013.** The federal government originally planned to announce by Jan. 1, 2013, the states that are on their way by Jan. 1, 2014, to a state-run health insurance exchange, the states that will partner on regulatory functions with the federally facilitated exchange, the states that will have a federally facilitated exchange with no partnership, and the states that will perform Medicaid eligibility decisions for the exchange. This announcement now may be sometime in January 2013.
- **Oct. 1, 2013.** Open enrollment begins on this date in the individual market exchange and the SHOP exchange. Any plans offered on the exchanges will be in effect as of Jan. 1, 2014. Prior to Oct. 1, 2013, the operator of a health insurance exchange must first have certified issuers and qualified health plans to be offered in the individual and small group markets, loaded the plans onto the website, and tested the website. Testing means that all the technical aspects of an exchange also must be in place. These include a way for a person trying to obtain insurance on the exchange to determine if he or she is eligible for Medicaid or for tax credits or cost-sharing reductions from the federal government for a qualified health plan[4] purchased

[4]The term "qualified health plan" indicates that the governing body of a health insurance exchange has determined that the plan meets the criteria for a plan offered on an exchange and thus is "qualified". The terminology also distinguishes health insurance exchange plans from those not offered on the exchange even if they are the same or similar.

through the exchange.[5] In this first year only, the open enrollment period for the individual market exchange will end on March 31, 2014, a longer enrollment period intended to allow people to become familiar with the exchange. (Small businesses in the SHOP exchange are to have open enrollment on a rolling basis, using a 12 consecutive month plan year.)

- **Jan. 1, 2014.** Health insurance plans offered on the health insurance exchanges go into effect. Also, on this date health insurance plans may no longer impose annual limits on benefits or discriminate on the basis of health status (including no denial for preexisting conditions). Under the "individual responsibility" portion of the Affordable Care Act, all individuals who file a federal income tax return will have to state on their 2014 income tax filing whether they had health insurance in the year 2014. If they did not have health insurance for even one month and were not exempt for various reasons (see later in this report), they may be assessed a penalty by the Internal Revenue Service as part of their 2014 tax filings.

Economic Affairs activities---- In deciding its time distribution for activities in the interim, the Economic Affairs Interim Committee adopted a limited HJR 33 study plan so there would be adequate time for other required activities. In short, under the HJR 33 study, the Economic Affairs Committee:

- heard in late August 2011 from federal officials that, even if Montana's 2013 Legislature acted quickly to authorize a state-run health insurance exchange, the state would not have enough time for a state exchange to be operating as of Oct. 1, 2013, as required under the Affordable Care Act. Therefore, Montana will have a federally run health insurance exchange.
- learned that there is a possibility of a federal-state partnership on the exchange and that a state could take over from a federal exchange after at least one year's notice and the submission of an approved transition plan. Federal guidance issued this summer indicated that federal grant funding may be used for implementation until Jan. 1, 2015, at which time the exchange is to be self-supporting.

---

[5]Some observers (Sen. Joe Balyeat made comments like these at one of the Committee's meetings) question whether the exchange deadline will have to be postponed because of the various difficulties of getting an exchange up and running. These include putting a federal "hub" into place as part of an exchange's eligibility checker to determine a person's eligibility for Medicaid or subsidies. The hub is to run a person's name through databases of various federal agencies, including the Internal Revenue Service and Immigration and Customs Enforcement, to make sure a person is eligible to participate in the exchange and, if so, whether the person is eligible for subsidies.

- decided to monitor activities related to health insurance exchanges nationwide and limited further action on the HJR 33 study until after the U.S. Supreme Court ruling.
- heard from insurers at the June 2012 meeting about what aspects of the Affordable Care Act insurers might continue if the act were to be overturned or revised;
- heard about expectations of how Medicaid and the Indian Health Service might interact with a health insurance exchange; and
- heard about access to health care including a discussion about a new health insurance cooperative that received startup funding under the Affordable Care Act and information regarding medical provider availability in light of an expected increase in the number of insured people trying to access their health care benefits.

This report provides some basic information that may be of help to Montana legislators as they debate the Affordable Care Act implementation in Montana or the more basic question of how to deal with an important sector of the economy affecting citizens as well as businesses that provide health insurance plans as a benefit to their employees. In Appendix A, there is a list of terms related to the Affordable Care Act along with descriptions from proposed -- or -- adopted federal rules. Appendix B provides questions for consideration on health care reform for as long as the Affordable Care Act remains on the books.

I. Committee Activities

The work plan--as proposed

The first step by the Committee involved a survey (Appendix B in the work plan) to determine the scope of the HJR 33 study. The survey indicated the Committee's top priorities for the HJR 33 study were:

- the scope of service in an exchange, insurance plan components, and how to address state mandates whether an exchange is state, regional, or federal (high + medium scores = 6 of 8). Because federal officials said in August 2011 that Montana would have a federal exchange, these aspects were not explored.
- the technological components of an exchange and what is needed for a state, regional, or federal interface. Because of some confusion about the term "technological", this was included even though "high" and "low" each had 3 votes. The committee had one presentation in August 2011 on the interface between an

exchange and Medicaid. All remaining interface questions were dependent on federal guidance as to how a state would interact with a federal exchange.

- the interaction of an exchange with Medicaid and the potential for premium assistance and Medicaid waivers. (Only 1 low-priority score, with 3 high, and 4 medium). There was a request to expand this section to address how the Indian Health Service and nonreservation Indians fit into the exchange concept, which was addressed indirectly at an August 2011 meeting (see below).

The following topics were not addressed because of tie votes or a predominance of low priority votes: whether to review the role of insurance producers and agents in an exchange, the issue of insurance competition in Montana and possible impacts if insurance sales were to be allowed across state lines, the interaction of the state health plan and an exchange; and whether to address factors related to aggregation of premiums for employees with multiple employers. (The latter was intended to look at options for employees who work several jobs but may not receive health insurance benefits at any of them and what an exchange might do to coordinate payments if any of the employers provided them.)

The work plan that developed (based on expectations for a federal exchange here)
The Committee asked at its first meeting in June 2011 if federal officials could address the Committee on whether Montana would be able to qualify to have a state exchange given the time constraints related to the late 2012 federal deadline for certifying the possibility of a state exchange by Jan. 1, 2013. Montana's legislature is not scheduled to meet until Jan. 7, 2013. Moreover, while governors issued executive orders in some states to begin the process of developing a state exchange, two separate legal opinions--one from the State Auditor's Office and the other from the legislature's Legal Services Division--said, respectively, the insurance commissioner and the governor in Montana had only the authority granted by law and that no state law grants the authority to establish a state-based exchange by executive order.

The Affordable Care Act requires that health insurance exchanges, whether state-operated or federally operated, be running as of Jan. 1, 2014, with enrollment in insurance plans taking place in the previous quarter (starting Oct. 1, 2013) so that policies are effective as of Jan. 1, 2014. Evidence that a state has made substantial progress towards establishing a state-based exchange must be presented in the Blueprint submitted by Nov. 16, 2012, before the Department of Health and Human Services gives the go-ahead for that state for a state-based rather than a federally facilitated exchange.

At the Committee's Aug. 23, 2011, meeting Marguerite Salazar from the Denver regional office of the Department of Health and Human Services met with the Committee in person and officials from the DHHS Center for Consumer Information and Insurance Oversight

(CCIIO) phoned in to discuss expectations for an exchange in Montana. Their basic response was that, because the 2011 Legislature did not pass authorizing legislation for a state exchange, Montana would have a federally run health insurance exchange.

But the federal officials opened the door on the prospect that Montana and other states still unsure about health insurance exchanges might eventually be able to take over an exchange in their state from the federal government or share the operational duties of an exchange. This concept generated a buzz the next day in Denver when CCIIO officials met with officials from several states in the region to discuss exchanges. Other states wanted to know what had been said in Montana about shared duties and transfer options.

In guidance released May 16, 2012, the Department of Health and Human Services reviewed these three types of health insurance exchanges and specified that for each type, there might be sharing of certain duties.

- A state-based exchange would operate all activities but may use federal services for premium tax credit and cost-sharing reduction determinations, or for the risk adjustment or reinsurance programs. Or the state may request exemptions from certain components.
- A state partnership would mean the state could choose to handle plan management or some consumer assistance activities (or both) on behalf of the federal exchange and may opt to determine Medicaid and CHIP eligibility. However, the federal government is ultimately responsible for all exchange functions.
- The federally facilitated exchange also would offer an option for states to operate the reinsurance program plus the assessment of commercial health insurers and determination of Medicaid or CHIP eligibility.[6]

These options all are predicated on the current Affordable Care Act remaining in place. Regardless of whether Montana voters approve Legislative Referendum 122, which would prohibit "the state or federal government from mandating the purchase of health insurance or imposing penalties for decisions related to purchasing health insurance",[7] in essence the state cannot prohibit federal officials from implementing the federal law.

Monitoring activities

---

[6]At an Aug. 22, 2012, Denver briefing Department of Health and Human Services officials pointed out that the Affordable Care Act allowed exchanges to both assess eligibility for Medicaid/CHIP and make at least a preliminary determination of Medicaid/CHIP eligibility. However, a person eligible for Medicaid/CHIP also can file directly with the state for Medicaid, and the state can make that determination. But no entity outside a health insurance exchange can determine what subsidies or assistance are available through the health insurance exchange for obtaining insurance.

[7]The language is from the Secretary of State website: http://sos.mt.gov/Elections/2012/BallotIssues/.

The combination of news that Montana would have a federally run exchange and the U.S. Supreme Court's decision in November 2011 to hear challenges to the Affordable Care Act put a damper on the Committee's study of an exchange, particularly because the Supreme Court was not expected to rule before late June 2012. At that late date the Committee would have only one meeting before completing its interim activities.

Keeping informed--The Committee asked to be kept informed of what activities were happening with health insurance exchanges. The following e-mail notifications went out:

- ***Aug. 20, 2011***, regarding responses to questions the Committee had about exchanges, plus federal reviews of insurance rates, and a description of how a computer system would be expected to work to determine eligibility for either subsidies on a health insurance exchange or eligibility for Medicaid;
- ***Dec. 16, 2011***, regarding federal guidance on essential health benefits that had to be covered in any plan offered on a health insurance exchange as well as on four types of health plans from which a state may choose a benchmark plan;
- ***Jan. 25, 2012***, regarding preliminary findings of three small group health insurance products ranked as the highest by enrollment that the state might consider as the essential health benefit benchmark plan. However, the State Auditor's Office later noted that the largest products by enrollment in 2011 were not all offered in 2012, so the 2012 versions would include some different names. The final determination of enrollment is being done now by CCIIO, based on enrollment numbers from the first quarter of 2012. This product is expected to be Blue Dimensions, offered through Blue Cross Blue Shield of Montana. If any essential benefit category is missing in the Blue Dimensions policy, a federal bulletin issued in late December 2011[8] said the state must supplement the policy with a benefit from another policy contained in the list of four choices. The four choices for a benchmark plan--if Montana had had the authority to choose--were: a) the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market, b) any of the largest three state employee health benefit plans by enrollment, c) any of the three largest national federal employee health benefit plan options by enrollment, or d) the largest insured commercial non-Medicaid health maintenance organization operating in the state.
- ***March 29, 2012***, regarding federal rate review of health insurance premium rate increases. Because Montana's insurance commissioner does not have rate review authority for major medical health insurance, the federal government assumed the task of determining whether insurers in the individual and small employer group market in Montana were requesting unreasonable rate increases as of September

[8]Department of Health and Human Services, Centers for Medicare & Medicaid Services, Frequently Asked Questions on Essential Health Benefits Bulletin, Dec. 16, 2011, accessed Sept. 5, 2012, at: http://cciio.cms.gov/resources/files/Files2/02172012/ehb-faq-508.pdf.

2011. The federal government does not review rate increases of less than 10%. The e-mail noted State Auditor Monica Lindeen in her review of her office's activities under the Affordable Care Act would be asked to address the posting of unreasonable rate increases. (She does this by posting a link to the CCIIO website regarding their findings on rate increases implemented in Montana.) The e-mail also noted that the U.S. Department of Health and Human Services had reviewed or would review 48 Montana policies with premium increases of 10% or more.

Impacts with Medicaid and Indian Health Service--Discussions about how an exchange would interact with Medicaid and with the Indian Health Service or tribal health services preceded Ms. Salazar's Aug. 23, 2011, presentation and responses by the CCIIO officials to questions posed by the Committee about health insurance exchanges.

Linda Snedigar with the Montana Department of Public Health and Human Services[9] provided information about the 30-plus categories of people who currently are eligible for Medicaid in Montana.[10] Existing Medicaid laws (prior to the Affordable Care Act) require coverage for children from lower-income families and pregnant women as well as low-income adults who are blind, disabled, or elderly. States vary in how they cover low-income adults with dependent children. Montana limits Medicaid for other adults to those with dependent children if the family's income is at or below 33% of federal poverty levels. This means single able-bodied adults between the ages of 18 and 65 are currently ineligible for Medicaid in Montana. Ms. Snedigar noted that the Affordable Care Act collapses existing categories into four main groups[11] and removed asset tests for many but not all of the categories. She also pointed out that under the Affordable Care Act more Montanans would be eligible as of Jan. 1, 2014, under a Medicaid expansion provision that makes all adults with incomes up to 133% (but actually up to 138%) of the federal poverty level eligible for Medicaid, including single, able-bodied adults.[12] However, Ms.

---

[9]Ms. Snedigar is now retired.

[10]See the categories for Medicaid eligibility at: http://leg.mt.gov/content/Committees/Interim/2011-2012/Economic-Affairs/Meeting-Documents/August/MedicaidCoveragegroups4-11.pdf.

[11]The simplification under the Affordable Care Act was intended to create four main groups eligible for Medicaid: parents, infants and children, pregnant women, and adults without children. The expansion would have replaced most asset tests with use of a modified adjusted gross income (MAGI) calculation, but the rules are not yet clear regarding asset tests and use of MAGI for existing Medicaid beneficiaries.

[12]Although not an issue unless a state opts for the Medicaid expansion and dependent on how the federal guidance may develop for states to expand their Medicaid programs, the Affordable Care Act generally said that as of Jan. 1, 2014, all adults not previously eligible for Medicaid and whose incomes were 133% of the federal poverty level, plus a 5% asset disregard, would be considered eligible for Medicaid. So Medicaid eligibility for adults under the Affordable Care Act generally was said to be up to 138% of federal poverty levels.

Snedigar's presentation occurred prior to the U.S. Supreme Court's ruling that had the effect of not only making the Medicaid expansion to childless, able-bodied adults an opt-in decision by each state but raised several other questions as to whether Affordable Care Act provisions would apply to existing Medicaid populations. In general, federal officials say all of the Affordable Care Act except the penalty provision related to Medicaid (which would have stripped states of all Medicaid funding for nonexpansion) remain intact, but that guidance is still being written on several questions.

The complexity of determining whether a person would be eligible for Medicaid or for subsidies under a health insurance exchange was apparent in a draft chart developed by Public Knowledge LLC under contract with the State Auditor's Office as part of the planning process for a health insurance exchange. Key to determining eligibility of one or the other form of assistance would be a federal "hub" that interacts with the Internal Revenue Service, the Social Security Administration, the U.S. Department of Health and Human Services, and the U.S. Department of Homeland Security (to determine citizenship).[13]

Ms. Snedigar noted that Montana's existing CHIMES eligibility system for Medicaid has the technological components necessary to meet the part of the process for consumers to determine if they are eligible for Medicaid. She explained that the public assistance officials would help with paper applications for those without access to the Internet and would be part of what is considered a "no wrong door" approach to helping people access Medicaid coverage as well as various public assistance benefits, including Temporary Assistance to Needy Families (TANF) funding or the Supplemental Nutrition Assistance Program (SNAP - formerly Food Stamps).

Under the Affordable Care Act's individual mandate, Indians and certain others[14] are not penalized if they do not obtain health insurance. However, other provisions of the Affordable Care Act still apply to Indians who have health insurance through employers. An Indian Health Service (IHS) representative was unable to present to the Committee his assessment of the impact of the Affordable Care Act on IHS or Indians getting health care on reservations, but a tribal health official with the Confederated Salish and Kootenai Tribes (CSKT) described how the CSKT expected to work with the Affordable Care Act. The CSKT administration operates health clinics under a self-governance compact with

---

[13]See the sample eligibility pathway at: http://leg.mt.gov/content/Committees/Interim/2011-2012/Economic-Affairs/Meeting-Documents/August/Exchange-Medicaid-pathway-sample.pdf.

[14]Others exempt from the penalty under the Affordable Care Act if they have not obtained health insurance are: people whose incomes are too low to require them to file federal income taxes, certain members of health-sharing ministries, those who find that a health care plan would cost more than 8% of their household income, and those who obtain an exemption from the Secretary of the Department of Health and Human Services.

the federal government.

Kevin Howlett of CSKT noted that the Affordable Care Act permanently reauthorized the Indian Health Care Improvement Act and further pointed out that the IHS is a payer of last resort, so that those who are eligible for Medicaid are expected to be enrolled in Medicaid before IHS pays. He noted that the state's eligibility determinations still would apply to Indians on Medicaid but that there is no state or tribal obligation to match Medicaid payments. This means 100% federal reimbursement for those on Medicaid at tribal clinics.

Mr. Howlett pointed out that because so-called urban Indians may not have ready access to Indian Health Service clinics or hospitals or tribally run health centers, he was uncertain how non-Indian agencies would provide services for Indians living in urban areas. Mr. Howlett reviewed reasons for Indians to sign up on a health insurance exchange. Among these were that the IHS is funded at only about 50% of its expected expenditures. For those who want to ensure coverage year-round or access to care other than "life or limb" emergency care from IHS, insurance or Medicaid is necessary. Mr. Howlett also noted that access to catastrophic care coverage is available through IHS but that access through a health insurance exchange to catastrophic coverage might make more sense. He emphasized that if Indians rely solely on IHS for care, they may not get the care they need because funds are unlikely to be available throughout the fiscal year.

Indians are eligible to purchase health insurance through the exchange. Unlike other citizens, they are eligible for affordability credits (no cost-sharing) if they have incomes up to 300% of the federal poverty level. Also available to all who are at least 19 years old and not yet 30 years old, whether they are Indian or not, is catastrophic coverage.

Reviewing insurers' expectations and plans for a Montana Health CO-OP--At the Committee's April and June 2012 meetings, insurers reviewed their expectations for serving Montana's health insurance needs, regardless of how the U.S. Supreme Court ruled on the Affordable Care Act.

In April 2012 Dr. Tom Roberts of Missoula, one of a group of Montanans working to obtain a grant under the Affordable Care Act to establish a health insurance CO-OP or consumer-operated and oriented plan, provided background information on the Montana Health CO-OP and noted that the organizing group expected to continue to operate the alternative insurance plan regardless of the U.S. Supreme Court's then-unknown ruling on the Affordable Care Act. Dr. Roberts noted that the roughly $58 million from the U.S. Department of Health and Human Services was part of a signed contract providing for start-up funds as well as for a loan to establish reserves in the early stages of the CO-OP.

At the Committee's June 2012 meeting, still not knowing the fate of the Affordable Care

Act, the Committee heard from Montana's major insurers[15] about what aspects of the Affordable Care Act they might continue if the act were to be overturned or revised. Although not all the insurers at the meeting were comfortable saying whether they would retain consumer-friendly portions of the Affordable Care Act that already were in place, several insurers noted that these provisions were popular and might be retained. The most commonly mentioned provisions likely to be retained were: allowing single or married adult children up to the age of 26 to stay on their parents' health insurance plans (similar to a Montana law that already allowed unmarried children up to the age of 25 to stay on their parents' plan), requiring coverage for children up to the age of 19 regardless of pre-existing conditions, eliminating lifetime limits on insurance policies and (for certain plans) removing cost-sharing for preventive or wellness care.

Hearing dissent--Also at the April 2012 meeting a representative of Americans for Prosperity, Henry Kriegel, presented at least 220 identical petitions, all individually signed by Montanans across the state who were opposed to the Affordable Care Act. Committee members also voiced concerns about the Affordable Care Act and questioned whether various deadlines would be extended. (At least in terms of the availability of establishment grants, the federal government did extend the deadline past late 2012.)

II. Committee Recommendations (if any)

III. Background Information

A. Issues regarding health insurance reforms

The health care reform debates involve not only individual responsibility but the roles of the federal and state governments in helping to maintain a healthy citizenry necessary for a secure nation and a sound economy. Not everyone agrees on the extent a state is to be involved or even the core problems. Complicating the discussion is a frequently made claim that the United States has some of the world's best health care (disputed by some), albeit at some of the highest prices and unavailable to or unaffordable by the entire population (rural and urban).

What may be helpful for legislators to keep in mind is that, when considering health care reforms, the following elements are involved and interact.

a) coverage expansion vis-a-vis coverage skepticism and the "individual mandate"

---

[15]Major insurers were determined generally by policyholder numbers and presence in Montana. Representatives at the meeting were from Blue Cross Blue Shield of Montana, Cigna/Allegiance, Pacific Source (which obtained some of New West's policies while Blue Cross Blue Shield obtained others after New West decided to focus on its Medicare Advantage business), New West, and Assurant (which is the parent of John Alden and Time Insurance companies.)

b) health care costs
c) costs to government/taxpayers
d) access to care.

Coverage Expansion - The Affordable Care Act built on two existing coverage options:

- private insurance, particularly for those with job-related health insurance or those who can afford insurance, and
- Medicaid plus CHIP (children's health insurance program - known in Montana as Healthy Montana Kids, which is a combination of Medicaid and CHIP funding for children) for those minimally able or unable to pay.

Although there is debate about whether the Affordable Care Act provided incentives for employers to stop providing health insurance to employees (because the cost of paying insurance premiums was more than the Affordable Care Act penalties for not providing the insurance), the Affordable Care Act's proponents generally contend the legislation was aimed at expanding the number of people covered by either private insurance or public coverage, such as Medicaid. The thought behind expanded coverage was that, with more people having insurance or health care financing there would be less uncompensated or charity care and more preventive care.

Health insurance exchanges also are intended to help individuals and small business employers compare insurance plans (in part because these insurance plans had to have similar basic components--including actuarial values[16]) and obtain coverage in a way familiar to them (like online airline ticket pricing). A health insurance exchange thus is intended to provide an easier way for consumers and small businesses[17] that choose to do so to compare policies and obtain health insurance.

In addition, not only are health insurance exchanges intended to be marketplaces where qualified health insurance plans can be compared, but they are the only way that individuals can obtain federal advanceable tax credits to help lower the cost of the health plans purchased through the individual health exchange for those with incomes between 100% and 400% of the federal poverty level.

16

[17]A report available on the federal government's website related to the Affordable Care Act noted that small businesses that do not have specialized departments to help sort through insurance plans may pay as much as 10% more than large businesses for broker fees and face administrative costs that are three times higher than those in the large group insurance market. See "Health Insurance Premiums: Past High Costs Will Become the Present and Future Without Health Reform", Jan. 28, 2011, at: http://www.healthcare.gov/law/resources/reports/premiums01282011a.pdf, accessed Aug. 20, 2012.

Coverage skepticism -- Not everyone believes that insurance or government-paid coverage for health care is necessary. Those with this general philosophy believe a person is individually responsible for his or her own health and health care bills and for negotiating any deductions based on cash or speedy payments. Another variant of this philosophy is that an insurance policy, particularly one purchased by a third party such as an employer or coverage provided by the government, results in a disconnect regarding use of medical care and its cost because those who access health care are not directly those who pay for either the insurance or the health care. Another variant is for people who participate in a type of religious or other health-sharing ministry in which the ministry contributes cash to help a member of the community meet budget-breaking medical bills. No insurance is involved and any charges are either full or reduced based on negotiation or an agreement to pay in cash or upon billing. This type of coverage is allowed under the Affordable Care Act, and individuals who participate in qualified health-sharing ministries are exempt from the individual mandate, called in the Affordable Care Act the individual responsibility requirement.

The beliefs of those who see payment for health care as a personal responsibility obviously conflict with the access-to-health-care-as-a-human-right group or those who see that having more people covered by health care financing of some kind is one way to help address health care costs. The theory behind insurance or health care financing as a way to combat rising health care costs is twofold:

- more people with major medical insurance, self-funded health plans, a public health plan, or other type of health care financing decrease the number of those uninsured who either pay on a long-drawn-out installment plan, receive charity care provided by hospitals, or go into medical bankruptcy and have their debt written off. These people also have little or no access to healthcare provider discounts. If more people have insurance or health care financing, the thinking goes, hospitals have less need to increase the hospital/provider charges to insurers and other reliable payers to offset the costs of those who do not pay or whose bills are reduced because of an inability to pay.[18] See Table 1 for Montana hospitals' charity care and debt writeoffs as a percentage of total charges for four Montana hospitals for 2009-2010.[19]

---

[18]Note that there is a difference between "costs" and "charges". Payments may be based on one or the other. For example, Medicare tends to pay based on "cost plus a percentage" and insurance plans tend to deduct a certain percentage of "charges" based on negotiations with providers.

[19]This memo for the Revenue and Transportation Interim Committee is available at: http://leg.mt.gov/content/Committees/Interim/2011-2012/Revenue-and-Transportation/Meeting-Documents/February%202012/SJ23%20Data%20memo%20summary%20020712.pdf. See also the fifth annual report for Montana Attorney General Steve Bullock on Montana hospitals' charity care, 2011, which may be accessed at: https://dojmt-zippykid.netdna-ssl.com/wp-content/uploads/2012-AG-Hospital-Report.pdf, The data in that report is based on charity care as a percent of operating expenses. It shows of larger

Table 1(a): Charity care and bad debt for selected Montana hospitals, 2009 and 2010

	2009			2010		
Hospital	**Bad debt as % of all charges**	**Charity care as % of all charges**	**Bad debt & charity care as % of all charges**	**Bad debt as % of all charges**	**Charity care as % of all charges**	**Bad debt & charity care as % of all charges**
Billings Clinic	3,75%	3.41%	7.16%	3.82%	3.65%	7.47%
Kalispell Regional	4.92%	2.60%	7.52%	3.35%	2.65%	6.00%
St. Peter's	2.17%	1.56%	3.73%	4.62%	2.48%	7.10%
St. Vincent	4.49%	4.36%	8.85%	3.34%	4.97%	8.31%

Source: Megan Moore memo to the Revenue and Transportation Interim Committee, "Hospital Bad Debt and Charity Care Updated Data for SJR 23 Study", Feb. 6, 2012.

Table 1(b) Charity care, bad debt, uncompensated care for selected hospitals, 2010

Hospital	**Charity costs (in millions)**	**Bad debt cost (in millions) (not a "community benefit")**	**Charity care and bad debt = uncompensated care (in millions)**	**Uncompensated care as % of operating expenses**
Benefis Hospital, Great Falls	$8.136	$6.940	$15.076	4.98%
Bozeman Deaconess	$4.785	$6.034	$10.819	7.12%
Community Medical Center, Missoula	$1.351	$3.428	$4.779	3.57%
St. James Hospital, Butte	$3.510	$4.497	$7.907	8.48%
St. Patrick Hospital, Missoula	$11.167	$4.982	$16.149	7.44%

hospitals: St. Patrick Hospital in Missoula at 5.14%, serving 3,976 approved applications, St. Vincent Hospital in Billings at 4.05% serving 2,215 approved applications, St. James Hospital in Butte at 3.66% serving 667 approved applications, Bozeman Deaconess Hospital at 3.15% serving 4,742 approved applications, Billings Clinic at 2.83% serving 8,933 approved applications, Benefis Great Falls at 2.69% serving 7,261 approved applications, St. Peter's in Helena at 1.98% serving 2,113 approved applications, Northwest Healthcare/Kalispell Regional Hospital at 1.47% serving 5,367 approved applications, Northern Montana Medical Center in Havre at 1.34% serving 267 approved applications, and Community Medical Center in Missoula at 1.01% serving 3,259 approved applications. At all the major hospitals, the accounts turned over for collection (bad debt) was higher as a percent of operating revenues than their charity care.

Source: Lawrence L. White, Jr., "Fifth Annual Report prepared for Montana Attorney General Steve Bullock: Montana's Hospitals, 2012", accessed Aug. 20, 2012, at https://dojmt-zippykid.netdna-ssl.com/wp-content/uploads/2012-AG-Hospital-Report.pdf.

The report being prepared by Gregg Davis and the Bureau of Business and Economic Research indicates that Montana hospitals provide approximately $150 million in uncompensated care annually, which is the combination of charity care and bad debt.

Individual mandate debate -- Further exacerbating the divided belief systems is the "individual mandate", termed in the Affordable Care Act as the individual responsibility requirement for most Americans[20] to have some form of essential health benefits coverage through private insurance, an employer health plan, or government coverage. In general, those opposed to the individual mandate either are less likely to support an insurance-based system and therefore dispute the premise of insurance coverage or they oppose a federal government requirement for coverage. In contrast, those who see a need for insurance saw the following dilemma potentially undermining the pooling-of-risk concept of insurance: once the Affordable Care Act required an insurance company to cover an insured person regardless of health status, then costs would increase for the insurance company to cover these conditions. Without additional participation (premium payments) by the healthy who have less immediate need of health insurance, the costs for those paying for insurance would only climb while those without insurance would be able to delay buying insurance until they had a health problem.

As decided in the U.S. Supreme Court's 5-4 ruling on the Affordable Care Act, the "individual mandate" is less a requirement to buy insurance than to pay a penalty (called a tax in the opinion by Chief Justice John Roberts) for not having insurance. The tax or penalty is for each month without coverage for each individual but not to exceed either a flat dollar amount of $695 in 2016 (increasing over time by an inflation index) or 2.5% of an individual's household income, whichever is greater, but not exceeding the cost of a bronze plan. A bronze plan annual premium must cover 60% of the cost of 10 specified services (that is, essential benefits).

Although the 2011 Legislature enacted 2-1-501, MCA (SB 125), which prohibits state employees from implementing the individual mandate, the Internal Revenue Service will

---

[20]Those with exemptions to the individual mandate include: Indians (whether living on a reservation or not), those who do not have incomes meeting the federal income tax filing threshold, those who find that a health care plan would cost more than 8% of their household income, those who receive a hardship exemption from the Secretary of the Department of Health and Human Services, and members of health care sharing ministries (described in the Affordable Care Act and requiring, among other conditions, a 501(c)(3) IRS status and a shared set of ethical or religious beliefs). Section 1411(b)(5) of the Affordable Care Act.

be handling enforcement, and the state law does not impede federal employee actions.[21]

Costs - Both those who don't see a need for insurance and those who do have an interest in reining in health care costs. Combined, the expanded coverage and easier access to health insurance were expected by Affordable Care Act proponents to help reduce the rapid rise in health care costs in previous decades. Yet, a big unknown related to the reform portions of the Affordable Care Act is whether all reforms combined will in fact increase the cost of health insurance.

With the U.S. Supreme Court's action to declare unconstitutional the penalty for not expanding Medicaid because it was "coercive" to the states, a significant number of low-income people are expected not to have the ability to pay for health insurance; this group was the population pool for the expanded Medicaid program. A report to the Children, Families, Health and Human Services Interim Committee on Aug. 20 by Gregg Davis of the University of Montana Bureau of Business and Economic Research indicates that about 72,000 Montanans would be in the new donut hole of those whose incomes are between 33% of the federal poverty level (the current threshold for adults with dependent children) and less than 100% (the percentage at which people may qualify for subsidies in a health insurance exchange). For this group, uncompensated care may still be a result of no coverage, which would lead to the hospitals continuing to shift their costs to those with insurance or others paying out-of-pocket. A related problem is that the Affordable Care Act offset the cost increases projected under the legislation with a reduction in disproportionate share hospital (DSH) payments, which have been paid to hospitals to help compensate them for serving high numbers of Medicaid patients and those uninsured patients who have trouble paying their hospital bills. (DSH payments are intended to offset the generally lower reimbursement hospitals receive from Medicaid than from private insurers.) DSH payments are scheduled to be decreased under the current law regardless of whether Medicaid expansion does not occur and a substantial number of people remain without insurance, potentially defaulting on their hospital bills.

Below are a combination of options variously proposed for reducing costs, some within the Affordable Care Act and some by those opposed to the Affordable Care Act yet still concerned about rising health care costs.

- ***Emphasizing prevention and wellness.*** To encourage use of health care services aimed at preventing health problems, the Affordable Care Act required all

[21]Interestingly, the U.S. Supreme Court's decision on the Affordable Care Act referenced a 1997 case, Printz v. United States, in which the U.S. Supreme Court ruled that a Ravalli County sheriff could not be forced to implement federal gun control laws. The decision, written by Justice Antonin Scalia, referred to the dual sovereignty of the federal government and state governments.

nongrandfathered[22] health plans to cover preventive services without charging a deductible, a co-pay, or coinsurance. (Insurers presumably redistribute these costs in premium calculations.)

- ***Tort reform.*** Advocates of tort reform say that many medical providers order too many needless tests as a way of protecting themselves against a lawsuit for errors of omission. Others say the high cost of malpractice insurance in general is a reason for higher medical costs and that million-dollar settlements are the reason for high malpractice insurance premiums. Montana and many other states limit noneconomic damages, which are often the focus of malpractice reforms.[23] Also, the most recent report (2010, released in October 2011) from the Montana Medical Legal Panel indicates that filed claims in 2010 hit an 11-year low of 177, of which another 11 year low of 51 were in lawsuits after the panel review.[24]

- **Competition.** There are at least two approaches here.
  - Under the Affordable Care Act competition is expected to increase by helping consumers more easily compare insurance plans through the exchanges and by having at least two multi-state plans offered in addition to whichever local plans are determined to be qualified. Funding to help set up local health insurance co-operatives also was a way of increasing competition under the Affordable Care Act. Studies[25] have shown that many states, including Montana, have a large share of their health insurance market concentrated among one or two insurers. (See Section B on health insurer status.)
  - Many proponents of competition have suggested that insurers ought to be

---

[22]The nongrandfathered health plan are those not meeting the Affordable Care Act's criteria for a grandfathered plan, which is a group health plan created (or an individual health policy purchased) on or before March 23,2010, and not changed significantly to reduce benefits or increase costs to consumers.

[23]A 2003-2004 study of medical malpractice reviewed noneconomic damages and various other tort reform ideas being discussed nationally. See: http://leg.mt.gov/content/Committees/Administration/Legislative%20Council/2003-4/Subcommittees/Staff%20Reports/final_3.pdf. The report notes on p. 38 that Montana law since 1995 has limited the award for medical malpractice against one or more health care providers in a single incident to no more than $250,000 for noneconomic damages. (See 25-9-411, MCA). Background information on defensive medicine is available in a briefing paper presented at a 2010 meeting of the Children, Families, Health, and Human Services Committee. See: http://leg.mt.gov/content/Committees/Interim/2009_2010/Children_Family/Assigned_Studies/SJR_35/sjr35-defensive-medicine-april2010.pdf

[24]See Montana Medical Legal Panel 2010 Annual Report, as of Oct. 27, 2011, accessed Sept. 5, 2011, at: http://www.mmaoffice.org/pdfs/MMLP%202010%20Annual%20Report.pdf.

[25]See, for example, a Kaiser Family Foundation "Focus on Health Reform: How Competitive are State Insurance Markets?", October 2011, accessed at http://www.kff.org/healthreform/upload/8242.pdf in in August 2012.

able to sell policies that conform to one state's policies in other states without having to meet all the regulations and mandates of each state in which a policy is sold. Opponents of this idea say that each state's insurance regulator provides consumer protection for policyholders and that state legislatures were responsible for the mandates and regulations initially and could revise them. They also point out that the Affordable Care Act requires all individual and small group market plans to include coverage for the 10 essential health benefit categories, some of which currently are not within neighboring states' mandates but will be required to be offered in all health plans in the individual and small group market. For a summary of nearby states' mandates, see Table 2. The essential benefit requirement will minimize the differences in mandates between Montana and neighboring states with fewer mandates. HB 445 in the 2011 session outlined ways to handle out-of-state policy sales in Montana, but the bill failed to get final legislative approval.

Table 2: Two calculations of health insurance mandates in nearby states

Mandate Types	MT	ND	SD	ID	WY	CO	UT
as calculated by the Blue Cross Blue Shield Association							
mandated benefits[a]	15	12	9	6	9	20	6
mandated benefit offerings[b]	1	1	2	0	2	4	4
mandated providers [c]	13	5	15	1	17	14	19
mandated provider offerings	0	3	0	0	0	0	0
as calculated by the Council for Affordable Health Insurance							
mandated benefits	19	21	12	6	11	30	16
mandated providers	12	10	10	2	19	20	3
Total range	29-31	21-31	26-22	7-8	28-30	38-50	19-29

(a) Mandated benefits include such requirements as newborn screenings for metabolic and PKU disorders, well-child care and immunizations, among others.
(b) Mandated offerings either require an option for coverage, which can be chosen or rejected by the purchaser, or say that if a benefit is offered then it must be equal across policies.
(c) Mandated providers require insurance to cover certain medical providers, including physicians, chiropractors, advanced practice registered nurses, and physician assistants.
Source: National Conference of State Legislatures website accessed July 13, 2012: http://www.ncsl.org/issues-research/health/state-ins-mandates-and-aca-essential-benefits.aspx#State_list

- **Minimizing regulation.** The American Legislative Exchange Council, among others, has suggested that because state and federal mandates and regulations regarding health insurance drive up costs for insurers then states ought to be able

to form interstate compacts that minimize both federal and state regulations. The Health Care Compact Alliance has provided model legislation for compacts, which as of April 2012, had been adopted by six states.[26] To be fully in effect, Congress has to approve the compact and this has not yet happened. A Montana version, HB 526, passed the 2011 Legislature but was vetoed by the governor. Part of the compact would require that federal funds, except for those for veterans and Indian health care but including Medicaid and Medicare, be distributed to the states, somewhat as a block grant. An interstate advisory health care commission consisting of one to two representatives appointed by each member state (each representative has one vote) and funded by the states would gather and publish health care data and make nonbinding recommendations. Key to the ability of the states to regulate health care is the following compact language:

> "Each member state, within its state, may suspend by legislation the operation of all federal laws, rules, regulations, and orders regarding health care that are inconsistent with the laws and regulations adopted by the member state pursuant to this compact".[27]

- **Increasing regulation (at least in Montana).** The Affordable Care Act contains a presumption that insurance companies have increased premium costs not just to pay for health care but to increase their operating revenues. Among measures in the Affordable Care Act to increase insurance company accountability was a requirement that insurers must spend 85 cents of each large group market premium dollar or 80% in the individual/small group market on health care costs while the rest can go toward overhead and administrative costs. These percentages are called the medical loss ratio. Insurers that failed to meet the medical loss ratio requirement were to issue rebates in August 2012 to policyholders. Rebates in Montana and nearby states are listed in Table 3.

  The Affordable Care Act also requires rate review of proposed premium increases of 10% or more in the individual and small employer group market. States that already had authorization under their own laws to review health insurance rates were to post the information about the increases. Most state insurance regulators have the authority to reject rate increases that are determined to be unreasonable or unjustified. For states like Montana that do not have major medical health insurance rate review authority, the federal government reviews rate increases. However, the federal government has no enforcement

[26]As reported by the National Conference of State Legislatures in an April 19, 2012, Patient Protection and Affordable Care Act; State Action Newsletter, the compact has been considered in 25 states and signed into law in Utah, Indiana, Georgia, Missouri, Oklahoma, and Texas.

[27]The Health Care Compact model legislation, accessed Aug. 19, 2012, is available at: http://healthcarecompact.org/sites/default/files/The_Health_Care_Compact_FINAL2.pdf.

other than a requirement to post which insurers have unreasonable rate increases. Separately, insurers are required to publish the determination of unreasonable or unjustified rate increases on their own website and may be barred from operating in a health insurance exchange. The federal government determined that all Assurant health plan premium increases reviewed (12 for John Alden Life Insurance Company and 12 for Time Insurance Company, each with a 15% increase) were unreasonable. (Assurant reportedly paid the premium rebates to its policyholders as required under the Affordable Care Act.) Blue Cross Blue Shield of Montana plans that were reviewed, including some with an 18% increase, received a "not unreasonable" label, with three BCBSMT plans still pending review in August 2012. These each had an 18.5% increase. In all, rate increases for half of the 48 plans reviewed by the federal government for Montana were considered unreasonable and the other half were not.[28]

Table 3: Rebates from insurers based on failure to meet the 80-20 or 85-15 requirement for benefits paid vs. administrative costs.

Rebate characteristics	MT	ND	SD	ID	WY	CO	UT
Individual market enrollees benefiting from a rebate	16,825	4,229	1,370	1,083	5,201	109,460	47,358
Average rebate for a family	$203	$5	$68	$323	$356	$44	$145
Small group market enrollees benefiting from a rebate	8,528	0	0	31,493	1,089	2,916	33,534
Average rebate for a covered family (if the policyholder decides to rebate the amount received from the insurer)	$180	$0	$0	$63	$319	$403	$7

Source: Department of Health and Human Services, "The 80/20 Rule: Providing Value and Rebates to Consumers. Appendix II, released June 21, 2012.

Another increase in regulation is that under the Affordable Care Act all nongrandfathered health plans in the individual and small employer group market must contain at least 10 essential health benefits. These are:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;

---

[28]Information accessed Aug. 12, 2012, at: http://companyprofiles.healthcare.gov/states/MT/rate_reviews?search_method=rate_reviews.

- 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.

Proponents argue that comparisons need to be equal for at least a certain set of benefits and that health care coverage must be more than just a few benefits to help cut down cost-shifting to cover uncompensated care. Opponents question how insurers are to offer choice and compete if every plan has to have the same basic coverage. As indicated by the choice of four options to determine a state's benchmark plan, variety is expected among the states. The benchmark plans named in late 2012 are to be in effect (with any designated supplements completing the 10 essential benefits) until 2016.

Costs to government/taxpayers - Not surprisingly, proponents of the Affordable Care Act point to the nonpartisan Congressional Budget Office's assertion that in 10 years the act will result in a budget benefit for the United States. Opponents say the act will increase the budget deficit. This may be a case where an economist phrase, "all things being equal", is important.

In March 2012, prior to the U.S. Supreme Court's decision that removed the penalty for expanded Medicaid noncompliance and the potential that all states would expand Medicaid with a 100% cost to the federal government for three years, the Congressional Budget Office estimated that for the years 2012 to 2021 net costs of the Affordable Care Act for insurance coverage would be $1.252 trillion. These costs include federal government outlays to:

- states for Medicaid expansion (100% of the costs to states that expand Medicaid as provided in the Affordable Care Act until 2016 when the percentage starts to drop);
- small businesses for tax credits if they provide health insurance to their employees; and
- people who are eligible for subsidized insurance premiums and are buying insurance through a health insurance exchange. Offsets[29] also are written into the bill for a net benefit to the economy over 10 years, as calculated by the CBO.

After the U.S. Supreme Court decision upholding most of the Affordable Care Act, the CBO revised its cost estimates and said the insurance coverage provisions of the Affordable Care Act would have a net cost of $1.168 trillion over the 2012-2022 period (note the extra year tacked on). The main reason for the lower estimate was, CBO said, because "reductions in spending from lower Medicaid enrollment are expected to more than offset the increase in costs from

---

[29]Some of the budgetary benefits are through reduced payments to health care or medical equipment providers. There is a concern that these offsets may not remain in effect. (Congress, for example, has routinely suspended cuts in Medicare rates to medical providers despite laws directing such reductions.)

greater participation in the newly established exchanges".[30] However, the new analysis did not include existing offsets from expected revenues or fees included in the Affordable Care Act. The initial analysis in March 2010, when the Affordable Care Act was passed, was a net decrease in the budget deficit for the 2010-2019 period of $143 billion. See Table 3 for an overview of CBO projected federal expenditures for Affordable Care Act insurance support.

Table 4: CBO estimates for federal insurance support under the Affordable Care Act

	2012	2014	2016	2018	2020
Medicaid/CHIP outlays	still looking for an apples-to-apples comparison				
Exchanges					

Costs to taxpayers for cadillac plans, threatened increases to Medicare costs, and the potential for more out-of-pocket costs are part of the debate over balancing budgets. The costs of the Affordable Care Act remain highly controversial but the key point is the difference of opinion between those who feel the Affordable Care Act may help control health care costs and those who feel the government's involvement will only increase costs. Costs for penalties for noncompliance with the individual mandate are expected to be lower than the cost of health insurance. The following are exempt under the Affordable Care Act from penalties: those who do not file federal income taxes because their income is too low (estimated at 165,259 families and individuals in Montana[31]), Indians, participants in a health-sharing ministry, those for whom plan costs exceed 8% of their income, and those given hardship exemptions by the Secretary of Health and Human Services.

B. Information gathered on the Affordable Care Act and health insurance exchanges

The overall Affordable Care Act was intended to expand in one of two ways the U.S. population that had some type of health care coverage. Those who were less likely to be able to afford insurance would be in the expanded publicly supported Medicaid population[32] while federal government subsidies would be available in the private insurance market through health insurance exchanges for those more able to purchase insurance. Although anyone buying

---

[30]Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decisions". Press release issued July 24, 2012. Accessed Aug. 19, 2012, at: http://www.cbo.gov/publication/43472.

[31]E-mail of Aug. 16, 2012, from Dan Dodds at the Montana Department of Revenue, based on 2010 income filing information of 506,372 families and individuals filing of which 341,113 Montana income tax returns had incomes above the federal income tax filing threshold.

[32]See p. 5 for the differences between the current and expanded Medicaid-eligible populations.

insurance individually or through a small employer might be able to obtain insurance either through a health insurance exchange (including what is called SHOP[33] or the small business health insurance option) or through the existing insurance market outside of an exchange, the subsidies are to be available only to those buying insurance on a the individual health insurance exchange who meet the following criteria:

- have incomes below 400% of the federal poverty level but above 100%; and
- are unable to buy health insurance through an employer group health plan, small or large.

In essence, health insurance exchanges are intended:

- to help individuals and employers of small businesses compare insurance options on a level playing field; and
- help those obtaining insurance in the individual health insurance exchange to get premium subsidies and cost-sharing credits.

Health insurance exchanges are more likely to be effective, according to the Affordable Care Act, if citizens are required to buy health insurance in advance of specifically needing to pay for health care. As outlined in the "shared responsibility" section of the Affordable Care Act:

> if there were no requirement [to buy insurance], many individuals would wait to purchase health insurance until they needed care. By significantly increasing health insurance coverage, the requirement [to purchase health insurance], together with the other provisions of this Act, will minimize this adverse selection and broaden the health insurance risk pool to include healthy individuals, which will lower health insurance premiums. The requirement is essential to creating effective health insurance markets in which improved health insurance products that are guaranteed issue and do not exclude coverage of pre-existing conditions can be sold.[34]

An additional incentive to enroll in a timely fashion is through use of enrollment periods. If someone does not enroll in the open enrollment period, they will not be able to enroll in an individual health insurance exchange and get tax credits until the following year.

i) health insurance coverage in Montana - indications from study by Bureau of Business and Economics Research for State Auditor

---

[33]In a federally facilitated exchange, the individual exchange market is going to be separate from the SHOP exchange. States that operate an exchange may combine their individual and small group markets under the same exchange. If a person enters the individual market exchange and answers the question "yes" that they have an employer health plan available to them, they will be redirected to their employer plan unless they can meet other eligibility provisions for an exchange.

[34]42 U.S.C. 18091(2)(I).

Potential participants - One question in Montana is whether sufficient numbers of uninsured people who are not eligible for Medicaid will participate on a health insurance exchange rather than pay a penalty. The "numbers" question is one that Gregg Davis and other researchers at the Bureau of Business and Economic Research at the University of Montana School of Business are seeking to answer under a contract with the State Auditor's Office. That contract was one of several funded through a $1 million federal planning grant received by the State Auditor's Office for a health insurance exchange.

Preliminary information from the Davis BBER group suggests that Montanans with health insurance number about 807,000 (out of a population estimated at 998,199 as of July 1, 2011). That comports with general observations that between 16% and 20% of Montana's population is uninsured, which translates to about 160,000 to 200,000 Montanans. Davis provided the Children, Families, Health and Human Services Interim Committee with two estimates for potential new Medicaid enrollees: 38,000 to 57,000 as projected by the Kaiser Family Foundation and 47,000 to 55,000 as projected by BBER.[35] That would leave roughly 136,000 Montanans eligible for a health insurance exchange. Compare that with California's expectation of 5 million people potentially eligible to participate in a health insurance exchange in that state, with 3 million potentially eligible for subsidies.[36] Even without knowing what Montana's legislators and political leaders expect to do regarding the expanded Medicaid option under the Affordable Care Act, the numbers of Montanans using a health insurance exchange to obtain insurance (with or without subsidies) may be so low that the administrative cost of running an exchange may be problematic.

The size of the risk pool may be further decreased if a federally facilitated exchange uses as its upper limit a business of up to 50 employees instead of an optional 100 employees (100 becomes automatic in 2016).[37] About 97.5% of Montana businesses employ less than 50 workers, with only 996 Montana businesses having 50 or more employers. (These employers hire more than 37% of the workforce.)[38] See Table 5 for more information on business size in Montana.

---

[35]Gregg, *op. cit.*

[36]Victoria Colliver, "Health care exchange will offer policies", SFGate.Com. Accessed 7/2/2012 at: http://www.sfgate.com/health/article/Health-care-exchange-will-offer-policies-3675063.php?t=0d441a9c3f.

[37]DHHS says the decision as to whether to use 50 or 100 as the number of employees eligible for a SHOP exchange is up to the state and, if no decision is made, then the decision basically defaults to what is defined in statute. The relevant definition of small business in Montana law is in 33-22-1803, where small employer is defined as employing at least 2 but not more than 50.

[38]Data from the Montana Department of Labor and Industry in an e-mail from Barb Wagner, Aug. 28, 2012.

Table 5: Montana businesses by size and percent offering health insurance, 2009

	under 10 employees	10-24 employees	25 to 99 employees	100 to 999 employees	with more than 1,000 employees
Total*	32,682	not available*	not available*	306	8
% offering health insurance	22%	57%	77%	97%	100%

*These are not available in these particular categories. However, The Census divides firms into different-sized groups from the Small Business Administration. This particular data set identifies groups of 10-19 employees (of which Montana had 4,289 businesses), 20-49 employees (of which Montana had 2,353 businesses), 50-99 employees (of which Montana had 694 businesses), 100-249 employees (of which Montana had 252 businesses), 250 to 499 employees (of which Montana had 38 businesses), 500 to 999 employees (of which Montana had 16 businesses) and 1,000 or more than employees (of which Montana had 8 businesses).

Source for total business size: U.S. Department of Commerce, U.S. Census Bureau, 2009--made available through the Montana Department of Labor and Industry Research and Analysis Unit..

Source for percent of health insurance: Small Business Administration, "Health Insurance in the Small Business Market: Availability, Coverage, and the Effect of Tax Incentives", published under contract by Quantria Strategies, LLC, Sept. 2011.

Other information to be made available by the BBER report, due out in the fall of 2012, includes:

- an evaluation of Montana's population by insurance status and stratified by income, age, employment, and health status. (Based on telephone and cell phone surveys.)
- responses of 500 surveyed businesses regarding health insurance expectations for their employees, including who is eligible, how much cost-sharing is done between employer and employees, what types of co-pays, deductibles, out-of-pocket provisions are offered, plus the acceptance rate by employees and whether dental, prescription ;
- responses from 2,500 household surveys as to reasons the uninsured do not have health insurance;
- estimates of how many Montanans will be eligible for premium tax credits or premium assistance on the health insurance exchange;
- a review of insurance plans available in Montana and the size of various markets (large group, small group, individual);
- estimates of the number of people who might be eligible for a catastrophic plan in a federally facilitated exchange; and
- mitigation strategies to address people who will move back and forth between being eligible for Medicaid and eligible for subsidies on a health insurance exchange (this is called the "bubble group". The BBER report for the State Auditor's Office estimated that between 9,700 uninsured and 14,000 insured Montanans would be in the group moving between Medicaid and exchange subsidies. (But these numbers were for those Montanans with incomes between 138% and 150% of FPL, and that number will

be affected by whether Medicaid is expanded or not.)

ii) status of health insurers in Montana - by premium in small group and individual market, by medical loss ratio, and regarding rate review (by federal officials and the State Auditor's Office through a contract with Leif Associates)

As mentioned earlier, one of the purposes of health insurance exchanges was to promote an element of competition in the health insurance market and make selection of a health insurer easier for buyers who had become accustomed to comparing prices and features for airline travel or consumer goods. The attention to competition, however, found that very few areas of the United States have competition in health insurance. A study by the American Medical Association of metropolitan markets found that 83% of those markets were "highly concentrated", using a Department of Justice term of art for calculating whether a merger creates an antitrust or anticompetitive situation.[39]

Montana similarly has very little competition in the health insurance market, with the biggest insurer in this state's market in 2010, Blue Cross Blue Shield of Montana, having about 50% of earned market premium for the individual market, about 80% of the small group market, and nearly 70% of the large group market.[40] However, Montana did not rank as one of the least competitive markets in the AMA study.[41] And a Kaiser Family Foundation report on state insurance markets noted that Montana had 3 insurers with more than a 5% market share (the 50-state median was 4), with Montana's largest insurer by enrollment having 51% of the market and the state not being that dissimilar to other states when calculated by a measure of competitiveness called the Herfindahl-Hirschman Index.[42]

Another study undertaken by the State Auditor's Office uses actuarial firm Leif Associates to review Montana's market for health insurance plans and assess insurers' compliance with existing Montana rating laws. At a Feb. 24, 2012, meeting of the Exchange Stakeholder Involvement Council one of the stakeholders asked why Montana's small group market is so

---

[39]Summary of an American Medical Association study reported in *Medical Benefits,* April 30, 2012, p. 12.

[40]Data provided by Leif Associates to the Exchange Stakeholder Involvement Council meeting in Helena, Feb. 24, 2012. Handouts 5 and 6.

[41]*Ibid.* The 10 bottom rankings in the AMA study reflecting the least competitive health insurance markets were: Alabama, Alaska, Delaware, Michigan, Hawaii, the District of Columbia, Nebraska, North Carolina, Indiana, and Maine.

[42]Kaiser Family Foundation Focus on Health Reform, "How Competitive are State Insurance Markets", October 2011. Montana's score of 3,459 on the Herfindahl-Hirschman Index was less than the 50-state median of 3,761. Only Wisconsin scored less than 1,500, which reflects a competitive market.

concentrated with so few players. Christina Goe with the State Auditor's Office noted that insurance markets nationwide are becoming more concentrated. Response to a request from the State Auditor's Office for detailed information from insurers revealed that six of the individual carriers were no longer active in Montana in 2011 and three of the small group carriers had ceased doing active business in Montana in 2011.[43] The State Auditor's Office later reported that the departed insurers had very small market shares and that two new insurers have been added to those companies actively marketing individual and small employer group coverage.

Leif Associates also studied whether insurers not based in Montana had much business here. For the small group and large group markets, Montana-based firms predominated for both earned premiums and covered lives. In the individual market for both measures, Montana-based firms had about 50% of the market with the remainder held by what is called "foreign" firms, or those not based in Montana, such as Assurant, also known as John Alden and Time Insurance companies. The federal government under the Affordable Care Act ordered both to provide rebates to Montana customers based on not meeting their medical loss ratios and determined, under a rate review process, that each had sought unreasonable 15% increases for 2012 premiums. However, there is no penalty other than the embarrassment of being posted as having an unreasonable rate increase.

iii) status of Montana Comprehensive Health Association and the federal high risk pool - The Montana Affordable Care Plan

Along with implementation of health insurance exchanges in 2014, new prohibitions go into effect to prevent insurance companies from denying coverage to a person on the basis of their health status or from basing premiums on health status (the usual process of underwriting). Prior to 2014, in an effort to help people who previously were uninsured based on preexisting conditions or charged extremely high premiums, the Affordable Care Act offered states the choice of running their own federally subsidized high risk pool or having the federal government provide coverage to these citizens. The Montana Insurance Commissioner chose to run the federally subsidized plan alongside the existing Montana Comprehensive Health Association plans. MCHA covers those Montanans who are eligible for portability coverage as set out under the Health Insurance Portability and Accountablity Act (HIPAA) or who either can prove the existence of a particular high-risk condition or have been refused insurance by at least one insurer[44] (prior to 2011 an applicant had to be

---

[43]Leif Associates presentation to Exchange Stakeholder Involvement Council, op. cit., slide 11.

[44]The rejection is one of two main eligibility criteria described in 33-22-1501(7). The other may be met by having a restrictive rider or preexisting condition limitation requirement by at least one insurer (or equivalent). A waiver by the Montana Comprehensive Health Association may offset either criteria.

rejected by two insurers). A participant in the MCHA state high-risk pool must be enrolled continuously for 12 months before the plan will cover any preexisting condition, unless they had previous creditable coverage. A participant in the federally subsidized MACP has no pre-existing condition exclusion but must have been uninsured for at least six months prior to enrollment. The MACP participant's premiums are 100% of the average market rate. MCHA has a premium subsidy program, which currently is closed to new enrollment because of limited funding. The subsidy is 45% of the premium for those meeting income limits. Table 6 provides a comparison of the Montana Comprehensive Health Association, created by the 1985 Legislature, and the Montana Affordable Care Plan.

The commissioner's office approved use of a single application for both high-risk pool programs in 2010 and began accepting applicants to the Montana Affordable Care Plan on July 1, 2010, with coverage available starting Aug. 1, 2010.

Table 6: Enrollment in MCHA and the MACP, 2012

	MT Comprehensive Health Assn.	MT Affordable Care Plan
Enrollment* *as of 6/30/2012	2,730 members	329 members (337 members as of 7/27/2012)
Monthly Premium range, selected ages	Six different plans - premiums range from:	
0-17	$103 - $292	$186
30	$189 - $540	$257
50	$346 - $988	$471
64	$543 - $1,550	$739
Deductibles	Ranges from $1,000 to $10,000, depending on plan option.	Deductible - $2,500

iv) subsidies paid to employers to help buy health insurance, under Insure Montana and under the Affordable Care Act and costs to businesses for not providing adequate coverage

Montana has had a program, Insure MT, to help small businesses of between two and nine employees receive tax credits and employee premium assistance for health insurance since 2005. The Affordable Care Act also instituted a small business tax credit to help offset the costs of employee insurance. Small businesses with between 2 and 50 employees became eligible for federal tax credits of up to 35% (25% for nonprofit organizations) under the Affordable Care Act for the 2010 tax year if they paid average annual wages below $50,000 and provided health insurance to the employees. In 2014 the tax credit is to increase to 50% for qualifying small businesses (35% for nonprofits) but only for small employers who enroll through the SHOP exchange.

Under Insure MT an employer of at least two but not more than nine employees may obtain either refundable tax credits for offering "qualified" insurance plans[45] to employees or a premium incentive payment to help for pay premium costs. Employees of a small employer receiving incentive payments (to help provide health insurance) may receive a premium assistance payment. The program also sets an upper personal income limit of $75,000 per employee, not counting the salaries of owners, partners, or shareholders in the business (33-22-2006).

A small business in Montana might be participating in both programs, but specific participation information is not available for either program. HB 612 in the 2011 session would have eliminated the potential for dual subsidies but the governor vetoed HB 612, saying that the bill "directly hurts small businesses and their employees" See Table 7 for an overview of Insure MT participation and costs and Table 8 for information on Affordable Care Act funding to government and businesses in Montana.

Table 7: Insure MT Participation, Costs, 2012

	February 2012	2/3/2011 Report to Joint Subcommittee
Purchasing Pool Group business participants	814	872
subscribers / covered employees	1,871	2,415
members / covered dependents	3,443	2,053
Total program annual cost		
Average annual cost per business		$3,496
Average annual cost per employee		$1,890
Number of businesses on waiting list		~125
Tax Credit Recipients		
Number of participating businesses		802
Average annual cost per business		$5,297
Total program annual cost		$4,248,194
Number of covered employees		2,687
Number of covered spouses		585
Number of covered dependents		2,053

[45]The insurance must be either a group health plan or a qualified association health plan, with both terms defined in 33-22-2002, MCA.

Number of businesses pending enrollment or on waiting list		52
Administrative costs		5% of program budget

Table 8 - Funding to Montana Government, Private Sector under the Affordable Care Act

Category	To Government	To Private Sector	Total Funding
Total Amount	*$18,559,360*	*$82,418,690*	*$100,978,050*
Employers/Businesses	$3,634,238	$3,131,625	$6,765,869
Health Care Facilities/Clinics	$500,000		$500,000
Health Centers	$185,498	$811,820	$997,318
Maternal - Pregnancy	$7,676,955	$212,000	$7,888,955
Medicare & Medicaid Special Projects	$201,824	$2,840,094	$5,471,920
Prevention & Public Health	$2,631,826	$2,840,094	$5,471,920
Private Insurance/Health Exchange	$2,769,016	$66,304,276*	$69,073,292
Workforce and Training	$960,003	$6,244,625	$7,204,628

*This amount includes the start-up funding of up to $6.7 million and up to $51 million in a loan for reserves for the Montana Health CO-OP insurance plan.
Source: The Henry J. Kaiser Foundation, ACA Federal Funds Tracker, accessed April 12, 2012: http://healthreform.kff.org/federal-funds-tracker.aspx

The Affordable Care Act will penalize some larger employers with more than 50 employees (full time and full-time equivalent) after Jan. 1, 2014, if they do not offer insurance to employees and one of their full-time employees receives a tax credit through the health insurance exchange. For large businesses, the assessment may be as much as $2,000 a year for each full-time employee--excluding the first 30 full-time employees. There also is a potential penalty if a large employer offers coverage that lacks a minimum value[46] or is unaffordable (costs more than 9.8% of that employee's income). That penalty could be $3,000 a year for each full-time employee who receives a subsidy through the exchange. However, there is a limit on this penalty. In 2018 insurance companies that provide expensive or "cadillac" health plans will face an assessment if individual coverage for the plan costs more than $10,200 and family coverage costs more than $27,500.

v) status of the health co-operative that has received federal funding under the Affordable Care Act to provide an insurance alternative

[46]The definition of minimum value remains to be completed but the term in part means that the actuarial value is less than 60%, which is to say that the consumer must pay through deductibles, co-pays, or out-of-pocket more than 40% for benefits.

The Affordable Care Act provided funding to help set up health cooperatives, which were intended to provide increased in-state insurance competition on a health insurance exchange. At least two multi-state plans under contract with the federal Office of Personnel Management also will be offered on the exchanges and are intended to provide more competition.

In April, the Committee heard from Dr. Tom Roberts, the chairman of the board of the Montana Health CO-OP, which has received federal start-up financing for a nonprofit health insurance company intended to offer insurance on a health insurance exchange. Dr. Roberts said the financing is in the form of a $6.7 million sstart-up loan, which will be distributed quarterly over the next two years if the Montana Health CO-OP meets certain requirements, plus initial funding for reserves of up to $51 million. The start-up loan is to be repaid over five years, with loans backing initial reserves to be paid back over 15 years.

Committee members asked Dr. Roberts what would happen if the U.S. Supreme Court overturned the Affordable Care Act. He noted that he had signed a contract with the federal government so he expected the Montana Health CO-OP to move forward. A report distributed to Committee members noted that the Montana Health CO-OP intends to start offering health insurance products in October 2013 with policies to be in force as of Jan. 1, 2014.[47]

vi) other information related to health insurance exchanges

Establishment of health insurance exchanges, whether by states or by the federal government, is complex. In addition, the Affordable Care Act contained many reforms in how health insurance is to function. The following topics, listed randomly, all affect health insurance exchanges.

- **Funding of health insurance exchanges--initially and over the long term.**
  The Affordable Care Act provides establishment funding for states but then requires that health insurance exchanges be self-sufficient by January 2015. Although the establishment grants were initially to expire, the deadline for application has been extended through 2014. Montana is one of 16 states as of mid-August 2012 that have not applied for an establishment grant. As a state that expects to have a federally facilitated exchange, the charge for operational costs presumably will be determined by the federal government, but information on that is not yet available.

  Long-term funding considerations typically include:
  - an assessment, collected from health insurers (with a question being whether all insurers are assessed or just those participating in an exchange);
  - an assessment, collected from individuals participating in the exchange, which is how Massachusetts, the first state to have a health insurance exchange, finances its operation. Massachusetts charges a 3% premium fee or assessment to individuals

[47]"Montana Health CO-OP", written submission from Dr. Tom Roberts to the Economic Affairs Interim Committee on April 20, 2012, p. 4.

participating in the exchange.

- a monthly fee to each subscriber, which is how Utah, which was the second state to have an online health insurance marketplace, funds operations. The monthly fee covers broker fees as well as administrative costs.[48]

- **Risk reinsurance, risk adjustment, and risk corridors.**
These terms relate to efforts to "even out the playing field" as changes take place in how health insurance premiums are calculated. One effort is to protect the insurers who, inadvertently, end up with all the high-cost policyholders. Another is to smooth the transition as insurers change their rate-setting based on underwriting (which allowed them to avoid risk by limiting exposure to preexisting conditions or other policyholder health conditions) to the new approach of setting rates based on value and quality of a health plan plus a limited set of factors related to the insured individual, such as tobacco use, age, and geography. The federal government will handle the three-year risk corridors program, which is to protect against inaccurate rate setting during the transition. The federal government allows states to determine if they will handle risk reinsurance and risk adjustment themselves or use the federal mechanisms. For Montana, the federal government is likely to handle all the risk options, unless the state enacts legislation to create a reinsurance entity.

  Risk reinsurance is to be paid for through a fee on all health insurance issuers, even self-insured health plans. These assessed fees in turn will be distributed to health insurance issuers in the individual market (inside and outside the exchange) that have the highest loss ratios. That is intended to help lower the costs in the individual market as well as smooth out the risks.[49] Risk readjustment, the only program to extend beyond three years, is intended to apply to health plans in the individual and small group markets, both inside and outside the exchange, but not to grandfathered plans. Data collection is key to the risk readjustment calculations, but a model remains to be developed by the federal government.

- **Health insurance reforms**
In addition to the changes in how insurers set their premiums, the Affordable Care Act included various other health insurance reforms. A Congressional Research Service briefing paper[50] noted that the market reforms imposed on insurance companies generally will be enforced by states, which remain the primary regulators of health insurance.

- **Navigators and the role of insurance brokers.**

---

[48]National Conference of State Legislatures.

[49]A discussion of the risk corridors, risk reinsurance, and risk adjustment is in the

[50]Bernadette Fernandez and Annie L. Mach, "Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA), Congressional Research Service, Aug. 15, 2012.

The navigators are to help people "navigate" or work through their choices on a health insurance exchange. Deciding the role of navigators and the role of insurance producers is a decision for the exchange authority operating in the state. The federal government will be making those decisions in Montana. At this time the federally facilitated exchange is to write the qualifications for navigators and hire them. Regulations have said that states may not require navigators to have a producer license.

- **Mandated benefits** (see Table 2 for an overview of nearby states' mandates).
  The Affordable Care Act said that any state mandates not included in the essential health benefits were to be subsidized or paid for separately by the state.[51] If the benchmark is the small employer group plan, as in Montana, the mandates are automatically included.

- **Regional exchanges.**
  Currently the only active attempt at a regional exchange has been by the New England States Consortium Systems Organization. The New England group received a planning grant, and in addition each state in the region also had its own planning grant. The group convened stakeholder meetings and discussed regional planning, coordination of procurement, and what functions might be handled by a regional exchange. Of the main exchange functions, the two most likely for a regional effort were determined to be the standardized benefit categories and a common website.[52]

- **Networks.**
  Each qualified health plan is to have an adequate network of health care providers. The federal government may be determining network adequacy for health plans in a federally facilitated exchange in Montana.

Not studied under the Affordable Care Act because they had little direct relation to health insurance exchanges were the following: a reinsurance health plan that covers retirees aged 55 and older and their eligible spouses if under an employer or union retiree health plan and coverage for prescription plans under Medicare that previously left those with certain levels of expenditures in a "donut-hole" of no coverage until they reached a higher level of expenditures.

vii) other??

---

[51] There has not been any guidance on how the state is to pay for any mandated benefits, whether the payments would be to insurers or as subsidies to policyholders. The only way this question arises in Montana is if new mandates are imposed by the 2013 Legislature or thereafter.

[52] NESCO (New England States Consortium Systems Organization) handout, "Opportunities for Regional Collaboration on Health Insurance Exchange Planning: results of Initial Meeting of New England States', January 2011.

C. What would a federally facilitated exchange would look like?

With Montana expecting a federally facilitated health insurance exchange, several questions arise beyond the main one of whether the federal government will be able to have all the moving parts in place before the October 2013 target date for having policies ready for people to review and purchase on a health insurance exchange website. The acting director of the Center for Consumer Information and Insurance Oversight (CCIIO), Michael Hash, said he expects a federally facilitated exchange to have a common "storefront" for all states in which a federally facilitated exchange operates, which is to say that people going online to compare insurance policies probably would plug in their state's name and be shown qualified insurance plans available in their state that they could compare.

Hash, the CCIIO acting director, told the National Conference of State Legislatures in August 2012 that the federal government will be in discussions with the insurance commissioner in each state that does not have a state-run exchange to help determine some of the approaches.

What needs to be in place for an exchange -- The following policy decisions or functions[53] are those listed in the "Blueprint" that federal officials have asked states to complete along with a declaration of intent as to whether they plan to operate a state exchange or have some type of partnership with a federally facilitated exchange. The Blueprint also includes how a state intends to handle existing Medicaid eligibility determinations. Essentially the following components will be required of an exchange, whether operated by the federal government or by a state:

- enabling authority (for Montana this would require legislation);
- a decision regarding the exchange governing structure (part of the state or a nonprofit entity);
- stakeholder consultation plan (Montana has a stakeholder group);
- tribal stakeholder consultation plan;
- outreach and education;
- a call center to answer questions about the exchange and help enroll people by phone;
- a website;
- navigators, who can help people enroll through a health insurance exchange;
- agents/brokers, if a state or the federal government decides to allow their participation;
- web brokers, again if a state or the federal government decides to allow their participation;
- a single streamlined application for either individual or small group policies;
- a coordination strategy with insurance affordability programs and the small business SHOP exchange;
- ways to handle redetermination of eligibility;

---

[53]These items are in the "Blueprint" that states wishing to either create their own exchange or partner with a federally facilitated exchange must provide to the federal government by Nov. 16, 2012. The Draft Blueprint was accessed Aug. 21, 2012, at: http://cciio.cms.gov/resources/files/Exchangeblueprint05162012.pdf.

- ways to handle annual redeterminations and enrollment;
- ways to verify information;
- a way to accept and process documents;
- a way to determine eligibility (for both the exchange and Medicaid/CHIP)
- eligibility determinations for the advanced premium tax credit and the cost-sharing reductions (the federal service may be used even for state-run exchanges)
- ways to notify applicants and employers;
- ways to handle determination of the individual responsibility requirement (mandate) and penalty exemptions;
- provisions to appeal determinations of ineligibility;
- authority to perform and oversee certification of qualified health plans;
- ways to determine which insurers are allowed to offer policies on an exchange, how to terminate and reasons why, and processing for the advanced premium tax credit and cost-sharing reduction information;
- a process for certification of qualified health plans;
- ways to provide electronic reports of eligibility assessments and determinations;
- a transition plan for high-risk pools (the Montana Affordable Care Plan and possibly MCHA);
- plan management system or processes that support collection of qualified health plan issuer and plan data. Insurers will begin using quality data and some provision other that health risks, age, geography, or other underwriting determinations to price premiums, so this data becomes important for insurers.
- assurance of ongoing compliance of qualified health plans;
- support for issuers, including technical assistance;
- processes to recertify, decertify, and handle appeals for inssuers;
- a timeline for accreditation of qualified health plans;
- a risk adjustment program (the federal service can be used even for state exchanges);
- a reinsurance program (state exchanges can use the federal service and those states in a federally facilitated exchange or in a state partnership may do this themselves);
- ways to determine SHOP compliance with rules on establishing a SHOP and its functions, eligibility standards, and processes;
- ways to handle premium aggregation in the SHOP exchange;
- ways to electronically report rsults of eligibility assessments and determinations for SHOP;
- an organizational structure and staffing resources for an exchange;
- a long-term operational cost, budget, and management plan;
- proof of compliance with HHS IT (information technology) guidelines;
- adequate technology infrastructure and bandwidth;
- quality management for independent verification and validation and test procedures;
- privacy and security standards, policies, and procedures;
- safeguards for privacy and security meeting HHS IT guidelines;
- safeguard protections for federal information;
- routine oversight and monitoring capability for an exchange's activities;

- ability to track and report performance and outcomes metrics related to the exchange;
- ability to uphold financial integrity provisions, including accounting, reporting, and auditing procedures;
- contracts and outsourcing agreements;
- plan management agreements for a state partnership or in a federally facilitated exchange;
- capacity to interface with the federally facilitated exchange (for those in a state partnership or states without their own exchange); and
- consumer assistance agreements.

How an exchange operates -- Most examples of a health insurance exchange operations indicate that a person[54] (or a small business) wanting to buy health insurance would access a health insurance exchange website and be presented with all insurance plans in a particular category to allow easy comparison by the buyer (whether an individual or the business--if a business were to choose to limit employee choices to certain categories). Both businesses and the employees of the business will be required to file applications in a SHOP exchange.

Types of plans -- The categories are the "metal levels", which is to say that the Affordable Care Act requires an exchange to offer plans in the following categories:

- bronze plans, which have an actuarial value of 60/40, meaning that the total cost to the policyholder is 40% (including co-pays, deductibles, and out-of-pocket costs but with a maximum out-of-pocket limit for all plans for $6,050 for single coverage and $12,100 for family coverage[55])
- silver plans, which have an actuarial value of 70/30. A silver plan is the only category for which someone can receive a federal subsidy or assistance.
- gold plans, which have an actuarial value of 80/20; and
- platinum plans, which have an actuarial value of 90/10.

Catastrophic plans also are allowed for those who are at least age 19 up until they turn age 30 if these younger adults do not have access to affordable coverage or have experienced a hardship. Catastrophic plans must include coverage for essential health benefits and for at least three no-cost primary care visits.

Federal officials say discussions are continuing about whether health savings accounts and high-deductible plans as well as health reimbursement accounts are to be allowed in the exchange.

---

[54]Not all people are eligible to participate in an exchange. For example, an unauthorized alien cannot obtain coverage through an exchange even if buying insurance without seeking a subsidy.

[55]Fernandez and Mach, *op. cit.*, p. 24, footnote 107. They noted that inflation is likely to change those limits in 2014, when catastrophic plans are to be made available in the individual health insurance market.

For low-income individuals there also is a basic health program, which serves those not eligible for Medicaid and is available to individuals not obtaining insurance through a health insurance exchange. This is a state option only; a state does not have to offer a basic health program. The criteria established under the Affordable Care Act for the basic health plan option includes household income between 133% of the federal poverty level and 200% of the federal poverty level. This option may help to fill the donut hole created by nonexpansion of the Medicaid population, but more information is needed to determine how a basic health program will work. Federal officials are considering various options and have said innovations will be considered in the Medicaid program. Among the innovations discussed in Montana is whether a Medicaid recipient could receive subsidies to participate in a health insurance exchange or some variation of that theme.

The schematic in Figure 1 indicates a simplified version of how an individual (or business) would travel through a health insurance exchange application, eligibility assessment (and determination of potential cost-sharing assistance or tax credits), plan selection, and payment of premium. For each of these tasks, many of the behind-the-scenes federal actions remain to be determined.

Premium costs in an exchange and ways to offset those costs - The Affordable Care Act states that people whose modified adjusted gross income is at 100% to 250% of the federal poverty level would be eligible for an advanceable tax credit as well as a cost-sharing subsidy (provided that they sign up for a silver plan). Table 9 provides criteria for tax credits or cost-sharing subsidies. Tax credits are advanceable (and there are questions of whether a portion of the amount may need to be paid back if income levels increase a certain amount during the year). Cost-sharing subsidies are intended to help individuals pay for deductibles or out-of-pocket expenses.

Table 9: Criteria for Tax Credits and Cost-Sharing Subsidies in a Health Insurance Exchange

Tax Credits	Cost-Sharing Subsidies
• Eligible to participate in the individual exchange because of citizenship or lawful presence for the noncitizen or national. Also is not incarcerated (other than awaiting disposition of a charge), and meets state residency requirements.	• Eligible to participate in the individual exchange because of citizenship or lawful presence for the noncitizen or national. Also is not incarcerated (other than awaiting disposition of a charge), and meets state residency requirements.
• Not eligible for minimum essential coverage through an employer.	• Meets the criteria for receiving advanceable tax credits (the criteria in the left column).
• Part of a tax-filing unit.	• Is enrolled in a silver plan through an exchange.
• Enrolled in a qualified health plan through an exchange.	• Has household income between 100% and 400% of the federal poverty level.

• Has household income that is either between 100% and 400% of the federal poverty level or, if the person is an alien lawfully present and not eligible for Medicaid, has income not greater than 100% of the federal poverty level.	

Source: Bernadette Fernandez and Annie L. Mach, Health Insurance Exchanges under the Patient Protection and Affordable Care Act, Congressional Research Service, Aug. 15, 2012, pp. 9-10, Tables 1 and 2.

Premium cost calculations vary according to plans, but various attempts are available to try to estimate what families will pay. One example provided by the Department of Health and Human Services anticipates that family health insurance premiums in 2014 would be as shown in Table 10(a). Another example, from the Congressional Budget Office, shows in Table 10(b) projected premium costs and total costs for both exchange coverage and employment-based coverage for a family of two adults and two children. However, the cost of health insurance premiums is uncertain in part because of unknowns related to changes in the health insurance market, fees related to health insurance exchanges, and projected offsets for cost-savings that also are in the mix.

A representative of one of Montana's insurers said that although underwriting will not be used to set premiums or deny coverage, the questions on health status will still be collected to help determine the risk readjustment payments and find ways to improve care coordination.

Table 10(a): Family Health Insurance Premiums with reform and without reform, 2014

	With reform	**Without reform**
Income of $33,525, based on a 150% federal poverty level	$1,400	$11,300
Income of $55,875, based on a 250% federal poverty level	$4,700	$11,300
Income of $78,225, based on a 350% federal poverty level	$7,800	$11,300

Source: Department of Health and Human Services, "Health Insurance Premiums: Past High Costs Will Become the Present and Future Without Health Reform", Jan. 28, 2011, p. 7, accessed Aug. 27, 2012, at: http://www.healthcare.gov/law/resources/reports/premiums01282011a.pdf

Table 10(b): Projected premium costs, total costs for exchange and work-based coverage.

	Annual family premium	**Subsidies* as % fed. poverty level**	**Cost after subsidies**

Employment-based coverage	$20,000, average out-of-pocket medical service costs $3,200 = $23,200	$5,900 $6,600 $7,800 $7,700		200% 300% 399% 500%	$17,300 $16,600 $15,400 $15,500
Exchange Coverage	$15,400, average out-of-pocket medical service costs $6,400 = $21,800	Tax credit $12,200 $8,200 $5,700 $0	Cost-sharing $3,600 $0 $0 $0	200% 300% 399% 500%	$6,000 $13,600 $16,100 $21,800

*Federal and state tax subsidies for an employer plan generally are those that provide health insurance as a pretax benefit. The Congressional Budget Office included the average marginal tax rate for each group as a percentage of the federal poverty level. Those are not included here but they ranged from 29.4% at 200% FPL to 38.7% at 500% FPL. (500% represents someone who has no potential subsidy because the upper limit is 400% of the poverty level for potential subsidization.)

Source: Congressional Budget Office, "CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance, March 2012, Table 1.

D. information related to ways to address health care efficiencies and access

i) health care provider status in Montana and shortages plus options for expanding access

At the June 2012 meeting of the Economic Affairs Interim Committee, representatives from a health workforce task force provided maps that showed certain counties in Montana with few to no medical providers of various types. Further, they noted that difficulties in the licensing process had stymied some medical providers, which the Montana Medical Association and the Board of Medical Examiners agreed to further examine.

Among the options for expanding access to medical providers, particularly physicians, was a suggestion that funding be expanded to allow more training of residents in Montana, because research indicates that where doctors-in-training serve their residencies is a likely indication of where the doctor will later practice.

ii) use of the Board of Medical Examiners and the Board of Nursing licensing and renewal process to improve data gathering needed by DPHHS and as a way of decreasing the amount of time spent by physicians and others in responding to the same questions by various credentialing organizations.

Answering questions for credentialing organizations, many of which already are requested by licensing boards, takes time. Under Montana's administrative rules (37.108.216, ARM):

> (1) Each health carrier shall establish and describe in its access plan the criteria utilized to review the credentials of the providers in its network. A health carrier must require a

provider's credentials to be reviewed prior to the health carrier employing or entering into contractual relationship with a provider and a provider's credentials are to be reverified at least every 3 years thereafter.

As the number of health carriers (insurers) increases in Montana, which is expected to be a byproduct of a health insurance exchange, so will the time spent meeting the credentialing requirement unless insurers coordinate their requirements or use a central credentialing entity.

Currently the Board of Medical Examiners, the Board of Nursing, the Montana Medical Association and the Montana Hospital Association, among others are working on ways to make the information-gathering process easier and more streamlined for a range of parties.

iii) network scope - status of primary care access in Montana

A June 2012 presentation to the Committee reviewed primary care physician shortages in Montana and the expectation that more residencies will soon be available for students studying to be doctors in the WWAMI program funded by the states of Washington, Wyoming, Alaska, Montana, and Idaho. Studies indicate that medical students often settle in the location where they do their residencies. Currently residencies are available in the Billings area, with another program being put into place in Missoula.

iv) other??

IV. What to expect in the near future

This report, being written before the November elections, recognizes that political winds will shape specific policies. However, in an effort to be helpful for the incoming 2013 Legislature, the following options may be considered (with no caveat each time regarding political implications):

- To provide a state role for some components of a federal health insurance exchange:
- To provide for a transition from a federal health insurance exchange to a state exchange:
- To address health care costs, which may take the shape of bills introduced in the 2011 session regarding tort reform, medical malpractice, insurance across state lines, and regulation of insurance.

Numerous questions remain regarding health insurance exchanges. For legislators, one of the key questions is whether to have a state-operated exchange. Federal officials, who formerly warned that costs will have to be assumed by the states, have modified that approach to say that the establishment grants will be available for a longer period (through 2014) and that primarily administrative costs will have to be assumed if a state decides to take over the duties of a federally facilitated exchange. The costs of building or assuming the information technology infrastructure

also may be passed on to a state that takes over from a federally facilitated exchange, but these details have not yet been worked out. Another question is whether, with a federally facilitated exchange, an insurer can sell products outside the exchange that they do not sell on the exchange. There remains debate about that, among other issues.

The following scenarios are possible for a federally facilitated exchange in Montana:

- the "do-nothing" approach.
- an indication of interest from the Montana Legislature of engaging in a partnership; or
- an indication of interest from the Montana Legislature of initiating a state-run exchange, which may be done one year after the state files a Blueprint (detailing how the above functions and policies are to be carried out).

If the legislature chooses not to seek a state-based exchange, the federal government:

- would continue handling rate review for insurers (unless the legislature provides rate review authority);
- would determine how many insurers participate on the exchange;
- would determine who can be a "navigator", which is a term used to describe someone able to help small businesses and individuals "navigate" the health insurance exchange, and how these agents are paid; and
- would determine risk corridors and risk adjustment mechanisms, as well as the payment structure.

The state's role in an insurance exchange would be minimal and perhaps involve consultations, including consultations with a stakeholder group.

If the legislature were to pass legislation for a state-based exchange, the following options are among those for the state to determine:

- whether all insurers or only certain insurers participate in an exchange;
- how navigators are named and paid;
- what reinsurance programs would look like;
- the role of insurance brokers;
- the type of outreach and education;
- whether an exchange ought to feature all insurers that have a qualified plan (termed a passive approach) or only a limited number (an active approach); and
- the size of the small group market? States that run an exchange can choose to include businesses with up to 100 employees under the small group market eligible to participate in the SHOP Exchange. The federal guidance now indicates that if a decision is not made as to what a small group market means, then the existing state definition will be used. In Montana a small employer is defined in 33-22-1803 as one that employs at least 2 but not more than 50 eligible employees. (The Affordable Care Act boosts that definition of a small employer as one hiring up to 100 full-time employees or full-time equivalents in 2016.) A

state that either partners with the federal government or runs its own exchange also can determine whether to merge the individual and small group markets to create a larger pool.

Creating a state exchange would not be easy but offers more direct regulation than would a federally facilitated exchange. However, a federally facilitated exchange at the very least offers the experience of seeing an exchange work before a state tries to run an exchange. Although federal officials stress their interest in having states run health insurance exchanges, the delay in running a state exchange may provide more time for other options, such as a regional exchange or other developments to take place.

Appendix A Common terms and how they are used/referenced in the Affordable Care Act

- **Benchmark Coverage** - New enrollees in an expanded Medicaid (including childless adults at 133% of the federal poverty level or 138% if certain assets are disallowed) may be offered a more limited set of benefits, known as benchmark coverage, than those available to enrollees under traditional Medicaid.
- **Disproportionate Share Hospital (DSH) Payments** - Under Medicaid, hospitals that provide a disproportionate amount of uncompensated care to low-income individuals or those on Medicaid receive DSH payments to help make up for uncompensated care and lower reimbursement rates paid to those who treat individuals receiving Medicaid. Montana in FY2011 received nearly $11.4 million in DSH payments. Under the Affordable Care Act, which was intended in part to reduce uninsured people and uncompensated care, the DSH payments will be reduced. One analysis is that the DSH payments will go down (as provided under the Affordable Care Act) regardless of whether a state expands its Medicaid population (unless Congress acts to change this reduction).[56]
- **Churning** - The flow of someone from Medicaid coverage to the health insurance exchange and potentially back. The "churning" population is called the "bubble" in the latest lingo.
- **Essential Benefits** - The Department of Health and Human Services outlined 10 essential benefits that must be included in a qualified health plan. The 10 categories are: 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. If a qualified health plan does not have pediatric dental care, these may be provided on a health insurance exchange by a stand-alone dental plan.
- **FFE** - Federally facilitated exchange.
- **Individual Responsibility Requirement** (some say "individual mandate") - Upheld as a tax by the U.S. Supreme Court, the penalties vary based on income. Some populations are exempt from the individual responsibility requirement.
- **MAGI - Modified adjusted gross income.** Under the Affordable Care Act the net income eligibility standards (including the assets test) for Medicaid and the Children's Health Insurance Program (Healthy Montana Kids) is to be replaced by the MAGI standards in an effort to provide a more seamless way for low-income people to transfer between the health insurance exchange and Medicaid. Those who apply for either Medicaid or subsidies on the health insurance exchange are to have an application that can be used for either program for gathering basic information so that after entering the "no wrong door" system, they will

---

[56]Lynn Blewett, director of the State Health Access Data Assistance Center, in a July 5, 2012, blog entitled "ACA Data Note: Hospitals, Medicaid Expansion, and Disproportionate Share Hospital (DSH) Payments". Accessed July 18, 2012 online at: http://www.shadac.org/blog/aca-data-note-hospitals-medicaid-expansion-and-disproportionate-share-hospital-dsh-payments.

be directed to the program most appropriate to their income levels.

- **Major Medical Heath Insurance** - This is the heath insurance that contains a range of benefits for a range of situations and is distinguished from a blanket policy or a rider, which is for one specific illness or disease. The policies written for an individual, small employer, or large group market (or self-funded plans) are major medical insurance. These also are distinguished from what are called "mini-med" policies, which have limited benefits and usually high deductibles.
- **Medical Loss Ratio (MLR)** - The ratio is the amount paid by an insurer on medical benefits and activities that improve the quality of care to the total premium dollar received. The Affordable Care Act sets the MLR for the individual market at 80% (meaning 80 cents out of every premium dollar goes for medical/improved care payments and 20 cents can go to overhead expenses, including salaries and agent commissions. The MLR for the small group market is 85%.
- **Medicaid** - The state-federal partnership that provides medical benefits to children from lower-income families (currently based on asset-weighed incomes as a percent of the federal poverty levels), lower-income pregnant women, adults with asset-weighed incomes of less than 33% of the federal poverty level if these adults have dependent children living at home, and low-income adults who are blind, disabled, or elderly. (See eligibility guidelines for Montana--each state is different-- at http://www.dphhs.mt.gov/programsservices/medicaid.shtml. Also, see: http://leg.mt.gov/content/Committees/Interim/2011-2012/Children-Family/Topics/Medicaid%20Monitoring/medicaid-overview-sept2011.pdf and http://leg.mt.gov/content/Publications/fiscal/interim/2012_financemty_June/SJ%2026%20HMK%20-%20ACA%20Medicaid%20expansion.pdf.) Medicaid is a payer for long-term nursing home residents.) The Affordable Care Act would expand the categories of eligibility to adults without children if the adult's income is under 133% (see note earlier for actual rate of 138%) of the federal poverty levels. Many states are debating whether to expand this category of Medicaid eligibility because the U.S. Supreme Court said the Affordable Care Act's punishment was coercive to states and could not be enforced.
- **Medicare** - The federal program that serves those who have enrolled and who are 65 and older or are persons who have qualified for Social Security Disability Income payments or have end-stage renal disease. (See http://www.medicare.gov/Publications/Pubs/pdf/11396.pdf for details.) There are four letter-assigned categories:
  - Part A provides hospitalization coverage. Paid through a trust fund accruing employer-employee or self-employed payroll taxes (1.45% of gross pay--see Med/EE on W-2 forms).
  - Part B is medical insurance to pay physicians, outpatient medical costs, lab tests, and some other costs). In addition to receiving federal general fund payments, Part B requires a premium, which in 2012 was $99.90 a month (more for those with higher

incomes), generally deducted from Social Security checks. Part B does not cover all costs; those with Part B may find they need to buy a Medigap or supplemental policy from a private insurer.

- Part C represents Medicare Advantage, in which approved private insurers charge premiums that are in addition to the Part B premiums but may offer vision, prescription (part D), and other benefits for those premiums. In addition to a separate enrollee-paid premium, Medicare Advantage receives a distribution from the federal government for enrollees' Parts A and B contributions. It works like regular insurance with co-pays and deductibles and handles Parts A, B, and D benefits. Those who have Medicare Advantage do not need a Medigap or supplemental policy.
- Part D is provided by approved insurers for prescription drug coverage. The federal government provides subsidies for Part D coverage. (See p. 121 or p. 157 of the 2012 report on the trust fund: http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/ReportsTrustFunds/Downloads/TR2012.pdf)

- **Pre-existing Condition** - Under Montana law (33-22-140), preexisting condition means: "with respect to coverage, a limitation or exclusion of benefits relating to a condition based on presence of a condition before the enrollment date coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before the enrollment date".
- **Risk Adjustment -** This program starts after the end of the benefit year 2014 and serves to protect against adverse selection by adjusting payments to heath plans to take into account the risk that each plan is being based on its enrollee population. The Congressional Research Service says that plans with enrollment of less than average risk will pay an assessment, which is to be redistributed to plans that have higher than average risk.
- **Risk Corridors** - The Congressional Research Service states that the risk corridors mechanism adjusts payments to health plans according to a formula based on each plan's actual, allowed expenses in relation to a target amount. The Affordable Care Act sets 3% as the threshhold at which a qualified health plan issuer with gains greater than 3% must remit an assessment to the Department of Health and Human Services. An issuer that experiences losses of more than 3% would receive assistance. The program is limited to 3 years.
- **Risk Reinsurance** - For a state to operate a risk reinsurance program, the state must complete and submit an Exchange Blueprint prior to Nov. 16, 2012, and submit a statement of intent to create its own reinsurance entity by Dec. 1, 2102. If the state does not, the federal government will operate the risk reinsurance program for that state. This program operates for 3 years, from 2014 through 2016.
- **QHP** - Qualified Health Plans are those that are approved for offering on a health insurance exchange.
- **SHOP - Small Business Health Options Program.** This component of a health insurance exchange will allow small businesses to purchase insurance for their employees in the SHOP exchange. The definition of small business depends on the state. Montana has a

definition of up to 50 employees. The Affordable Care Act allows up to 100 employees initially and after 2016 up to 100 employees.

- **Student Health Insurance** - Student health plans are allowed a phase-in period prior to being required as of Jan. 1, 2014, to have no annual limits on essential benefits. By July 1, 2012, limits may not be less than $100,000 for essential health benefits. For policy years between September 23, 2012, and January 1, 2014, the annual limits may not be less than $500,000.[57] Student health plans also have a different methodology for determining a medical loss ratio until January 1, 2014, at which time the standard rule for medical loss ratios apply.[58] Student coverage is to be aggregated nationally as a pool, not by state.
- **SBC or Summary of Benefits and Coverage** - The Affordable Care Act requires health insurers to provide consumers with a standardized nontechnical summary of what the insurers' plan covers and how it works. The summary also must indicate whether the plan meets standards for minimum essential benefits and whether the plan pays medical expenses of at least 60% (with the insured paying the remainder.) All individual and group plans, including self-insurers, must be in compliance by September 23, 2012.
- **SBE** - State-based exchange.
- **Tax Considerations** - As related to determining eligibility for a subsidy on a health insurance exchange, rules provide that a person must authorize sharing of tax information to obtain the subsidy. An authorization is to last for 5 years, but may be rescinded and renewed.

---

[57] http://www.healthcare.gov/news/factsheets/2012/03/student-health-plans03162012a.html. Accessed 3/19/12.

[58] *Ibid.*

Appendix B Questions for Legislative Consideration (Recognizing that the Affordable Care Act may be repealed or altered by Congress but in the meantime is law.)

Medicaid

Do the governor and the Legislature want to expand Medicaid as allowed under the Affordable Care Act?

- If a state opts in, the state government will not provide payments for the expanded population (the federal government is to pay 100% of the coverage for the expanded population through 2016, with the federal matching rate gradually dropping to 90% by 2020. (State administrative costs are expected to be affected even with the 100% federal coverage). The regular Medicaid program cost-sharing determined by the Federal Medical Assistance Percentage (FMAP) is about a 34-66 state-federal split.) Without expansion, a doughnut hole for health insurance coverage will develop for lower-income adults without children living at home and who have incomes between 33% and 100% of the federal poverty level. An individual is only eligible for premium tax credits and cost-sharing reductions on a health insurance exchange if their income level is at lest 100% of the federal poverty level, they qualify to be on a heath insurance exchange, and their income is not more than 400% of the federal poverty level.
- More information is available at the Children, Families, Health, and Human Services website under the Aug. 20-21, 2012, materials: http://leg.mt.gov/css/Committees/Interim/2011-2012/Children-Family/Meeting-Documents/meetings.asp#meeting8

Essential Health Benefits

The Department of Health and Human Services has listed for each state the four options from which an entity responsible for determining the state's essential health benefits must choose. The decision must be made by Sept. 30, 2012. The federal default option is likely to be implemented in Montana, but there is a question as to who has the authority to make that decision. Without a decision, the default option is the largest small employer group plan in the state, according to enrollment in the first quarter of 2012. A review by the Center for Consumer Information and Insurance Oversight of DHHS indicates that the Blue Dimensions plan issued by Blue Cross Blue Shield of Montana would be the default plan option in Montana. However, as of this report, whether the plan is the default option is not official.

What next on health insurance exchanges?

Recognizing that all decisions are political, committee members and the 2013 Legislature may want to consider the following:

Planning for some sort of state role in a federal exchange:

- The Department of Health and Human Services continues to write guidance and rules to implement the Affordable Care Act. Those still being developed include rules related to the

state's role in a federal exchange. The following decisions may be presented to the 2013 Legislature:

- whether the state should create a reinsurance program;
- whether the state should have authority to review and approve/disapprove health insurance rates;
- whether to seek to transfer from a federal exchange to a state-run exchange and, if so, how to fund an exchange, whether an exchange should be privately operated by a nonprofit organization or run by a state agency or a quasi-governmental entity.

Potential bill drafts related to the Affordable Care Act and other health care reforms:

- LC 63, requested by Sen. Jason Priest, for the 2013 session would require state, county, and municipal employees to buy their health insurance through federal health insurance exchanges.
- LC 64, requested by Sen. Priest, would require newly expanded Medicaid populations to buy health insurance through a federal exchange.

Some legislators have noted that they expect a reintroduction of a series of bills introduced by Republican legislators in the 2011 session related to tort reform, most of which were vetoed by Gov. Brian Schweitzer. These include:

- HB 275 to provide an offset of personal consumption expenses in survival actions.
- HB 405 to provide civil immunity for medical providers for errors of omission, change the standard of evidence to "clear and convincing" from the broader term "preponderance", and addressing other medical malpractice provisions (this was vetoed by the governor);
- HB 408 to change from 3 years to 2 years the time for the statute of limitations for filing medical malpractice claims (this was vetoed by the governor);
- HB 464 to provide a "clear and convincing" burden of proof for medical liabilities to pediatric and geriatric, board-certified or board-eligible physicians;
- HB 531, not specific to medical malpractice, would have revised the process for addressing multiple defendants in a lawsuit after a settlement with some of them;
- HB 555 to prevent duplication of insurance benefits.