HB 609 -- Show-Me Health Insurance Exchange Act

Sponsor: Molendorp

This bill establishes the Show-Me Health Insurance Exchange Act to comply with a requirement of the federal Patient Protection and Affordable Care Act (PPACA) of 2010 to facilitate the purchase and sale of qualified health plans in the individual market and to provide for the establishment of a small business health option program (SHOP exchange) to assist qualified small employers enrolling their employees in qualified health plans offered in the small group market. The intent of the exchange is to reduce the number of uninsured; provide a transparent marketplace; increase competition in the health insurance market; reduce health care costs; provide consumer education; and assist individuals with access to programs, tax credits, and cost-sharing reductions. The exchange must conduct extensive consumer outreach to increase the awareness of the exchange which must include, but is not limited to, print and television advertising and developing a web site.

SHOW-ME HEALTH INSURANCE EXCHANGE

The bill:

(1) Establishes the exchange as a quasi-governmental agency under the direction of the 13-member Show-Me Health Insurance Board of Trustees including two members of the House of Representatives, one from the majority party and one from the minority party, appointed by the Speaker; two members of the Senate, one from the majority party and one from the minority party, appointed by the President Pro Tem; the directors of the departments of Mental Health, Health and Senior Services, Social Services, and Insurance, Financial Institutions and Professional Registration; and five members to be appointed by the Governor with the advice and consent of the Senate to include a licensed health insurance broker, a licensed health carrier, a public health consumer advocate for individuals who purchase coverage through the exchange, a small employer representative, and an at-large member. The duties and powers of the board are specified including the hiring of an executive director and preparing annual audits and reports of the financial condition of the exchange. The provisions regarding the Health Insurance Advisory Committee are repealed and its duties assigned to the board;

(2) Requires the exchange to facilitate a mechanism to assist individuals who purchase coverage in the individual market and qualified small employers to enroll their employees in a qualified health plan through a unified exchange market place

system; and

(3) Allows the exchange to contract with an eligible entity for any or all of its functions. An eligible entity can be a state agency but cannot be a health carrier or an affiliate of a health carrier. The exchange can allow the Department of Insurance, Financial Institutions and Professional Registration to perform health benefit plan certifications, re-certifications, and de-certifications. The exchange can enter into information-sharing agreements, subject to confidentiality laws, with state and federal agencies and other state exchanges to carry out its responsibilities.

REQUIREMENTS AND DUTIES OF THE EXCHANGE

The exchange must make qualified health plans and qualified dental plans available to qualified individuals and employers beginning on or before January 1, 2014. An individual or employer is not prohibited from purchasing a plan outside the exchange. The exchange cannot offer a health plan or a dental plan that does not meet the requirements of the PPACA. A health carrier or health plan can offer a federally approved plan that provides limited scope dental benefits through the exchange separately or in conjunction with a qualified health plan if the plan provides pediatric dental benefits which meet the requirements of the PPACA.

The exchange must also:

(1) Implement procedures to certify, re-certify, or de-certify a health plan as a qualified health plan consistent with the PPACA guidelines;

(2) Operate a toll-free hotline;

(3) Provide for an initial enrollment period, annual open enrollment periods, and special enrollment periods in accordance with the PPACA, as well as on a quarterly basis;

(4) Maintain a web site that provides comparative data on qualified health plans available through the exchange;

(5) Assign a rating, in accordance with PPACA guidelines, regarding quality and price for each qualified health plan offered through the exchange and determine the level of coverage provided by each qualified health plan in accordance with federal regulations regarding actuarial guidelines for standard populations;

(6) Use a standardized format for presenting health benefit

options in the exchange, including the use of the PPACA outline of coverage;

(7) Inform individuals of eligibility requirements for the federal Medicaid Program, the Children's Health Insurance Program, or any other state public program; screen applications to determine eligibility for programs; and enroll any individual who is eligible;

(8) Establish and make available by electronic means a calculator to determine the actual cost of coverage, any cost-sharing reduction, and a consumer tool to calculate the out-of-pocket cost of coverage;

(9) Establish a unified exchange serving both the individual and small group markets that allows employers in the small group market to access coverage for their employees at a specified level of coverage for any of its employees;

(10) Develop a standardized application for qualified individuals and small employers to use to apply for health benefits through the exchange. Each health carrier or health plan that offers a qualified health plan through the exchange must use this application;

(11) Grant, subject to PPACA exemption criteria, an individual a certification attesting that the individual is exempt from the PPACA individual responsibility requirement or from the penalty to obtain health care coverage if affordable coverage cannot be obtained through the exchange or the individual meets additional exemption requirements;

(12) Provide the federal Secretary of Treasury with the names and taxpayer identification numbers of individuals exempted from obtaining health care coverage; the name and identification number of each individual eligible for the federal premium tax credit because the employer didn't provide minimum essential coverage, affordable coverage, or the required minimum actuarial value; the name and identification number of each individual who notifies the exchange that he or she changed employers and each individual who ceases coverage under a qualified health plan during a plan year;

(13) Notify an employer when an employee ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

(14) Perform the required duties of the PPACA related to determining eligibility for premium tax credits, reduced cost-sharing, or individual responsibility requirement

exemptions;

(15) Establish a navigator program to award grants to selected entities to carry out the functions of a navigator. Grants must be made from the exchange's operational funds; and grant eligibility requirements include relationship requirements with employers, employees, consumers, and self-employed individuals as well as compliance with PPACA requirements. A navigator grant can be awarded for public awareness activities, fair and impartial enrollment information distribution, enrollment activities, consumer assistance referrals, and culturally and linguistically appropriate information. Entities selected to be navigators must be subject to established licensure requirements, disclose any conflict of interest, and not be or work directly or indirectly for a health carrier or health plan. The exchange must establish a compensatory broker-referral network to assist with enrollment;

(16) Apply any qualified employee free-choice voucher to the monthly premium collected from the offering employer;

(17) Consult with health insurance industry stakeholders regarding the activities of the exchange; and

(18) Conduct appropriate accounting activities and submit an annual report of the activities to the federal Secretary of Treasury, Governor, and General Assembly and fully cooperate with federal investigations.

HEALTH PLAN CERTIFICATION

The bill specifies that it is in the best interest of individuals and small employers for the exchange to certify health plans that meet the requirements established by the exchange and the PPACA in order for the plan to participate in the exchange. The exchange is allowed to establish rules to standardize health benefits and cost-sharing to encourage competition of health plans offered. A health plan cannot be excluded from the exchange because it is a fee-for-service plan through the imposition of premium price controls or on the basis that the health plan provides death-preventing treatments that are inappropriate or too costly. In order to have a health plan certified by the exchange, a health carrier must provide premium increase justification; disclose the health plan specifics in plain language; and provide timely updates on cost, benefit changes, and provider network changes to consumers. A health carrier seeking certification for a qualified health plan cannot be exempted from state licensure or solvency requirements to ensure a level playing field between or among health carriers participating in the exchange. A carrier must be licensed to

offer dental coverage but does not need to be licensed to offer other health benefits. Dental plans must offer at a minimum the PPACA-required essential pediatric benefits as well as those of the exchange. A carrier can offer a comprehensive plan that includes health and dental benefits if the benefits are priced separately and are also made available for purchase separately at the same price. In order for a health plan to be certified, the Director of the Department of Insurance, Financial Institutions and Professional Registration must determine if it meets all licensure and solvency requirements and the exchange must determine if it meets all other PPACA and exchange requirements.

EXCHANGE FUNDING

Federal funds must be provided for the direct costs related to the development and operation of the exchange through 2014. The exchange must charge assessment or user fees to health carriers and health plans, regardless of exchange participation, for each individual policy and each employee of an employer-sponsored policy issued in the state to fund the operations of the exchange. Assessments must be limited to the minimum amount necessary to pay for administration and capital costs, considering other available funding sources. Any unexpended exchange funds must be used to further exchange operations or credited or returned to the health carriers. The exchange must publish its fees and costs on a web site.

EXCHANGE AUTHORITY

None of the provisions of the act can be construed to preempt or supersede the authority of the Director of the Department of Insurance, Financial Institutions and Professional Registration to regulate the insurance business within this state.

The bill contains a severability clause making the provisions of the bill void if a provision in the PPACA authorizing the establishment of the exchange is declared unconstitutional or the PPACA in its entirety is declared unconstitutional.