Considering a Health Insurance Exchange in Montana

Report for House Joint Resolution No. 33

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*Any errors in this report are those of the author.

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 study (out of 13) for the 2011-2012 interim--three 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 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 complete certainty as the interim began in mid-2011 that the U.S. Supreme Court would have a role in determining the fate of the

[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 put to a vote in November 2012 before the Montana electorate the question of 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. The report was written before the vote.

[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.

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 only one meeting left in the 2011-2012 interim in which to consider HJR 33 topics.

Considerations moving forward--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 set 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 U.S. House, U.S. Senate, or the White House and whether there will be sufficient votes in Congress to overturn the Affordable Care Act. Some current members of Congress and candidates for national office have campaigned on a repeal of the Affordable Care Act, either in part or in whole.

Taking into consideration that November's elections are 2 months after the Economic Affairs Interim Committee finished 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. Given that the law is currently in effect, the report will not continuously add the qualification "unless repealed".

The following dates are sufficiently important to implementation of the Affordable Care Act to be put into the overview. The topics will be explained in more detail in the report.

- **Sept. 30, 2012.** At this time all states were 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 by the Department of Health and Human Services in the first quarter of 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 so-called 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 to having by Jan. 1, 2014, 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.[4]
- **Oct. 1, 2013.** Open enrollment begins on this date in the individual market exchange and the small business health options program exchange, known as SHOP. 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[5] purchased through the exchange. 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 benefit expenditures or discriminate on the

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[4]Some observers cite this delay and their concerns about the complexities of the Affordable Care Act in suggesting that various exchange deadlines are likely to be postponed because of the difficulties of getting an exchange up and running.

[5]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 both plan types are the same or similar.

basis of health status (including no denial for preexisting conditions). Under the "individual responsibility" or individual mandate portion of the Affordable Care Act, all individuals who file a federal income tax return in 2015 will have to state when they file their 2014 income taxes 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[6] by the Internal Revenue Service as part of their next year's 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 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 offering insurance plans 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 1 year's notice and the submission of an approved transition plan. Federal guidance issued in the summer of 2012 indicated that federal grant funding may be used for implementation until Jan. 1, 2015, at which time the exchange is to be self-supporting.
- 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

[6]The Congressional Budget Office estimates that nearly 80% of those facing a penalty would be earning roughly $55,850 or less as an individual or $115,250 or less for a family of four. The penalty was projected at about $1,200 in 2016, far less than the estimated average 2012 premium costs, which a Kaiser Family Foundation survey said were $4,300 a year for an individual plan and nearly $15,800 for an employer-provided family plan.

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 newly acquired 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. Appendix A contains 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 of Committee members (see the HJR 33 work plan on the Committee website) 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. Because federal officials said in August 2011 that Montana would have a federal exchange, these aspects were not explored.
- the interaction of an exchange with Medicaid and the potential for premium assistance and Medicaid waivers. 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 August 2011 meeting also included a presentation on the interface between an exchange and Medicaid.

The following topics were not addressed because of tie votes in the Committee survey 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 an employee's multiple employers contributed toward a premium.)

The work plan that developed (based on expectations for a federal exchange here)
Given that Montana's Legislature is not scheduled to meet until Jan. 7, 2013, the Committee asked that federal officials address the Committee on whether Montana would be able to meet the late 2012 deadline set by the Department of Health and Human Services for certifying in January 2013 whether a state would be able to operate a state exchange by 2014. Although governors in some states have issued executive orders 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 a blueprint to be submitted by Nov. 16, 2012, before the Department of Health and Human Services gives the go-ahead to 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 Montana would have a federally run health insurance exchange because the 2011 Legislature did not pass authorizing legislation for a state exchange.

But the federal officials opened the door on the prospect that Montana 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 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 risk adjustment or reinsurance programs. Or the state may request exemptions from handling certain components of an exchange that then would be carried out by the federal government.
- A federally facilitated exchange in partnership with a state would allow the state to handle management of the qualified insurance plans presented on an exchange. A state partner in plan management would assume primary responsibility for certifying and monitoring qualified health plans. Monitoring would include oversight of the insurance companies issuing the qualified health plans and evaluation of network adequacy, including whether essential community providers are in the networks. The state partner also would verify compliance with essential health benefits and review rate increases.[7] Also an option for state partners handling plan management are some consumer assistance activities and eligibility determinations for Medicaid and the Children's Health Insurance Program (CHIP), known here as Healthy Montana Kids. However, the federal government would ultimately be responsible for all exchange functions.
- A federally facilitated exchange that handles almost all the functions of an exchange would allow an option to states to operate just the reinsurance program plus the assessment of commercial health insurers and determination of Medicaid or CHIP eligibility.[8]

Monitoring activities

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 a health insurance exchanges, particularly because the Supreme Court was not expected to rule before late June 2012. At that late date the Committee would have only one more meeting before completing interim activities.

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[7]See Department of Health and Human Services, Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight,"Plan Management Partnership in the Federally Facilitated Exchange (FFE)". May 21-23, 2012, accessed Oct. 18, 2012, at: http://cciio.cms.gov/resources/files/hie-plan-management-partnership-in-the-ffe.pdf.

[8]Department of Health and Human Services officials pointed out at an Aug. 22, 2012, briefing that the Affordable Care Act allows 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 if an individual qualifies for a subsidy to obtain health insurance through the health insurance exchange or other payment assistance.

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 members 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 by the Department of Health and Human Services 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.[9] CCIIO is now determining the final enrollment numbers from the first quarter of 2012 for the small group plans. The small group health insurance plan with the highest first-quarter 2012 enrollment is one of four options from which states were allowed to choose for a benchmark plan.

The four choices are:

- the largest plan by enrollment in any of the three largest small group insurance products in the state's small group market;
- any of the largest three state employee health benefit plans by enrollment;
- any of the three largest national federal employee health benefit plan options by enrollment; or
- the largest insured commercial non-Medicaid health maintenance organization operating in the state.

If a state was unable to choose by Sept. 30 among these options, the default product would be the largest small group product by enrollment. In Montana, that plan 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, the state must supplement the policy with a benefit from another policy contained in the list of four choices, according to a federal bulletin issued in late December 2011.[10]

- ***March 29, 2012***, regarding federal rate review of health insurance premium rate

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[9]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.

[10]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.

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 2011. The federal government does not review rate increases of less than 10%. The e-mail to Committee members noted that 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 did this by posting a link to the CCIIO website regarding CCIIO's 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 proposed for plan years beginning after Sept 1, 2011. (At least 71 plans had been submitted for review by mid-October 2012.)

Additional federal guidance on health insurance exchanges came forward in May, July, and August 2012, but much of that information was included in drafts of this report rather than being distributed in e-mails. The guidance included: information on federally facilitated exchanges (May 15, 2012); a final rule on establishment of exchanges and qualified health plans (May 29, 2012); a final rule on data collection related to essential health benefits and information on accreditation of qualified health plans (July 20, 2012); and information related to state reports to the federal government in the form of "blueprints" for state-operated health insurance exchanges or state partnerships with federally facilitated exchanges (Aug. 14, 2012).

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[11] provided information about the 30-plus categories of people who currently are eligible for Medicaid in Montana.[12] Existing Medicaid laws (prior to the Affordable Care Act) require coverage for children from lower-income families and for pregnant women as well as for low-income adults who are blind, disabled, or elderly. States vary in the extent to which they cover low-income adults with dependent children. Montana limits Medicaid for nondisabled and nonelderly adults who are not pregnant to only adults with dependent children if the family's income is at or below 33% of

[11]Ms. Snedigar retired in late 2011.

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

federal poverty levels (working adults may be eligible up to about 60% of the federal poverty levels). This means that 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[13] and removes asset tests for many but not all of the categories (asset tests remain for the elderly, for example). She also pointed out that, under the Affordable Care Act, more Montanans would be eligible for Medicaid as of Jan. 1, 2014, under a provision that expands Medicaid eligibility to all adults with incomes up to 133% (but actually up to 138%) of the federal poverty level, including single, able-bodied adults.[14] However, Ms. Snedigar's presentation occurred prior to the U.S. Supreme Court's ruling that had the effect of making the Medicaid expansion to childless, able-bodied adults an opt-in decision by each state. 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) remains intact, but they note that guidance is being written on several issues.

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 following federal agencies to determine modified adjusted gross income for subsidy and assistance eligibility as well as citizenship eligibility: 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.[15]

Ms. Snedigar noted that the Combined Healthcare Information in Montana Eligibility System for Medicaid, called CHIMES, 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 public assistance officials would help with paper applications for individuals without access to the Internet and would be part of what is considered a "no wrong door" approach to helping people access Medicaid coverage.

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[13]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. However, asset test are expected to remain for the elderly who rely on Medicaid to pay nursing home costs.

[14]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 says generally that as of Jan. 1, 2014, any adult not previously eligible for Medicaid and whose income in 2013 was less than 133% of the federal poverty level, plus a 5% asset disregard, would be considered eligible for Medicaid. So eligibility for adults under Medicaid expansion in the Affordable Care Act generally is up to 138% of federal poverty levels.

[15]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.

Under the Affordable Care Act's individual mandate, Indians and certain others[16] 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 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 at tribal clinics for tribal members on Medicaid regardless of whether a state chooses the Medicaid expansion option. (The Medicaid expansion provides 100% federal reimbursement for all those in the Medicaid expansion population until 2016 when the federal reimbursement starts to drop to a 90% reimbursement by 2020, except for tribal members who remain at 100% reimbursement.)

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, then 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 IHS 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.

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[16]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; any individual who finds that a health care plan would cost more than 8% of his or her household income; and individuals who obtain an exemption from the Secretary of the Department of Health and Human Services.

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. He 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 that the Montana Health CO-OP had been awarded 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[17] 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 preexisting 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 petitions, all individually signed by Montanans from across the state who were opposed to the Affordable Care Act. Some 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.) A copy of the petition is available at the Committee website (http://leg.mt.gov/eaic) under meeting materials for the April 2012 meeting.

II. Committee Recommendations

[17]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.)

At the September 11, 2012, final meeting of the Committee the following recommendation related to a health insurance exchange was adopted on a 4-3 vote:[18]

> We recommend that the executive branch and the legislative branch take all necessary steps to preserve and exercise Montana's ability to make choices and decisions regarding the development and implementation of the health insurance exchange.

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 to which 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 as they relate to the "individual mandate" or "individual responsibility" requirement to buy health insurance;
b) health care costs;
c) costs to government/taxpayers; and
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 (known in Montana as Healthy Montana Kids, which is a combination of Medicaid and CHIP funding for children) for those whose parents meet income criteria.

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

[18] Sen. Windy Boy was absent and did not provide a proxy.

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 must have similar basic components--including actuarial values[19]) 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[20] 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 participants with incomes between 100% and 400% of the federal poverty level.

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 have health insurance and access health care do not directly pay for either the insurance or the entire health care bill. 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. The recipient either pays full charges or individually negotiates a reduced rate, possibly based on an agreement to pay

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[19]The term "actuarial values" is defined at http://www.healthcare.gov as the percentage of total average costs for covered benefits that a plan will cover. If the insurer pays 60% of covered benefits and the policyholder pays 40% the plan has an actuarial value of 60-40.

[20]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.

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.

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 proposes that 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 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. Uninsured people also have little or no access to health care provider discounts unless they negotiate their own discounts. If more people have insurance or health care financing, the thinking goes, hospitals have less need to increase the hospital and 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.[21] The payment-to-cost ratios calculated by the American Hospital Association from its survey data for 2010 for community hospitals show Medicare payments fall short of 100% costs by paying 92.4% of costs, Medicaid with disproportionate share payments[22] is 92.8% of costs, and private payers pay 133.5% of costs, or 33.5% more than costs, an amount that reportedly is used to offset uncompensated care.

Two tables below provide different views of Montana hospitals' charity care. Table (1)(a) shows four Montana hospitals' charity care and debt writeoffs *as a percentage of total charges* for 2009-2010[23] while Table (1)(b) shows five other Montana hospitals' charity care and bad debt writeoffs *as a percent of operating expenses* for 2010.

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[21]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.

[22]In the past, disproportionate share payments or DSH payments have helped hospitals compensate for serving high numbers of Medicaid patients and those uninsured patients who have trouble paying their hospital bills. The Affordable Care Act removes these payments as one way to offset the costs of expanding the number of people with health care coverage.

[23]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.

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%

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.

Overall uncompensated care at Montana hospitals, a combination of charity care and bad debt write-offs, amounts to approximately $150 million a year, according to preliminary indications for a report being prepared by Gregg Davis and the Bureau of Business and Economic Research for the State Auditor's Office under a health exchange planning grant.

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[24] 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 also see 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 experienced a significant health problem.

Those opposed to the individual mandate had hoped that the Affordable Care Act would be declared unconstitutional partly because of the mandate. However, the U.S. Supreme Court's 5-4 ruling on the Affordable Care Act upheld the individual mandate under the authority of the U.S. Congress to tax.[25] The opinion noted that the "individual mandate" is less a requirement to buy insurance than to pay a tax (as the penalty is described in the opinion) or a penalty for not having insurance. The penalty is for each month without coverage for each individual but is limited in several ways. Among the limits are that the tax is not to exceed either a flat dollar amount of $695 in 2016[26] (increasing over time by an inflation index) or 2.5% of an individual's household income, whichever is greater, with a cap set at the annual cost for essential benefits represented by the average of national premiums for a bronze plan. A bronze plan is the lowest cost plan (other than a catastrophic plan) available on a health insurance exchange. One estimate by the Congressional Budget Office is that the premiums for a bronze plan may annually run

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[24]Individuals who are exempt from the individual mandate include: Indians (whether living on a reservation or not); an individual whose income does not meet the federal income tax filing threshold; an individual who finds that a health care plan would cost more than 8% of his or her household income; an individual who receives a hardship exemption from the Secretary of the Department of Health and Human Services; and a member of a health care sharing ministry as that term is described under 501(c)(3) of the Internal Revenue Code if the ministry has a shared set of ethical or religious beliefs. See Section 1411(b)(5) of the Affordable Care Act.

[25]The U.S. Supreme Court opinion in the National Federation of Independent Business et al. v. Sebelius, Secretary of Health and Human Services, et al., No. 11-393, is available at: http://www.supremecourt.gov/opinions/11pdf/11-393c3a2.pdf.

[26]The 2014 penalty under the flat amount calculation is $95 and the 2015 penalty is $325. If a household does not cover a child 18 years old and younger the penalty is half of that assessed against adults. A cap limits a family's flat tax calculation to triple the adult's penalty so that in 2016 a family of four or more without insurance would pay a penalty of $2,085 (unless the household income calculation is triggered). For more on the individual mandate tax see: http://factcheck.org/2012/06/how-much-is-the-obamacare-tax/.

$4,500 to $5,000 for an individual policy or $12,000 to $12,500 for a family policy.[27] The national average premium would be expected to increase with medical inflation.

Although the 2011 Legislature enacted section 2-1-501, MCA (SB 125), which prohibits state employees from implementing the individual mandate, the Internal Revenue Service will be handling enforcement, and the state law does not impede federal employee actions.[28]

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 that occurred in previous decades. Yet a big unknown related to the reform portions of the Affordable Care Act is whether all reforms combined will ultimately increase the cost of health insurance more than without reform.

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 doughnut hole, essentially a gap in coverage for nondisabled, nonelderly adults who are ineligible for Medicaid because their incomes are between 33% and 100% of the federal poverty level.[29] At 100% of the federal poverty level an individual 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 hospitals and other health care providers continuing to shift their uncompensated care costs to those with insurance or others paying out-of-pocket.

A related problem regarding whether people will choose to pay a penalty rather than have insurance or be unable to access Medicaid is that the Affordable Care Act offsets some of

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[27]Congressional Budget Office letter to Sen. Olympia Snowe, Jan. 11, 2010, and referenced at http://factcheck.org/2012/06/how-much-is-the-obamacare-tax/.

[28]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. That decision, written by Justice Antonin Scalia, referred to the dual sovereignty of the federal government and state governments.

[29]Gregg Davis PowerPoint, Aug. 20, 2012. See http://leg.mt.gov/content/Committees/Interim/2011-2012/Children-Family/Topics/Medicaid%20Monitoring/aug2012-bber-powerpoint-insurance-survey-results.pdf.

the cost increases projected under the legislation with a reduction in disproportionate share hospital (DSH) payments, which have been paid to DSH hospitals to help compensate their costs for serving high proportions of Medicaid patients and those uninsured patients who have trouble paying their hospital bills. (DSH payments are intended to offset the generally lower reimbursement amounts that hospitals receive from Medicaid than from private insurers.) DSH payments are scheduled to be decreased under the current law regardless of what happens with Medicaid expansion and whether or not a substantial number of people who remain without insurance are unable to pay their hospital bills.

Below are various options proposed for reducing costs, either within the Affordable Care Act or 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 nongrandfathered[30] 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 or 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.[31] Also, the most recent report from the Montana Medical Legal Panel indicates that filed medical malpractice claims in 2011 hit a 20-year low of 93, involving 166 providers (inclusive of hospitals, physicians, dentists, podiatrists, and other licensed health care facilities). Over the past 3 years, there have been four jury trials, all of which originated from claims filed in earlier years. The data indicate most claims are

[30] A nongrandfathered health plan is one that does not meet 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 after that date to reduce benefits or increase costs to consumers.

[31] 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). 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.

resolved prior to going to court.[32]

- **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 cooperatives also is a way of increasing competition under the Affordable Care Act. Studies[33] 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 of this report on health insurer status.)
  - Many proponents of competition have suggested that insurers ought to be 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. In a related vein, proponents of a state health insurance compact (see below) also suggest that states could combine to write their own approach to what benefits must be offered. As such, a compact approved by Congress would be exempt from the Affordable Care Act. Opponents of both approaches 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. Another factor potentially complicating competition is 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 gross data on nearby states' mandates, see Table 2. The essential benefit requirement will minimize the differences in mandates between Montana and those neighboring states that have 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

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[32]See "Montana Medical Legal Panel 2011 Annual Report, as of Aug. 23, 2012". The information can be accessed at http://www.mmaoffice.org/about_panel.htm.

[33]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.

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

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
(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.
*The Council for Affordable Health Insurance is a research and advocacy organization of insurance carriers who serve the individual, small group, health savings account, and senior markets. See http://www.cahi.org.

- **Minimizing regulation.** The American Legislative Exchange Council,[34] among others, has suggested that states ought to be able to form interstate compacts that minimize or bypass federal and state regulations regarding health insurance. The Health Care Compact Alliance[35] has provided model legislation for compacts, which as of April 2012, had been adopted by six states.[36] For a compact to go into effect, Congress must also approve the compact; this has not yet happened. A Montana version, HB 526, passed the 2011 Legislature but was vetoed by the governor. The model act for the compact says that federal funds, except for those for veterans and Indian health care but including Medicaid and Medicare, are to be distributed to the

[34]The American Legislative Exchange Council promotes free-market enterprise, limited government, and federalism through a public-private partnership of legislators, private-sector partners, and the general public. See http://www.alec.org.

[35]The Health Care Compact Alliance website, http://healthcarecompact.org, says the organization is organized under section 501(c)(4) of the Internal Revenue Code to offer Americans more influence over decisions that govern health care.

[36]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 had been considered in 25 states and approved in Utah, Indiana, Georgia, Missouri, Oklahoma, and Texas.

states, somewhat as a block grant. The compact also proposes 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, which would gather and publish health care data and make nonbinding recommendations. Key compact language regarding the ability of the states to regulate health care is:

> "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".[37]

- **Increasing regulation (at least in Montana).** The Affordable Care Act contains a presumption that high premium costs are due, in part, to insurance companies not only paying for health care but increasing their revenues. To increase insurance company accountability the Affordable Care Act requires that for each premium dollar an insurer spend 85 cents of large group market premiums on health care costs or 80 cents of the individual or small group market premium dollar; the remaining 15 or 20 cents is for overhead and administrative costs. The 85:15 or 80:20 shares of health care costs to administrative costs are called the medical loss ratio. Insurers that failed to meet these medical loss ratios were to issue rebates in August 2012 to policyholders. Rebates in Montana and nearby states are listed in Table 3.

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.

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

*The 80-20 requirement is for individual and small group policies. The 85-15 requirement is for large group policies.

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. Many state insurance regulators have the authority to reject rate increases that are determined to be unreasonable or unjustified. Some states have review authority without the ability to reject increases. Montana is one of three states without major medical health insurance rate review authority, so the federal government has been reviewing rate increases for Montana health insurance policies. However, the federal government has no enforcement other than a requirement to post the names of insurers whose rate increases have been determined to be unreasonable. 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.

For 71 Montana policies submitted for review, the federal government determined as unreasonable rate increases 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). To date, all of the reviewed Blue Cross Blue Shield of Montana plans, including some with an 18% increase, received a "not unreasonable" label. Of the 11 BCBSMT plans still pending review in October 2012, most had an 18.5% increase, with one having a 22% increase. Four Everence Association, Inc. Vantage policies gained a not unreasonable tag, with 4 pending review. Also pending review are 5 individual policies sold by Celtic Insurance Co., all with rate increases of 32.76%. Of all reviewed policies, 24 were considered unreasonable, 23 were not unreasonable, and 24 are pending review.[38]

Another increase in regulation under the Affordable Care Act is that 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;
- prescription drugs;

[38]Information accessed Oct. 16, 2012, at: http://companyprofiles.healthcare.gov/states/MT/rate_reviews?search_method=rate_reviews.

- 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 provide 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 Congressional Budget Office's assertion that in 10 years the act will result in a budget benefit for the United States or, in essence, a decrease in the federal budget deficit of approximately $143 billion. 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 3 years, the Congressional Budget Office or CBO estimated that for the years 2012 to 2021 the costs of the Affordable Care Act just for insurance or health care coverage would be $1,252 billion. Offsets[39] also are written into the bill for a net benefit to the economy over 10 years, as calculated by the CBO. For the insurance and coverage costs, the federal government expenditures are primarily 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 until reaching a 90% federal share in 2020);
- 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.

After the June 2012 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 billion over the 2012-2022 period (note

[39]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.)

the extra year tacked on) or a reduction of $84 billion from the 2010 estimate. The main reason the CBO lowered the number was because "reductions in spending from lower Medicaid enrollment are expected to more than offset the increase in costs from greater participation in the newly established exchanges".[40] The revised analysis pointed out that the new estimates did not include offsets from expected revenues or fees in the Affordable Care Act. The offsets have not been updated by the CBO. Table 4 shows some (but not all) of the April 2010 projections for offsets along with the CBO's July 2012 projected federal expenditures for Affordable Care Act insurance support.[41] The table cannot provide a bottom line impact on the federal deficit because completely comparable information in all areas is lacking. In addition, some offsets from FY 2012 and FY 2013 are not shown here; these include some that already are impacting hospitals, among others.

Table 4: CBO estimates for fiscal impacts of federal insurance support under the Affordable Care Act, selected years for FY 2014 - FY 2019 (in billions of dollars) with comparison to 2010 analysis

Items 1-4 were affected by the Supreme Court decision. Positive numbers represent offsets/ revenues. Negative numbers indicate expenditures/ revenue loss.	FY 2014		FY 2016		FY 2018		FY 2019		FY 2021
	For fiscal years (above) CBO analysis for July 2012 and April 2010								
	7/12	*4/10*	7/12	*4/10*	7/12	*4/10*	7/12	*4/10*	7/12
Insurance Support-Related Outlays (Negative # is for expenditures/ revenue loss.)									
1-Medicaid/CHIP outlays[(a)]	-$26	*-$29*	-$62	*-$81*	-$77	*-$91*	-$83	*-$97*	-$92
2-Exchange subsidies & related spending[(b)]	-$25	*n/c*	-$97	*n/c*	-$129	*n/c*	-$137	*n/c*	-$148
3-Small employer tax credits	-$3	*-$5*	-$2	*-$3*	-$2	*-$4*	-$2	*-$4*	-$2
4-Other revenue changes Exchange premium credits		*-$5*		*-$18*		*-$24*		*-$26*	
Other Medical or Insurance-Related Offsets (Positive # represents offsets/ revenues)									
5-Penalty payments by: (combined in 2010) -- employers[(c)] -- uninsured individuals	 $4 0	*$3*	 $11 $6	*$12*	 $14 $7	*$13*	 $15 $7	*$14*	 $17 $9
6-Excise tax on high-premium insurance plans[(c)]	0	*0*	0	*0*	$11	*$12*	$18	*$20*	$27
7-Other effects on tax revenues and outlays	$4	*n/c*	$16	*n/c*	$31	*n/c*	$36	*n/c*	$37

[40]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.

[41] *Ibid.*, p. 2.

8-Medicare/Other Medicaid-CHIP - Lower annual fee-for-service updates for payment rates for: --Medicare --Medicare Advantage - Disproportionate Share payment reductions		*$13* *$13* *$1*		*$25* *$19* *$5*		*$41* *$23* *$9*		*$51* *$25* *$11*	
9-Fees on certain drug and medical device manufacturers, health insurers		*$12*		*$15*		*$19*		*$18*	
10-Additional hospital insurance tax[(d)]		*$17*		*$33*		*$37*		*$39*	
11-Other revenue changes Associated effects of coverage on revenues	$4	*$1*	$16	*$14*	$31	*$10*	$36	*$7*	$37
Bottom line: Data elements presented here do not add to a definitive assessment of the effect on the budget deficit.									

Source: Congressional Budget Office, "Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision", July 2012, for Medicaid/CHIP outlays, Exchange Subsidies and Related Spending, Small Employer Tax Credits, Penalty Payments by Uninsured Individuals, Penalty Payments by Employers, Excise Taxes on High-Premium Insurance Plans, and Other Effects on Tax Revenues and Outlays. Table 4. This July 2012 report did not include offsets other than the net budgetary impact from reinsurance collections, for example, on exchange subsidies and related spending. For the April 2010 columns, the source was the Congressional Budget Office, "Payments of Penalties for Being Uninsured under the Patient Protection and Affordable Care Act", Revised - April 30, 2010. Table 2: Estimate of Changes in Direct Spending and Revenue Effects of the Reconciliation Proposal Combined with H.R. 3590 as Passed by the Senate.
n/c = not comparable
(a) CBO anticipates that not all states will expand Medicaid. Rather than the $73 billion overall increase projected prior to the Supreme Court decision, the estimated amount now is $41 billion.
(b) The July 2012 estimate includes spending for high-risk pools, premium review activities, loans to CO-OP plans, grants to states for the establishment of exchanges, and the net budgetary effects of proposed collections and payments for risk adjustment and transitional reinsurance. The CBO reported the latter category separately in the 2010 estimates.
(c) The effects on the deficit include CBO's estimates of the impacts on tax revenues related to changes in employees' taxable compensation.
(d)The additional hospital insurance tax takes effect in 2013 and increases from 0.5% to 0.9% the withholding on higher incomes (individuals earning more than $200,000 and families earning $250,000 or more).

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 federal budgets. The costs of the Affordable Care Act remain highly controversial between the people who feel the Affordable Care Act may help control health care costs and the people 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 from penalties under the Affordable Care Act:

- people who are not required to file federal income taxes because their income is too

low (estimated at 165,259 married couples and individuals in Montana[42]);
- Indians;
- participants in a health-sharing ministry;
- people for whom plan costs exceed 8% of their income; and
- people granted hardship exemptions by the Secretary of Health and Human Services.

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

The Affordable Care Act was intended to expand health care coverage in one of two ways to the uninsured U.S. population. Individuals unable to afford health insurance would be in the expanded publicly supported Medicaid population,[43] and individuals who are marginally able to purchase insurance would receive federal government subsidies to help them buy a plan on the private insurance market through a health insurance exchange. A health insurance exchange would be open to anyone buying insurance individually, but an individual also is able to buy in the existing insurance market outside the exchange. Those employees working for a small employer might be directed to what is called the small business health insurance option or SHOP[44] exchange. However, only through a health insurance exchange are federal tax credit and premium assistance to be available if the individual buying insurance on the health insurance exchange meets the following criteria:
- has a marginal adjusted gross income below 400% of the federal poverty level but above 100%; and
- if offered a plan through an employer group health plan, the individual can show that the employer plan costs more than 9.8% of the household's income.

In essence, health insurance exchanges are intended to help:
- individuals and employers of small businesses compare insurance options on a level playing field; and
- individuals obtaining insurance in the individual health insurance exchange to get tax credits to pay premiums and, possibly, additional assistance to pay out-of-pocket costs.

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[42]E-mail of Aug. 16, 2012, from Dan Dodds at the Montana Department of Revenue, based on 2010 income filing information of 506,372 married couples and individuals filing, of which 341,113 Montana income tax returns had incomes above the federal income tax filing threshold. This counts married couples filing separately on the same form as one return.

[43]See part 1 of this report for the differences between the current and expanded Medicaid-eligible populations.

[44]In a federally facilitated exchange, the individual exchange market is going to be separate from the SHOP or small group 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 "yes" to the question of whether an employer health plan is available to them, he or she will be redirected to their employer plan unless they can meet other eligibility provisions for an exchange.

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.[45]

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, he or she will not be able to enroll in an individual health insurance exchange and get federal assistance until the following year's enrollment period. This person then might buy insurance on the open market or, if not exempt from having to purchase insurance, be subject to the penalty for not having insurance.

i) Health insurance coverage in Montana and indications from a study by the Bureau of Business and Economics Research for the State Auditor

Potential participants - One question in Montana is whether sufficient numbers of uninsured people who are not eligible for Medicaid will participate in 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 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. In August, 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

[45] 42 U.S.C. 18091(2)(I).

55,000 as projected by BBER.[46] Subtracting 55,000 potential Medicaid enrollees from those without insurance, if the Legislature were to expand Medicaid, 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 people potentially eligible for subsidies.[47] 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 purchasing 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).[48] More than 97% of Montana establishments (a business might have more than one establishment) employ fewer than 50 workers; only 996 Montana establishments have 50 or more employees. (These employers hire more than 37% of the workforce.)[49] See Table 5 for more information on business size in Montana.

Table 5: Montana establishments by size and percent offering health insurance

Establishment	Employees				
	under 10	10-24	25 to 99	100 to 999	with more than 1,000
Total*	32,682	not available**	not available**	306	8
Percentage in MT*	81%	18.1% (10.6% have fewer than 20)		0.8%	less than 0.1%
% offering health insurance	22%	57%	77%	97%	100%

*Data from First Quarter 2011.

**Data are not available in these categories. The table combines information from the U.S. Census and the Small Business Administration. Each uses different sizing criteria.

Source for total establishment size/percentage: Montana Department of Labor and Industry and the U.S. Bureau of Labor Statistics, "Quarterly Census of Employment and Wages", First quarter, 2011.

Source for percent of health insurance: Small Business Administration, "Health Insurance in the Small Business Market:

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[46]Gregg, *op. cit.*

[47]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.

[48]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.

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

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:

- a review of Montana's population by insurance status and stratified by income, age, employment, and health status;
- 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, and out-of-pocket provisions are offered, plus the acceptance rate by employees, and other available benefits, including dental or prescription options;
- responses from 2,500 household surveys as to reasons the uninsured do not have health insurance;
- estimates of how many Montanans may 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 group of people is called the "bubble group"). The BBER report to the Children, Families, Health, and Human Services Interim Committee estimated that between 9,700 uninsured and 14,000 insured Montanans would be in the bubble group moving between Medicaid and exchange subsidies. (But these numbers were for Montanans with incomes between 138% and 150% of the federal poverty level, and that number will be affected by whether Medicaid is expanded.)

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

One of the stated purposes of health insurance exchanges is to promote an element of competition in the health insurance market and make selection of a health insurer easier for buyers who increasingly go to the internet to compare prices and features for airline travel or consumer goods. A study of insurance competition, however, found that very few areas of the United States have competition in health insurance. An American Medical Association study 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.[50]

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.[51] However, Montana did not rank as one of the least competitive markets in the AMA study.[52] Separately, 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.[53]

Another study undertaken by the State Auditor's Office used 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 concentrated with so few players. Christina Goe with the State Auditor's Office noted that insurance markets nationwide are becoming more concentrated. For example, the State Auditor's Office reported that six carriers in the individual market were no longer active in Montana in 2011 and three of the small group carriers had ceased doing active business in Montana in 2011.[54] The State Auditor's Office noted that the departed insurers had very small market shares and that two new insurers have been added to the list of companies actively marketing individual and small employer group plans.

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

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[50]David W. Emmons, et al., "Competition in Health Insurance: A Comprehensive Study of U.S. Markets, 2011 Update", American Medical Association. As summarized in *Medical Benefits,* April 30, 2012, p. 12.

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

[52]*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.

[53]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. A lower number indicates greater competition. For example, scores between 1,000 and 1,500 indicate a competitive market, between 1,500 and 2,500 moderate market concentration, and above 2,500 highly concentrated. Only Wisconsin scored less than 1,500.

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

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 John Alden and Time Insurance companies to provide rebates to Montana customers based on not meeting their medical loss ratios. As mentioned earlier, both companies received determinations of unreasonable rate increases during a federal rate review of various policy premium increases for 2012. However, there is no penalty for the failure to meet the medical loss ratio benchmark except for whatever embarrassment might be linked to having a rate increase determined to be "unreasonable".

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 the person's 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 because of preexisting conditions or who were 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 (MCHA) plans. The MCHA plans cover those Montanans who are eligible for portability coverage as set out under the Health Insurance Portability and Accountability 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.[55] 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 the enrollee had previous creditable coverage. There is no exclusion based on a preexisting condition for a participant in the federally subsidized Montana Affordable Care Plan (MACP), but an applicant first must show he or she has been uninsured for at least 6 months prior to enrolling in MACP. The MACP participant's premiums are 100% of the average individual market rate. Although the MCHA has a premium subsidy program, funding limits mean no subsidies currently are available. The subsidy, when available, 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 MACP program dissolves Jan. 1, 2014, and its participants will receive notices that they can enroll on the health insurance exchange.

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. Once the insurance exchanges go into effect, the MACP is to dissolve because insurers will no longer be able to deny coverage to these individuals. The risk

[55]Of two main eligibility criteria described in section 33-22-1501(7), MCA, one is having an application rejected by an insurer. The other may be met if an insurer imposes a restrictive rider or preexisting condition. The Montana Comprehensive Health Association may issue a waiver for either criteria.

to the insurers is to be adjusted through various risk programs discussed under the risk reinsurance, risk adjustment, and risk corridor portion of this report.

Table 6: Enrollment for the Montana Comprehensive Health Association and the Montana Affordable Care Plan, 2012

	Enrollment, 6/2012	Monthly Premium Range**				Deductibles
Montana Comprehensive Health Association	2,730 members	0-17	30	50	64	Range from $1,000 - $10,000 depending on the plan option.
		$103-$292	$189 - $540	$346 - $988	$543 - $1,550	
Montana Affordable Care Plan	329 members*	$186	$257	$471	$739	$2,500

*There were 337 members as of 7/27/2012.

**There are 6 different plans for MCHA, providing various premium and deductible options.

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

Assistance - Since 2005, Montana has had a program, Insure MT, to help small businesses of between two and nine employees receive either tax credits or business premium incentives and to provide their employees with premium assistance to buy health insurance. A business that pays any employee (other than the owner, partner, or shareholder) more than $75,000 is not eligible for the Insure MT program. (See section 33-22-2006, MCA.)

The Affordable Care Act also instituted a small business tax credit to help offset the costs of employee health insurance, but a business can request this credit only until 2016 and only get a tax credit for 2 years. Small businesses with between 2 and 25 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. For the federal tax credit, an employee does not include an owner or any 2%-and-above shareholder. A family-only business does not qualify for a federal tax credit, which is different from the Insure MT program. A fiscal note on HB 612 in the 2011 session noted that about one-third of the businesses receiving a tax credit under Insure MT in 2010 were family-owned; these businesses would have been ineligible for the federal tax credit.

In 2014 the small business federal 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 and only temporarily. After the SHOP exchange begins operating, there is to be no income eligibility limit for participating in the exchange, but subsidies will be based on employees' wages as a percentage of the federal poverty level.

The Montana and the federal programs differ in other ways. Insure MT participants may buy two types of "qualified" insurance plans as defined in section 33-22-2002, MCA: one type being a choice of three plans (that vary based on deductibles) offered through an Insure MT contractor and the other type being a plan offered through a qualified association (like the Chamber of Commerce). Once the SHOP exchange is running in 2014, federal tax credits will be available to any participating small business (under 50 employees) that buys a plan offered on the SHOP exchange. Plans will be available in four cost-based tiers (determined by the percentage the insurer pays and the amount the policyholder pays). The plans are: bronze with an actuarial value of 60/40; the silver with a 70/30 value; the gold with an 80/20 value; and a platinum plan with a 90/10 value. A catastrophic plan also is available to individuals under the age of 30. The Affordable Care Act does not allow buyers of association plans to obtain tax credits. Only Insure MT businesses under the tax credit option are also eligible for the federal credits. Information is not available as to how many small businesses have received the federal tax credit so far in Montana or how many businesses participate in both programs.[56]

Another difference is that the small business under Insure MT may receive tax credits for the owner or owner's family member even if the owner's salary is not considered in calculating the tax credit for the business. The federal program does not provide tax credits for owners or the owner's family members. Table 7(a) provides an overview of Insure MT participation and costs, and Table 7(b) shows examples of firms getting a tax credit under Insure MT and the federal program. The reduction in program costs seen in Table 7(a) is due in part to a reduction of available tax credits and to income audits of the purchasing pool that reduced available subsidies.

Table 7(a): Insure MT Participation and Costs, 2011 and 2012

	October 2012	2/3/2011 Report to Joint Subcommittee
Purchasing Pool Participation and Costs		
Businesses	779	872
Employees	2,058	2,415
Employees + dependents (covered lives)	3,844	4,468
Average annual cost per business	$3,466	$3,496
Average annual cost per employee	$1,584	$1,890
Average employees in a business	2.66	~ 3
Annual program cost	$5,985,680	$7,806,494

[56]HB 612 in the 2011 session would have eliminated the potential for dual federal and InsureMT tax credits but the governor vetoed HB 612.

Number of businesses on waiting list	188	~125
Tax Credit Participation and Costs		
Businesses	700	802
Employees	2,394	2,687
Employees + dependents (covered lives)	4,085	4,427
Average annual cost per business	$3,716	$5,297
Total annual program cost	$2,600,942	$4,250,600
Number of businesses on waiting list	104	52
Administrative costs	6%	5% of program budget

Table 7(b) Examples of a fictitious small business obtaining both Insure MT and federal tax credits*

Portion of premium initially paid by business	Nominal initial cost to business	Insure MT tax credit	Federal tax credit	Final nominal cost to business
Scenario 1: 100% premium	$50,400 / year	$8,400 / year	$17,640 / year	$24,360 / year
50% of premium	$25,200 / year	$8,400 / year	$8,820 / year	$7,980 / year
Scenario 2: 100% premium	$21,600 / year	$3,600 / year	$2,520 / year	$15,480 / year
50% of premium	$10,800 / year	$3,600 / year	$1,260 / year	$5,940 / year

Scenario 1: Business with 7 employees (average age under 45**) in group health plan with $600/month premiums.
Scenario 2: Business with 3 employees (average age under 45**) in group health plan with $600/month premiums and two of the employees are owners.
*The participating business must be eligible for both Insure MT and federal tax credits.
**Under section 33-22-2006, MCA, tax credits may not be more than $100 for an employee or employee's spouse under 45 years of age or $125 for an employee or employee's spouse who is age 45 or older.

A Henry J. Kaiser Foundation report[57] tallied for each state the amount of money received by both the state government and the private sector under the Affordable Care Act. In that table, Montana employers and businesses were said to receive $3.1 million, which most likely included some form of the small business tax credit as well as subsidies for retiree health costs paid by businesses;

[57]The Henry J. Kaiser Foundation, ACA Federal Funds Tracker, accessed Oct. 29, 2012, and reflecting funds awarded from passage of the Affordable Care Act to roughly October 2012: http://healthreform.kff.org/federal-funds-tracker.aspx.

specific information is not available. Table 8 shows the amount of Affordable Care Act funding that Montana government and businesses have received since 2010 to date.

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

Category	To Government	To Private Sector	Total Funding
Total Amount	*$32,659,895*	*$104,043,587*	*$136,703,482*
Employers/Businesses	$3,634,238	$3,131,625	$6,765,863
Health Care Facilities/Clinics	$500,000		$500,000
Health Centers	$11,381,207	$7,201,978	$18,583,185
Maternal - Pregnancy	$8,676,955	$212,000	$8,888,955
Medicare & Medicaid Special Projects	$201,824	$13,374,139	$13,575,963
Prevention & Public Health	$4,436,017	$5,261,074	$9,697,091
Private Insurance/Health Exchange	$2,869,651	$67,632,445*	$70,502,096
Workforce and Training	$960,003	$7,230,326	$8,190,329

*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 Oct. 29, 2012: http://healthreform.kff.org/federal-funds-tracker.aspx

Penalties - The Affordable Care Act will penalize employers with more than 50 employees (full-time and full-time equivalent) after Jan. 1, 2014, if the employer does not offer insurance to employees and one or more of the employer's full-time employees receives a tax credit or cost-sharing assistance through a health insurance exchange. For large businesses, the assessment may be approximately $2,000 a year for each full-time employee--excluding the first 30 full-time employees.[58] There also is a separate penalty if a large employer offers coverage but the coverage lacks a minimum value[59] or is unaffordable (costs more than 9.8% of that employee's income). Again, the penalty, which could be $3,000 a year, would be triggered for each full-time employee who receives a subsidy through the exchange. However, there is a limit on this penalty. Also subject to an assessment, starting in 2018, are insurance companies that provide expensive or "cadillac" health plans, which amount to an individual coverage plan costing more than $10,200 a year and family coverage costing more than $27,500 a year. The Henry J. Kaiser Foundation in

[58]See U.S. Department of Labor Technical Release No. 2012-01, issued Feb. 9, 2012. Full-time is considered 30 hours or more a week.

[59]The definition of "minimum value" remains to be completed, but the term in part means that the actuarial value of benefits 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.

September 2012 reported that annual premiums for employer-sponsored health coverage rose 4% to $15,745 for a family and 3% for an individual to $5,615. Employees on average paid $4,316 toward the family premium or $951 for worker-only coverage.[60]

A September 2012 estimate[61] by the Congressional Budget Office indicates that nationwide in 2016 about 6 million Americans may have to pay a penalty, of which about one-third of that number are expected to have incomes above 400% of the federal poverty level (and thus not able to get federal subsidies on a health insurance exchange).

v) Status of the health cooperative that has received federal funding under the Affordable Care Act to provide an insurance alternative

The Affordable Care Act provided funding to help set up health cooperatives, which are 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 are to be offered on all exchanges and are intended to provide more competition.

In April 2012, the Committee heard from Dr. Tom Roberts, the chairman of the board of the Montana Health CO-OP. The Montana Health CO-OP 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 start-up loan, which will be distributed quarterly over the next 2 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 5 years, and the loans backing initial reserves are 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. Dr. Roberts 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.[62]

vi) Other information related to health insurance exchanges

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[60]News release from the Kaiser Family Foundation, "Family Health Premiums Rise 4 Percent to Average $15,745 in 2012, National Benchmark Employer Survey Finds", September 11, 2012. Accessed Oct. 11, 2012, at: http://www.kff.org/insurance/ehbs091112nr.cfm.

[61]Congressional Budget Office, "Payments of Penalties for Being Uninsured Under the Affordable Care Act", September 2012, accessed at: http://www.cbo.gov/sites/default/files/cbofiles/attachments/09-19-12-Indiv__Mandate__Penalty.pdf.

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

Establishment of health insurance exchanges, whether by states or by the federal government, is complex. In addition, the Affordable Care Act contains 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 14 states that, as of Sept. 26, 2012, had a planning grant but had not applied for an establishment grant.[63] Charges for states that expect to have a federally facilitated exchange for operational costs have not yet been determined. Information from the Centers for Medicare and Medicaid Services issued in November 2011 noted that states with a federally facilitated exchange will not have to contribute to the costs associated with Medicaid and CHIP eligibility determinations but that the cost of interfacing between systems may be shared as they are currently. Other potential charges were not detailed.[64]

  Long-term funding considerations for exchanges typically include:
  - an assessment to be collected from health insurers. Yet to be determined is whether all insurers are assessed or just those participating in an exchange.
  - an assessment to be collected from individuals participating in the exchange. Massachusetts, the first state to have a health insurance exchange, uses this approach to finance its exchange and charges 3% of the premium to individuals participating in the exchange.
  - a monthly fee to each subscriber. Utah, which was the second state to have an online health insurance marketplace, funds operations with a monthly subscription fee, which covers broker fees as well as administrative costs.[65]

- **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 or a disproportionately high share of the high-cost policyholders for whom premiums are insufficient to cover costs. Another is to smooth the transition as insurers change their rate-setting based on underwriting. (See health insurance

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[63]See http://www.healthcare.gov/news/factsheets/2011/05/exchanges05232011a.html, for information on Affordable Care Act planning and implementation grants to states, commonwealths, and territories.

[64]Department of Health and Human Services, Centers for Medicare and Medicaid Services, "State Exchange Implementation Questions and Answers", Nov. 29, 2011.

[65]The information on both Massachusetts and Utah is from the National Conference of State Legislatures, "Patient Protection and Affordable Care Act: State Action Newsletter," under article titled "States Consider Funding Options for Exchanges', April 5, 2012.

reforms, below, for information on these changes.) The federal government will handle the 3-year risk corridors program, which is to protect insurers from insolvency because of inaccurate rate setting during the transition. The Department of Health and Human Services says states can choose to run the risk reinsurance and risk adjustment programs themselves or to use the federal mechanisms. Montanans are likely to see the federal government handle all the risk options unless the state enacts legislation to create a reinsurance entity. Only states with a state-based exchange can do the risk adjustment.

Another impact for consumers is that insurers are likely to pass on the cost of risk assessments through premiums. 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. The distribution is intended to help lower the costs in the individual market as well as smooth out the risks.[66] Risk readjustment, the only program to extend beyond 3 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 Department of Health and Human Services.

- **Health insurance reforms**
  In addition to changing how insurers set their premiums, the Affordable Care Act stimulated various other health insurance reforms. A Congressional Research Service briefing paper[67] noted that the market reforms imposed on insurance companies generally will be enforced by states, which remain the primary regulators of health insurance. Among these reforms are changes to how insurers calculate the premiums for their policies. Instead of underwriting a policy based on health status (which allowed insurers to avoid risk by limiting exposure to preexisting conditions or other policyholder health conditions), insurers will be trying new approaches and setting rates based on value and quality of a health plan, plus a limited set of factors related to the insured individual's tobacco use, age, and place of residence.

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

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[66]More information on risk corridors, risk reinsurance, and risk adjustment is in Appendix A. Also, see Bernadette Fernandez and Annie L. Mach, "Health Insurance Exchanges Under the Patient Protection and Affordable Care Act (ACA), Congressional Research Service, Aug. 15, 2012.

[67]Fernandez and Mach, *op. cit.*

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 an insurance producer license.

- **Mandated benefits.**

  Table 9 shows the list of essential health benefits under the Affordable Care Act plus a list of benefits mandated under Montana law and how they relate to the following:

  - a plan offered by the Montana Comprehensive Health Association. This is a proxy for benefits that prior to the Affordable Care Act's establishment of essential health benefits were required by Montana law for individual and group policies.
  - current Medicaid benefits (future benefits may be changing to a version of the essential health benefit plan); and
  - the largest plan by enrollment for small employers in Montana, the Blue Dimensions plan of Blue Cross Blue Shield of Montana, which is expected to be the designated plan for essential health benefits on which health insurance exchange plans are to be based.

  The Blue Dimensions plan of Blue Cross Blue Shield of Montana already offers Montana's mandated benefits so that avoids triggering a provision of the Affordable Care Act that says any state mandates not included in the essential health benefits plan are to be subsidized or paid for separately by the state.[68]

Table 9: Essential Health Benefits required under the Affordable Care Act and Montana's mandated benefits as they relate to MCHA plans, Medicaid, and the Blue Dimensions plan

Essential Health Benefits Required Under the Affordable Care Act	MCHA plans, state statutes	Medicaid (1)	Montana Blue Dimensions
Ambulatory patient services • Outpatient hospital services		x	x - outpatient services
Emergency Services • Ambulance services • Emergency room care	33-22-1521	 x	x
Inpatient hospital services	33-22-1521[2]	x	x
Rehabilitative and habilitative services and devices. Insurers to define habilitative.		may be included	rehabilitation - with limits
Laboratory, x-ray services, including mammograms as defined in section 33-22-132, MCA	33-22-1521 with limits*	depends on group	x -- includes diagnostic tests

[68] There has not been any guidance on how the state is to pay for any mandated benefits, including 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.

Maternity Services: prenatal & postpartum care, delivery		depends on group	x
Mental health services and substance use disorder services, including behavioral health treatment • Montana lists severe mental illness separately	33-22-1521	x	outpatient & inpatient
Newborn initial care (listed with maternity care in essential health benefit list)		depends on group	x
Preventive and wellness services + chronic disease management)		depends on group	x
Well-child care (Pediatric services, including oral and vision care required for essential health benefits) If a default plan does not cover oral and vision coverage for children, federal employee plan benefits may be incorporated for essential health benefits.	(may be included)	may be included	x (does not cover dental or vision for kids)
Prescription drugs	33-22-1521	x	with limits
MANDATED BENEFITS IN MONTANA			
Outpatient self-management training/education for diabetes plus limited equipment benefit	33-22-129	may be included	x with limits
Coverage for children from birth and to adopted children from placement on, if covered by insurance	33-22-301 33-22-130 33-22-504		x (see well-child care above)
Coverage for well-child care (may be limited to one visit for each type of coverage - immunizations, exam, labs). This is similar to the essential health benefits requirement above.	33-22-303 33-22-512	may be included	x (see well-child care above)
Treatment of inborn errors of metabolism	33-22-131	may be included	x
Coverage for mammography examinations[3]	33-22-132	x	x
Coverage for minimum stay after childbirth[3]	33-22-133	may be included	x
Postmastectomy care[3]	33-22-134	may be included	x
Reconstructive breast surgery after mastectomy[3]	33-22-135	may be included	x
Continuation of benefits to dependents (group policies)	33-22-503		x

Notes: 1) Medicaid coverage depends on the type of group that is covered. Children, for example, may have a separate set of benefits than the aged, disabled, or blind. Also, Medicaid essential benefits may be subject to change for the expansion group or possibly the existing Medicaid population. The lack of an "x" for Medicaid regarding state-mandated benefits does not necessarily mean benefits are not provided. They may be, depending on the type of Medicaid group.
2) Section 33-22-1521, MCA, outlines minimum benefits for a plan under the Montana Comprehensive Health Association and, under section 33-22-245, MCA, the MCHA plan benefits must be included in an individual health benefit plan offered in Montana.
3) These benefits are mandated by federal laws as well.

- **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 each state in the region additionally 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.[69]

- **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 or may rely on the State Auditor's Office for the determinations. The qualified health plans are to limit participant enrollment to those who live or work within their service area. Although an insurance plan may have a sufficient complement of health care providers in its network, the number of physicians or other health care providers who are able to accept new patients may still be limited because of a general shortage of health care providers in Montana.[70]

vii) Not included here

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; or
- coverage for prescription plans under Medicare that previously left those with certain levels of expenditures in a "doughnut-hole" of no coverage until they reached a higher level of expenditures.

C. What would a federally facilitated exchange 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

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[69]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.

[70]A Montana Department of Labor and Industry report, "Montana Employment Projections 2011-2021", noted that Montana's aging population and overall population growth will increase demand for health care services and health care providers. This is even without taking into account an increase in demand if more formerly uninsured people seek to access services because of gaining health insurance.

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 told the National Conference of State Legislatures in August 2012 that his office or related federal offices 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[71] are those listed in the "Blueprint" that federal officials have asked states to complete. States also have been asked to complete 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;
- 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);

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[71]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.

- eligibility determinations for the advanced premium tax credit and the cost-sharing reductions (the federal eligibility "hub" 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 an insurer's participation 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 processes that support collection of qualified health plan issuer and plan data. Insurers will begin collecting data on quality care and factors other than health risks as the insurers transition from using underwriting determinations to price premiums. This is why data on quality 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 plan issuers;
- 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 regarding SHOP and its functions, eligibility standards, and processes;
- ways to handle premium aggregation in the SHOP exchange;
- ways to electronically report results of eligibility assessments and determinations for SHOP;
- an organizational structure and staffing resources necessary for an exchange;
- a long-term operational cost, budget, and management plan;
- proof of compliance with Department of Health and Human Services IT (information technology) guidelines, along with safeguards for privacy and security meeting those guidelines;
- adequate technology infrastructure and bandwidth;
- quality management for independent verification and validation and test procedures;
- privacy and security standards, policies, and procedures;
- 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 health insurance exchange operations indicate that a person[72] (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. The website information is intended 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 of $6,050 for single coverage and $12,100 for family coverage[73]);
- 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 individuals who are at least age 19 and 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 a year.

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.

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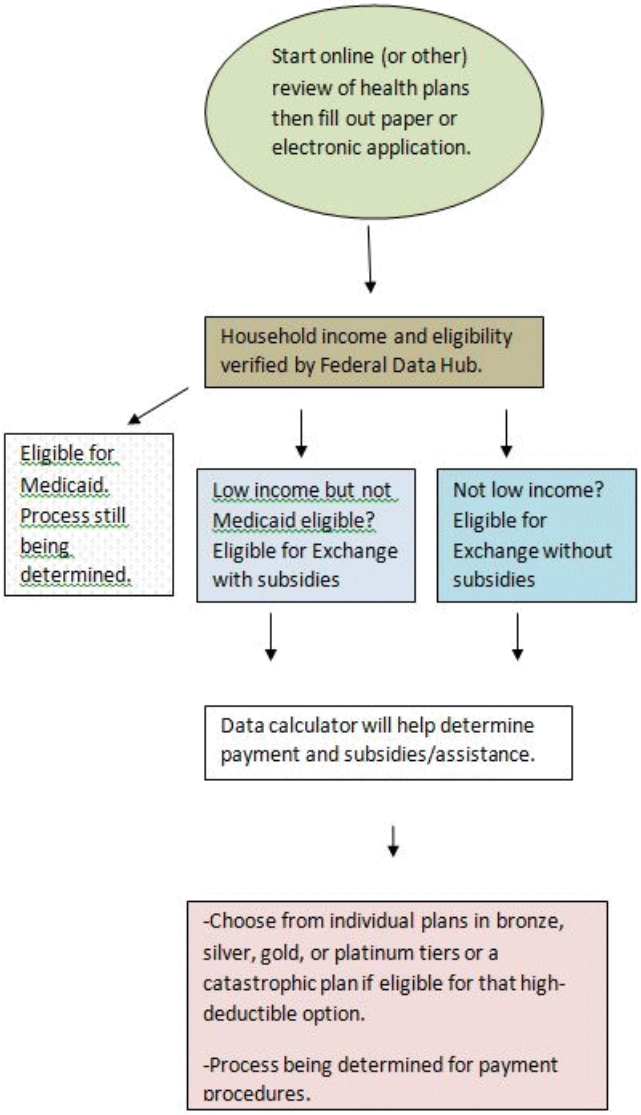
[72]Not all people are eligible to participate in an exchange. For example, an unauthorized alien cannot obtain coverage through an exchange even if buying insurance without seeking a subsidy.

[73]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.

There also is a basic health program that serves those not eligible for Medicaid and that is available to other low-income individuals not obtaining insurance through a health insurance exchange. The basic health program is optional at the state's discretion; a state does not have to offer a basic health program. The Affordable Care Act criteria for the basic health plan option, if that option is chosen by the state, require household income to be between 133% of the federal poverty level and 200% of the federal poverty level. This option may help to fill the coverage gap 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 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 but federal officials say the process will be up and running by October 2013 when plan selection on a federally facilitated exchange is to be available.

Figure 1: SIMPLIFIED EXAMPLE OF AN INDIVIDUAL EXCHANGE



Among likely questions to be asked:

- **Eligibility for exchange purchase:**
  - -Are you a citizen, a national, or a lawfully present alien?
  - -Are you incarcerated?
  - -In what state are you a resident?
  - -Do you file federal income tax returns?
  - -What is your social security number?
  - -Does your employer offer a health insurance plan?

- **Eligibility for tax credits/assistance**
  - -What is your household size for federal income tax purposes?
  - -What is your modified federal adjusted gross income for the latest tax year?
  - -What is your current monthly income or projected annual income (this is subject to verification)?

Employer in SHOP Exchange:

-Reports number of employees (to determine if eligible for small business credits).

-Reviews plans and may limit options for employees, but employees are to have some choice.

-Provides payment (either to employee or directly to exchange—still to be determined).

Premium costs in an exchange and ways to offset those costs - The Affordable Care Act states that people whose modified federal adjusted gross income is between 100% and 400% of the federal poverty level would be eligible for an advanceable tax credit, with some people also eligible for a cost-sharing subsidy but only if they sign up for a silver plan. Table 10(a) shows the correspondence between gross annual income (not the modified federal adjusted gross income to be used for exchange purposes) and percentages of the federal poverty level based on household size. Also included is a column showing the percentage of Montana households whose income is below $25,000, based on U.S. Census data from 2011. More than 56% of all Montana households had 2011 income and benefits of less than $50,000 a year. Table 10(b) shows the criteria for tax credits and cost-sharing subsidies in a health insurance exchange. Tax credits are advanceable (and there have been 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 10(a): Income as a percentage of the 2012 federal poverty levels for households of 1-7 people

% of MT households with income:	% Fed. Poverty Level	*Income for Households of 1 to 7 people*						
		1	***2***	***3***	***4***	***5***	***6***	***7***
under $10,000 = 7.2% ___ $10,000-$14,999 = 7.1% ___ $15,000-$24,999 = 13.3%	33%	$3,686	$4,993	$6,300	$7,607	$8,913	$10,220	$11,527
	100%	$11,170	$15,130	$19,090	$23,050	$27,010	$30,970	$34,930
	133%	$14,856	$20,123	$25,390	$30,657	$35,923	$41,190	$46,457
	150%	$16,755	$22,695	$28,635	$34,575	$40,515	$46,455	$52,395
	200%	$22,340	$30,260	$38,180	$46,100	$54,020	$61,940	$68,860
	250%	$27,925	$37,825	$47,725	$57,625	$67,525	$77,425	$87,325
	300%	$33,510	$45,390	$57,270	$69,150	$81,030	$92,910	$104,790
	400%	$44,680	$60,520	$76,360	$92,200	$108,040	$123,880	$139,720

Source:

1) U.S. Census Bureau for percent of Montana households at various income levels..

2) Department of Health and Human Services for Federal Poverty Level Income Percentages for 2012 and FamiliesUSA for percentages other than 100% except 33% and 250%. CoverageforALL.org used for 250%. Math used for 33%**.**

Table 10(b): Criteria for tax credits & 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 250% 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(c). Another example, from the Congressional Budget Office, shows in Table 10(d) 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(c): Family Health Insurance Premiums with reform and without reform, 2014

Income as % federal poverty level-FPL	Premium cost with reform	Premium cost without reform
Income of $33,525, based on 150% FPL	$1,400	$11,300
Income of $55,875, based on 250% FPL	$4,700	$11,300
Income of $78,225, based on 350% FPL	$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(d): Projected premium costs plus total costs for exchange and work-based coverage

	Sample family premium	Tax benefit* as % fed. poverty level	Cost after benefits

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

*Federal and state tax benefits for an employer plan recognize that health insurance is a pretax benefit. The Congressional Budget Office and the Joint Committee on Taxation included the average marginal tax rate for each group to account for that benefit. For example, the average marginal tax rate including federal and state income taxes and payroll taxes was 29.4% at 200% of FPL the federal poverty level)
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 access and efficiencies

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

At the June 2012 meeting of the Economic Affairs Interim Committee, representatives from a health workforce task force and other health care experts provided maps that showed certain counties in Montana with few to no medical providers of various types. Kris Juliar, director of the Office of Rural Health and Montana Area Health Education Center in Bozeman, reported that based on the Montana Healthcare Advisory Workforce research, data showed that about 20,000 Montanans have no access to primary care in their counties. (See Table 11.) Although physician assistants and advanced practice nurse practitioners may be providing primary care, there were no physicians in the following counties: Carter, Garfield, Granite, Judith Basin, McCone, Musselshell, Petroleum, Powder River, Treasure, and Wibaux. While the Affordable Care Act is expected to drive up the number of people trying to access health care and requires insurers to have adequate networks, providers may not be available. Based on the Healthcare Advisory Workforce research, only four counties in Montana have an adequate supply of primary care physicians, meaning that 52 counties have a shortage. The two counties with the largest population to primary care physician ratios (among all counties with at least one physician) are Valley County and Teton County.

While access to care is a current problem, population growth and the aging of the current supply of doctors are expected to exacerbate the shortage problem. Larry White, director of the Western Montana Area Health Education Center in Missoula, told the committee that studies indicate Montana will need nearly 20 new primary care doctors every year just to stay at the status quo. Speakers told the Committee in June that proposals would be put before the Legislature to increase the number of medical residencies made available in Montana because studies indicate that many doctors stay in the same area where they complete their residencies. Students participating in the Washington, Wyoming, Alaska, Montana, and Idaho medical school program called WWAMI, which

is partly funded by each state,[74]are encouraged to apply for residencies in Montana. Montana has the nation's lowest number of residency slots per capita, averaging 2 residencies for each 100,000 people, as compared with the national average of 25 for each 100,000 people. In 2012 there were 24 residents training in Billings (8 for each of the 3 years of training). Montana had 800 applications for the eight slots in this past year, White said. He noted that 73% of the doctors trained in the Billings residency stayed in Montana. He further noted:

> So, if we are last in the nation in the numbers of training slots that we have in residencies in primary care and all the rest of the United States is going to experience shortages in primary care going forward and have more slots than we do, then we are constantly going to be at the very most difficult position of trying to attract new doctors into our state.

White pointed out that a second residency program will begin in Missoula in July 2013 with 10 students in each of the 3-year classes. The projected budget is $7 million. He noted that educating a resident costs about $930,000 over the 3 years but that for each year in a primary care practice a physician generates about $430,000 a year in an outpatient practice. If the physician works at a critical access hospital, White said, the revenues can be more than $1 million. The return on investment, with spin-off economic effects, is projected at $2.1 million a year, he said.

A residency in internal medicine in Billings is to start in 2014, which would graduate six physicians, according to Dr. Doug Carr of the Billings Clinic. With all the new residencies, he said, Montana would be seeing roughly 20 physician replacements each year.

Table 11: Primary Care and Total Physicians by Montana County, 2012

County	Primary Care Physicians					Ratio of Population to Primary Care Physician	Total all Physicians
	Family Medicine	General Practice	Internal Medicine	Pediatrics	Total		
Beaverhead	8	0	5	0	13	712	16
Big Horn	9	0	2	1	12	1,075	12
Blaine	3	0	0	1	4	1,599	4
Broadwater	2	0	0	0	2	2,963	4
Carbon	5	0	0	0	5	2,038	9
Carter	0	0	0	0	0	NA	0
Cascade	26	2	28	15	71	1,148	217

[74]In the FY2012-2013 biennium, Montana contributed $6.3 million to the WWAMI program for training doctors and another nearly $1.7 million for medical training in the WICHE program (Western Interstate Commission for Higher Education). Funding for residencies is through a separate budgeting mechanism.

Chouteau	1	0	0	0	1	5,782	1
Custer	4	0	6	4	14	836	24
Daniels	1	0	0	0	1	1,705	1
Dawson	2	0	2	1	5	1,790	12
Deer Lodge	8	0	3	0	11	843	23
Fallon	1	1	0	0	2	1,451	3
Fergus	10	0	4	0	14	823	17
Flathead	45	2	31	9	87	1,091	257
Gallatin	51	0	31	10	92	1,035	224
Garfield	0	0	0	0	0	NA	0
Glacier	14	0	0	1	15	895	16
Golden Valley	0	0	0	0	0	NA	1
Granite	0	0	0	0	0	NA	0
Hill	7	1	2	0	10	1,599	25
Jefferson	5	0	0	0	5	2,343	9
Judith Basin	0	0	0	0	0	NA	0
Lake	22	1	1	0	24	1,218	33
Lewis & Clark	38	0	31	8	77	846	190
Liberty	2	0	0	0	2	1,189	2
Lincoln	11	1	2	2	16	1,242	25
Madison	3	0	0	0	3	2,627	9
McCone	0	0	0	0	0	NA	0
Meagher	0	0	0	0	0	NA	1
Mineral	1	0	0	0	1	4,297	3
Missoula	66	0	41	15	122	921	365
Musselshell	0	0	0	0	0	NA	0
Park	11	0	3	0	14	1,116	23
Petroleum	0	0	0	0	0	NA	0
Phillips	0	1	0	0	1	4,189	1
Pondera	4	0	0	0	4	1,525	4
Powder River	0	0	0	0	0	NA	0
Powell	5	0	0	0	5	1,399	6
Prairie	1	0	0	0	1	1,175	1
Ravalli	20	0	6	1	29	1,418	67
Richland	3	0	2	1	6	1,627	14

Roosevelt	3	0	0	0	3	3,462	6
Rosebud	5	0	0	0	5	1,841	5
Sanders	6	0	1	0	7	1,668	12
Sheridan	1	0	0	0	1	3,265	2
Silver Bow	10	0	13	7	30	1,137	75
Stillwater	3	0	0	0	3	3,107	3
Sweet Grass	1	1	0	0	2	1,830	2
Teton	1	0	0	0	1	6,003	2
Toole	5	0	0	0	5	1,067	6
Treasure	0	0	0	0	0	NA	0
Valley	0	0	1	0	1	7,310	9
Wheatland	1	0	1	0	2	1,076	1
Wibaux	0	0	0	0	0	NA	0
Yellowstone	87	3	66	26	182	836	523
Totals	514	13	282	102	911	1,109	2,264

Source: Montana Medical Association (for primary care physicians the data is from May 2, 2012). Population estimates for 2012 used Census data from 2000 and 2010, with average growth over those years projected to 2012. Calculation made for the Healthcare Workforce Advisory Council.

ii) Increasing efficiencies

Also at the June 2012 Committee meeting, panels discussed options for improving efficiencies that ranged from better licensing processes to improved patient care under a model called patient-centered medical homes.

Licensing issues - Committee meetings in April, June, and September addressed elements of:

- delays in licensing physicians; and
- opportunities to use the licensing process to improve data gathering.

The difficulties experienced by some medical practitioners in the licensing process first came before the Committee in April 2012. One problem was related to physician license renewals, which was partly caused by a switch to a new computer system at the Department of Labor and Industry's Business Standards Division where the Board of Medical Examiners is housed. But other physicians also noted problems with getting licensed at all. The Board of Medical Examiners responded at the April meeting that on average the process took less than 90 days from receipt of application to license approval. The Committee asked that the Board of Medical Examiners work with the Montana Medical Association and others to improve the process. Meetings over the summer led to both board representatives and Montana Medical Association representatives reporting at the Committee's September 2012 final meeting that progress was being made to

improve the licensing process. Reports on these issues are available online on the Committee's web page and include a briefing paper entitled "Licensing Concerns for Medical Personnel in Montana", a response from the Board of Medical Examiners on Physician Licensure Review Times, and comments from the Montana Medical Association at both the June 2012 and September 2012 meetings.[75]

Regarding data gathering, panelists noted that detailed data basically is voluntarily given and, even then, the data may be incomplete. For example, Dr. Carr noted that general internal medicine physicians with outpatient practices number just 114 in Montana, which contrasts with the 282 listed in May 2012 by the Montana Medical Association. One of the reasons for the variance is that physicians may be licensed but not practice, which is the situation for Dr. Carr as an administrator. Jean Branscum with the Montana Medical Association pointed out that a request for specific data, such as the type of a physician's practice, had been made to the Board of Medical Examiners in past years but that the Department of Labor and Industry had not moved to change the questions on the license application or renewal form because department legal counsel said that legislative authorization would be needed. The Montana Medical Association and the Board of Medical Examiners agreed to further examine this issue. Their report at the September 2012 Committee meeting continued to be that legislation would be required, but none was proposed at that time.

Patient-centered medical homes - Dr. Carr also discussed the use of patient-centered medical homes, which is a way of using a team of care providers following certain standards spelled out in the medical home model. The model emphasizes prevention and care of chronic conditions, Dr. Carr said. He referenced the work of an advisory council under the State Auditor's auspices that has been working on the model to develop voluntary guidelines for patient-centered medical homes and payment mechanisms other than the traditional fee-for-service. The State Auditor has proposed LC 378 to establish standards and a structure for patient-centered medical homes.

IV. What to expect in the near future

This report, being written before the November elections, recognizes that political winds and public pressure will shape specific policies. However, in an effort to be helpful for the incoming 2013 Legislature, legislators may find the following ideas proposed (recognizing that each could have a caveat regarding political implications):

- A state role for some components of a federal health insurance exchange;
- A transition from a federal health insurance exchange to a state exchange;

[75]See the Committee website under Meeting Materials for June 2012 and September 2012: http://leg.mt.gov/css/Committees/Interim/2011-2012/Economic-Affairs/Meeting-Documents/meetings.asp.

- A way 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, which means the federal government would carry this out;
- 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 1 year after the state files a Blueprint (detailing how certain functions and policies are to be carried out).

If the Legislature chooses not to seek a state-based exchange, the federal government will:
- continue handling rate review for insurers (unless the Legislature provides rate review authority to the state's insurance commissioner);
- determine how many insurers participate on the exchange;
- determine who can be a "navigator" (a term used to describe someone able to help small businesses and individuals "navigate" the health insurance exchange), and how navigators are paid; and
- 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 or a partnership, 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 authorized 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 section 33-22-1803, MCA, 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 of potential buyers and less administrative hierarchy.

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. Some private insurers are offering exchanges to clients, but under current federal law private for-profit exchanges would not be able to handle the subsidies or assistance for those whose modified federal adjusted gross incomes are between 100% and 400% of the federal poverty guidelines.

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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).[76]
- **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, the pediatric dental care 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 on household federal income tax filings.

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[76]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.

Under the Affordable Care Act the net income eligibility standards (including the assets test) for some people eligible for Medicaid and the Children's Health Insurance Program (Healthy Montana Kids) are 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 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 a policy for a 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 for medical benefits and activities that improve the quality of care as a percent of 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 income-eligible 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 income-eligible 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)
- **Preexisting Condition -** Under section 33-22-140, MCA, "preexisting condition exclusion" 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. 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 a threshold. 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, 2012. 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.[77] Student health plans also have a different methodology for determining a medical loss ratio until January 1, 2014, at which time the standard rules for medical loss ratios apply.[78] 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

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

[78] *Ibid.*

information to obtain the subsidy. An authorization is to last for 5 years but may be rescinded and renewed.

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 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 and the state contribution increasing. Even with the federal government paying 100%, the state would expect to pay various administrative costs. The regular Medicaid program cost-sharing determined by the Federal Medical Assistance Percentage (FMAP) is currently about a 34-66 state-federal split in Montana. Without expansion, a coverage gap is likely to develop for an individual who is not eligible for Medicaid and not eligible for premium tax credits and cost-sharing reductions on a health insurance exchange because the individual's income is less than 100% of the federal poverty level, the limit required to qualify for federal premium assistance through a heath insurance exchange. The people in this coverage gap generally earn more than 33% of the federal poverty level (more than $3,686 and less than $11,170 a year for an individual) and do not have children living at home.
- If a state does not opt in, there is no federal penalty because the U.S. Supreme Court said the penalty was unconstitutional as related to the expansion.

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 was to have been made by Sept. 30, 2012. According to the National Conference of State Legislatures, 24 states and the District of Columbia have selected or recommended the types of services for the essential health benefits package. Montana apparently will have the federal default option, which is the largest small employer group plan in the state based on enrollment in the first quarter of 2012. That plan, based on 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 is the default plan option in Montana. Some states have taken public comment on the plan, which is to serve as a baseline for 2014 plans operating either inside or outside of the exchange and possibly for certain Medicaid populations. Montana's Legislature would have an option of reviewing this plan and making recommendations (if

the federal government timeline provides that flexibility) or making recommendations for services in a future plan beyond 2014.

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 questions may be presented to the 2013 Legislature:

- should the state create a reinsurance program;
- should the state have authority to review and approve or disapprove health insurance rates;
- should the state seek to transfer from a federal exchange to a state-run exchange and, if so, how would the state fund an exchange and should an exchange 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 would require state, county, and municipal employees to buy their health insurance through federal health insurance exchanges;
- LC 64 would require Medicaid populations expanded under the Affordable Care Act to buy health insurance through a federal exchange;
- LC378 would establish standards and structure for patient-centered medical homes; and
- LC 379 would provide the state insurance commissioner with health insurance rate review authority.

Some legislators have noted that they expect a reintroduction of a series of bills introduced in the 2011 session related to tort reform. 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 address 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.