



# A PREVIEW OF MONTANA'S HEALTH INSURANCE MARKETPLACE

*by Gregg Davis and Christina Goe*

One of the more visible changes soon to be brought to the forefront by passage of the Affordable Care Act (ACA) is the health insurance exchange, or marketplace. More than 350,000 Montanans may have some change in health insurance as a result of the ACA, although not all will enter the marketplace.

The “No Wrong Door” approach to applying for individual health coverage directs applicants toward the appropriate insurance option, such as Medicaid, the Children’s Health Insurance Program (CHIP), or private insurance policies sold in the marketplace. The applications are available online at <http://www.healthcare.gov/blog/2013/04/marketplace-application.html>.

In theory, the health insurance marketplace will enhance competition among health insurers while at the same time offering consumers the ability to make apples-to-apples comparisons of benefit designs, provider networks, and limits on cost-sharing. It is designed to operate similarly to the

dozens of online travel sites that allow users to compare prices based on select criteria such as travel dates, destination, and number of travelers. But buying health insurance, it turns out, is far more complicated and confusing than buying a plane ticket.

One challenge for the marketplace is creating a consumer-friendly health insurance shopping experience. The purpose of the marketplace is to foster competition among health insurers, but sometimes when consumers face too many choices — whether it is jams at the supermarket, 401(k) plans, or Medicare prescription drug plans — they struggle to make selections that are optimal for them.

Over the past seven years, the cost of individual coverage for employees in Montana with access to employer-provided

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health insurance increased 45 percent, more than five times the rate of general inflation for the same period and nearly twice the rate of growth in wage earnings. This rate of increase is similar throughout the country. The insurance marketplace, if in fact it does make health insurance more affordable, will primarily do so through economies of scale made possible by the individual mandate and increased competition among health insurance providers. Whether competition will thrive in the marketplace is unknown. In Montana, three or four insurers will participate in a federally facilitated individual health insurance marketplace (FFM), and three will participate in the federally facilitated small business health options program (FFSHOP). This is similar to the number of health insurers active in those markets now. However, there are also some additional health insurers selling outside the exchange, including some insurers that are new to the individual and small employer group market.

States have three operational choices for their health insurance marketplaces. Eighteen states and the District of Columbia will run state-based marketplaces, providing a higher degree of autonomy from the federal government. The vast majority of states, 32 of them, including Montana, will have a federally facilitated marketplace (FFM). Fifteen of the FFM states are marketplace partners, where the state insurance department is participating in plan management. Under the federally facilitated marketplace, the U.S. Department of Health and Human Services (HHS) will assume primary responsibility for operating the exchange, except in the 15 states where the department of insurance is performing some of the plan management functions (including Montana) and, in some states, also consumer assistance functions.

Plan management includes certification of Qualified Health Plans, collecting and reviewing rate information, collecting quality information, and coordinating with HHS on quality rating and enrollee satisfaction. Consumer assistance includes overseeing the navigator program (see sidebar), maintaining a website and call center, providing outreach and education, and helping people shop for qualified

health plans, including comparing premiums, calculating the tax credit, and choosing a plan. Eligibility determines whether an individual qualifies for the tax credit and cost-sharing reductions, such as deductibles and copayments. Marketplaces must also verify whether individuals have access to “affordable” insurance coverage through an employer, and will also screen applicants to determine eligibility in Medicaid or the Healthy Montana Kids (HMK+) program.

**How Many Montanans Will Buy in the Marketplace?**

What will the new plans look like for Montana residents and small businesses entering the marketplace to shop for health insurance? How many Montanans will shop in the marketplace since health insurance will still be available and sold outside the marketplace as well? Approximately 195,000 non-institutionalized Montanans do not have health insurance. Given the individual mandate to purchase insurance, a significant number of uninsured may enter the marketplace in search of cheaper policies, subsidies, and cost-sharing assistance. Particularly for individuals with incomes less than 400 percent of the federal poverty level (FPL), or \$46,000, the marketplace will be an attractive option since they may qualify for sliding-scale advanceable premium tax credits (APTC's). Individuals with incomes up to 250 percent of the FPL (\$29,000) may also qualify for cost-sharing reductions based on silver plans sold in the marketplace. Silver plans on average promise to pay 70 percent of the insured's health care costs, while bronze, gold, and platinum plans pay on average 60 percent, 80 percent, and 90 percent, respectively. Others in the marketplace may include employees with employer-provided health insurance that does not provide minimum essential value, or whose share of the employee-only premium is 9.5 percent or more of their adjusted gross income, and individuals with individual health insurance who wish to compare products in the marketplace. All plans are subject to a maximum cost-sharing limitation (maximum out-of-pocket) of \$6,350 for an individual and \$12,700 for a family.

As many as 181,000 Montanans may qualify for the advanceable premium tax credit. Since the 2013 Montana Legislature opted out of the Medicaid expansion, 29,000 Montanans with incomes between 100 percent and 138 percent of the federal poverty level may also enter the marketplace for the advanceable premium tax credits. Approximately 37,000 Montanans may be too rich for Medicaid and too poor for the advanceable tax credits available in the marketplace and as a result will have no options for affordable coverage. The estimated marketplace population will likely fall somewhere between 229,000 and

## NAVIGATORS

The navigator program is modeled after the State Health Insurance Assistance Program (SHIP), which offers assistance to Medicare beneficiaries as they face the complexities of the Medicare Advantage and Prescription Drug Plan offerings. However, the SHIP organizations focus on the Medicare-eligible and are NOT navigators for the exchange. The navigator program gives grants to community and small business organizations to educate and provide unbiased information to both individuals and small employers to help them “navigate” the new health insurance marketplace and enroll applicants in appropriate health insurance plans. Navigators cannot accept compensation from health or stop-loss insurers and cannot have any other conflict of interest. While navigators will not determine eligibility, they will help consumers through the enrollment process by providing fair, impartial, and accurate information to assist consumers in submitting eligibility applications, clarifying the distinctions among qualifying health plans, and helping consumers make informed decisions. The navigator and its role in the health insurance exchange is illustrated below. Noteworthy is that consumers are still free to use insurance agents or enter the marketplaces directly on their own. Montana received \$600,000 in navigator funding along with 12 other states, one of the lowest awards by HHS. The highest award (\$8.2 million) went to Texas, where almost 5 million residents are uninsured.

278,000. Although health insurance will be sold both inside and outside the marketplace, individual market coverage is only available to individuals who enroll during the open enrollment period.

While much is yet to be seen as we enter the new arena of health insurance created by the Affordable Care Act, among the certainties is that more than one-third of Montanans will experience some change in health insurance.

## Who Will Be Selling Health Insurance in Montana's Marketplace?

A central tenet of the health insurance marketplace is to foster side-by-side competition among health insurance providers. In Montana, the largest insurer captures 57 percent of the total individual market for health insurance, compared to 46 percent for the largest insurer in the small group market. But when compared to the individual and small group markets nationally, Montana's individual market is comparable to the level of competition nationally. The small group market, however, is considerably less concentrated in Montana relative to the degree of competition nationally. Whether or not the health insurance marketplace in Montana will foster more competition is unknown. At the time of this article's writing, three carriers have announced plans to offer policies in the FFM and FFSHOP: the Montana Health Cooperative, a member-owned nonprofit; Blue Cross Blue Shield of Montana; and PacificSource. Other insurers



have indicated their intentions of offering individual, small group, and large group health insurance outside the marketplace.

The ACA also created the Multi-State Plan Program. The Office of Personnel Management, which administers the Federal Employees Health Benefits program, is responsible for certifying at least two multi-state health insurance issuers (one nonprofit and one for-profit) to sell coverage in at least 60 percent of all states by January 1, 2014. Within four years, all states are supposed to have at least two multi-state carriers. Each multi-state carrier will offer two plans in every marketplace at the gold and silver levels of coverage. The Office of Personnel Management will announce the plans that will participate in the marketplace late this summer.

### **Shared Responsibilities and Potential Penalties under the ACA\* Employers with More than 50 Employees**

There is no express “employer mandate,” but the ACA has an “employer-shared responsibility” provision and provides for some penalties for employers with more than 50 full-time or full-time equivalent employees to ensure that employers continue to provide coverage. Employers with 51 or more full-time employees may face penalties if they do not offer minimum essential coverage or affordable

*\* The information in this section comes from the Congressional Research Service, “Potential Employer Penalties under the Patient Protection and Affordable Care Act (ACA),” Janemarie Mulvey, April 2, 2013; www.crs.gov R41149.*

## **QUALIFIED HEALTH PLANS**

Qualified Health Plans, or QHPs, are health plans certified to sell products in the marketplace. All health plans sold both inside and outside the marketplace in the individual and small employer group markets must provide essential health benefits that meet the benchmark in that state and follow limits on cost-sharing, including deductibles, copayments, and coinsurance that fall into platinum, gold, silver, or bronze actuarial value level. All plans have a maximum out-of-pocket limitation of \$6,350 for individuals and \$12,700 for a family for health services provided in-network. All health plans are subject to the same rating rules and rate review and must meet network adequacy standards for that state. QHPs also have a few extra requirements that do not apply to the rest of the market, such as an accreditation requirement and quality ratings.

## **ESSENTIAL HEALTH BENEFITS**

Essential Health Benefits (EHB) are a core package of services including ambulatory, emergency, hospitalization, maternity and newborn care, mental health-substance abuse-behavioral health, prescription drugs, rehabilitative and habilitative services, laboratory, prevention and wellness, and pediatric care, including oral and vision care services. EHB are to be equal in scope to the benefits offered by a “typical small employer plan.” In Montana, the benchmark plan is the federal default choice, which is the “largest small employer group health plan” according to enrollment in the first quarter of 2012. This plan is “Blue Dimensions Preferred Provider Organization Plan” provided by Blue Cross Blue Shield of Montana. This benchmark is in effect until 2016



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when the federal regulations regarding EHB benchmarks may change. The final rule issued by HHS in February outlines standards not only related to essential health benefits but also actuarial value. Together, both EHB and actuarial value will increase the consumers' ability to compare and make informed choices about available health plans. In addition, the essential health benefit categories cannot have annual or lifetime dollar limits.

## RATING REFORMS

An insurer selling individual or small employer group health plans must combine the risk of all their insureds into a single risk pool for all coverage sold both inside and outside the marketplace. In Montana, the individual and small employer group risk pools are separate. Health status rating is no longer permitted, although premiums may still vary according to four rating variables: four geographic areas in Montana, a 3:1 variance according to age, family composition, and a 1.5:1 variance if the individual uses tobacco products (amounting to a 50 percent surcharge on premium.)

## While many believe the marketplace will foster competition and slow the increase in health insurance premiums, others remain skeptical.

coverage that offers minimum value. The penalty calculations vary according to the circumstances. A full-time employee is defined as one who works 30 or more hours per week. The number of employees for determining group size is calculated by counting both full-time employees and full-time-equivalent employees (adding together the hours of part-time employees). However, the penalty only attaches to full-time employees working 30 hours or more per week. There is a detailed method that employers may use to determine whether or not "variable hour" employees must be treated as "full-time." Employers can "average" worker hours over a period of time not to exceed 12 months. After that determination is made, the employer must provide an "administrative period" (no less than 30 days) during which employees determined to be full-time have an opportunity to enroll. Employers must offer coverage to all FTEs and their dependents. The definition of dependent for this purpose does not include spouses.

Determining the penalty amount can be complicated. The following description is an example. The annual penalty can be \$2,000 per full-time employee (minus the first 30 employees) if the employer fails to offer a health plan that offers minimum essential coverage and at least one of his employees purchases coverage on the exchange and receives an APTC. If an employer offers a health plan that is unaffordable or does not offer minimum value, the penalty can be calculated as \$3,000 per year for each employee who receives an APTC in the exchange, but the total amount of penalty is limited to \$2,000 per FTE, minus the first 30 FTE. The penalty amount is adjusted every year by the IRS.

The potential penalty applies to all employers with more than 50 FTE or FTE-equivalent employees, including nonprofit organizations and government employers, such as a state, county, city, or school district. The actual amount of the penalty depends on whether the employer currently offers minimum essential coverage. A large employer who does not offer coverage will be subject to a penalty if even one full-time employee obtains coverage in the marketplace and receives an advanceable premium tax credit.

## Employers Who Offer Unaffordable or Below Minimum Value Plans

Under the ACA, an employer-provided health plan is "unaffordable" if the employee's premium contribution for "self-only" coverage is more than 9.5 percent of the employee's household modified adjusted gross income. However, because employers need to provide employees with an advance notice regarding the adequacy and affordability of their health plans, the IRS has provided a "safe harbor" provision. This safe harbor allows the employer to calculate affordability based on the employee's W-2 income alone because employers do not generally have access to an employee's household income. A health plan provides adequate (minimum) coverage if the plan's actuarial value is at least 60 percent. The

Table 1

**Tax Credits and Cost-Sharing by Income Levels**

2013 Federal Poverty Level (%)	FPL Income Thresholds		Required Premium Contribution: Percent of Income
	Individual	Family of 4	
100%	\$11,490	\$23,550	2%
133%	\$15,282	\$31,322	
150%	\$17,235	\$35,325	4%
200%	\$22,980	\$47,100	6.3%
250%	\$28,725	\$58,875	8.05%
300%	\$34,470	\$70,650	9.5%
350%	\$40,215	\$82,425	
400%	\$45,960	\$94,200	

**TAX CREDITS AND COST-SHARING ASSISTANCE**

Tax credits are available to all with household incomes between 100 percent and 400 percent of the federal poverty level. Cost-sharing reductions are available only to individuals and families with income levels up to 250 percent of the federal poverty level. American Indians and Alaska natives with incomes up to 300 percent of FPL will not be responsible for any cost-sharing. The maximum out-of-pocket cost-sharing limitation (in-network services) for all non-grandfathered health plans is set by the IRS each year and is based on the out-of-pocket limits that apply to high deductible health plans with Health Savings Accounts.

This table is not exact because the determination of APTCs is based on a formula that also includes the cost of the second lowest cost silver plan premium available in Montana’s marketplace. That determination will be made by the FFM, but not until September.

actuarial value is measured according to a standard population and a standard set of allowed charges and benefits. The Centers for Medicare and Medicaid Services has an actuarial value tool for large employers to use when making this determination. The minimum value calculator relies on claims data (and benefits covered) for a typical self-insured employer plan. Individuals who are eligible for an employer health plan that is affordable and offers minimum value are not eligible for APTCs in the FFM.

**What Will We Learn from the Health Insurance Marketplace?**

The Affordable Care Act is now three years old. Next year, the launch of marketplaces around the country will prove to be a study in how many of the behavioral changes facilitated by the ACA will play out. While many believe the marketplace will foster competition and slow the increase in health insurance premiums, others remain skeptical. Exactly how consumers, providers, and employers will respond to incentives and penalties in the marketplace is for the most part unknown. There is even considerable debate as to how many uninsured will gain health insurance coverage. With all the unknowns and uncertainty, both federal and state governments will need to be flexible and ready to respond to unforeseen challenges certain to emerge in the marketplace. □

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