Affordable Care Act Update and the Federally Facilitated Exchange

Presented by

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The CSI's Goal in Health Insurance Reform

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

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

ECONOMIC AFFAIRS IC
APRIL 20, 2012
EXHIBIT 3

2014 Reforms

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

Uniform Explanation of Coverage Documents and Standardized Definitions

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

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

Internal Claims Appeals Process

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

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

Internal Claims Appeals Process, cont.

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

External Review of Claim Denial After Internal Appeal

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

External Review of Claim Denial After Internal Appeal, cont.

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

Rate Increases: Disclosure and Review Requirements

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

Rate Increases: Disclosure and Review Requirements, Cont.

The Interim Final Rules provide as follows:

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

Rate Increases: Disclosure and Review Requirements, Cont.

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

Premium Rate Review in Montana

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

Adjusted Community Rating

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

Benefits of Reform to Small Business

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

The Federally Facilitated Health Insurance Exchange

Regulatory Sharing Arrangement

- There are five core functions that must be performed by any exchange: consumer assistance, plan management, eligibility, enrollment and financial management.
- The Center for Consumer Information & Insurance Oversight (CCIIO) has identified two areas where states may use their existing regulatory authority to streamline certain exchange functions within the operation of the federally-facilitated exchange:
  - Plan Management
  - Selected consumer assistance functions

Regulatory Sharing Arrangement, cont.

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

Plan Management

- Plan management functions include:
  - plan selection
  - collection and analysis of plan rate and benefit package information
  - ongoing issuer account management
  - plan monitoring, oversight, data collection and analysis for quality
- It is possible that CCIIO will allow the state insurance department to perform some of these functions, even if they are not able to perform all of them.

Public Knowledge Presentation for the Health Insurance Exchange Stakeholder Meeting

February 24, 2012

Agenda

IT Blueprint Document	Public Knowledge Lisa Bullock	5 minutes
ACA Medicaid Expansion and Vision	Public Knowledge Lisa Bullock	5 minutes
DPHHS 90-10 Application	DPHHS CIO Ron Baldwin	10 minutes
Questions and Answers		10 minutes

Public Knowledge Montana Health Insurance Exchange Deliverables

- Requirements Document
- Information Technology (IT) Gap Analysis
- Peer Survey and Comparison of Alternatives
- Information Technology (IT) Blueprint

Information Technology (IT) Blueprint

- Implementation Timelines
  - Federally Facilitated Exchange
  - Federal-State Regulatory Relationship
  - Transition from a Federally Facilitated Exchange to a State-based Exchange
- Roles and Responsibilities
- Information Technology (IT) Resources
  - IT Staffing
  - IT Policies and Procedures
- Potential Bidders

Integrated Enrollment Systems Planning

What are states doing?

- Evaluating costs and system requirements
- Preparing RFPs and specifications for systems upgrades
- Articulating a vision for integrated systems

Source: State Reforum

Aligned Medicaid Eligibility Criteria to Avoid Coverage Gaps

What are states doing?

- Monitoring how Notice of Proposed Rulemaking (NPRM) and final regulations affect existing Medicaid eligibility criteria
- Implementing policies to promote seamless transitions and improve Healthy Montana Kids and Medidaid renewals

Source: State Reforum

Implementation of Eligibility Categories

What are states doing?

- Drafting timelines and guidelines
- Considering ways to quickly and efficiently enroll those that will be newly eligible for Medicaid and Healthy Montana Kids

Source: State Reforum

DPHHS 90-10 Application

- Implement ACA modifications to Medicaid eligibility (Planning APD)
- Modernize the Medicaid eligibility system to interoperate with DPHHS' new SNAP and TANF eligibility systems and enterprise architecture (EA) framework (Implementation APD)