HCS#2 HB 609 -- SHOW-ME HEALTH INSURANCE EXCHANGE ACT (Molendorp)

COMMITTEE OF ORIGIN: Committee on Health Insurance

This substitute establishes the Show-Me Health Insurance Exchange Act to comply with the requirements of the federal Patient Protection and Affordable Care Act (PPACA) of 2010 to facilitate the purchase and sale of qualified health plans and qualified dental 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 and dental 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; increase portability of health insurance coverage; 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 and effectiveness of the exchange.

SHOW-ME HEALTH INSURANCE EXCHANGE

The exchange is established as a quasi-public governmental agency under the direction of the 17-member Show-Me Health Insurance Exchange 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 nine members to be appointed by the Governor with the advice and consent of the Senate to include a licensed health insurance producer, a large market-share licensed health insurer, a small market-share licensed health insurer, a public health consumer advocate for individuals who purchase coverage through the exchange, a small employer representative, a large employer representative, an individual with expertise in administering and negotiating health plan contracts on behalf of employees, and two at-large members. 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.

DUTIES OF THE EXCHANGE

The exchange must:

(1) Facilitate the purchase and sale of qualified health plans and qualified dental plans;

(2) Provide for the establishment of a unified exchange to assist both individuals who purchase coverage in the individual market and qualified small employers in this state in facilitating the enrollment of their employees in qualified health plans and dental plans in the SHOP exchange;

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

(4) Operate a toll-free hotline;

(5) 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;

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

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

(8) Use a standardized format for presenting health options in the exchange, including the use of the PPACA outline of coverage;

(9) 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;

(10) 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 out-of-pocket costs of coverage;

(11) Develop a standardized application for a qualified individual or small employer to use to apply for health benefits through the exchange. Each health insurer or health plan that offers a qualified health plan through the exchange must use this application;

(12) 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;

(13) Transfer specified information to the United States Secretary of the Treasury regarding the individuals exempted from obtaining health care coverage; employed individuals eligible for the federal premium tax credit because the employer didn't provide minimum essential coverage, affordable coverage, or the required minimum actuarial value; and individuals with changes to their employer-sponsored coverage;

(14) Notify an employer when an employee becomes eligible for the federal premium tax credit;

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

(16) 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 federal funds received by the state to establish the exchange cannot be used for grants;

(17) Establish a fair and impartial health insurance producer referral network to assist with enrollment. The producers in the network must be compensated in an appropriate manner to the health insurance producer industry;

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

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

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

(21) Develop guidelines for qualified health plans and dental plans to mitigate the occurrence of adverse selection within the exchange; and

(22) Review the rate of premium growth within and outside of the

exchange and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers.

CONTRACTING AUTHORITY

The exchange is allowed to enter into a contract or a memorandum of understanding with an eligible entity or the Missouri Consolidated Health Care Plan (MCHCP) for any or all of its administrative functions. If the exchange contracts with MO HealthNet, MO HealthNet beneficiaries may select any plan offered by a health insurer contracted with MO HealthNet. MO HealthNet beneficiary plans must be maintained in a separate and distinct risk pool within the exchange from all other qualified health plans and qualified dental plans. An insurer participating in the exchange cannot be required to offer a health plan to MO HealthNet beneficiaries. A state employee may select a qualified health plan or dental plan through the exchange. The exchange may contract with the Department of Insurance, Financial Institutions and Professional Registration for the certification, re-certification, and de-certification of health plans and dental plans as qualified health plans and dental plans. An eligible entity that contracts with the exchange cannot offer a qualified health or dental plan through the exchange. The exchange may enter into information-sharing agreements, subject to state and federal confidentiality laws, with state and federal agencies and other state exchanges to carry out its responsibilities.

HEALTH AND DENTAL PLAN CERTIFICATION

The exchange must certify a health plan as a qualified health plan or qualified dental plan if that plan has met federal requirements. The exchange cannot exclude a health plan because it is a fee-for-service plan; through the imposition of premium price controls by the exchange; on the basis that the health plan provides death-preventing treatments that are inappropriate or too costly; or on the basis that the health plan is offered by a health issuer that is not contracted with MO HealthNet. In order to have a health or dental plan certified by the exchange, a health insurer must provide premium increase justification; disclose the health plan specifics in plain language; provide consumer education; provide notification of health plan changes; and provide timely updates on cost, changes, and provider network changes to consumers.

The exchange cannot exempt a health insurer seeking certification of a qualified health or dental plan from state licensure or solvency requirements. An insurer must be licensed to offer dental coverage but does not need to be licensed to offer other health benefits. The exchange cannot make available a health or

dental plan that is not a qualified health plan or dental plan. A dental plan must offer at a minimum the PPACA-required essential pediatric dental benefits as well as any benefits as the exchange or the United States Secretary of the Treasury may specify by regulation. An insurer can jointly offer a comprehensive plan through the exchange that includes health and dental plans.

In order for a 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. The exchange must establish a health insurance issuer appeals process for a health issuer to appeal a decertification decision or the denial of certification as a qualified health plan or dental plan.

IMPLEMENTATION OF HEALTH AND DENTAL PLANS

Beginning January 1, 2014, the exchange must be operational to make qualified health and qualified dental plans available to qualified individuals and employers but may disclose price and coverage information prior to that date. An individual cannot be charged a fee or penalty for terminating coverage and enrolling in another health plan if he or she has become newly eligible for the coverage or because it has become more affordable under federal standards. A qualified employer in the small market group may make its employees eligible for one or more qualified health plans at a specified level of coverage so that any of its employees may enroll in a qualified health plan or dental plan offered through the SHOP exchange at the specified coverage level. The exchange can encourage health insurers participating in the exchange to include a personal health record component in the qualified health plan benefits.

EXCHANGE FUNDING

Federal funds must be provided under federal law for the direct costs related to the development and operation of the exchange through 2014. By January 1, 2015, the exchange must be financially self-sustained through health insurer fees and assessments. The board must submit an annual budget to the Speaker of the House of Representatives and the President Pro Tem of the Senate until 2015. The exchange must charge assessments or user fees to health insurers, regardless of exchange participation, for each policyholder of an individual health insurance policy issued in this state and for each employee covered under a small group policy issued in the state to fund the operations of the exchange. The assessments or fees must be limited to the minimum amount necessary to pay for the

administration and capital costs and expenses that have been approved in the annual budget process, considering other available funding sources. Any unexpended exchange funds must be used to further exchange operations or be returned to health insurers and health plans as a credit for future imposed assessments or fees. Any unexpended funds at the end of the biennium cannot revert to the credit of the General Revenue Fund. The exchange must publish specified information regarding its fees and costs on a web site. Taxes, fees, or assessments used to finance the exchange must be considered a state tax and, therefore, be excluded from being considered an administrative cost for a health plan for the purpose of calculating medical loss ratios or rebates as allowed by federal regulation.

GENERAL PROVISIONS

The provisions of the substitute cannot prohibit a qualified individual or employer from purchasing any health or dental plan outside the exchange. Certain supplemental insurance policies are exempt from the provisions of the substitute.

The provisions of the act cannot be construed to preempt or supersede the authority of the Director of the Department of Insurance, Financial Institutions and Professional Registration to regulate insurance businesses within this state.

The provisions of the substitute will become null and void and be unenforceable in this state as of the date the PPACA in its entirety or Section 1311 of the act is declared unconstitutional or otherwise invalid by the United States Supreme Court or is repealed by the United States Congress.

FISCAL NOTE: No impact on state funds in FY 2012, FY 2013, and FY 2014.