WISCONSIN LEGISLATIVE COUNCIL
STAFF MEMORANDUM

Memo No. 5

TO: MEMBERS OF THE SPECIAL COMMITTEE ON HEALTH CARE REFORM IMPLEMENTATION

FROM: Laura Rose, Deputy Director, and Heidi Frechette and Margit Kelley, Staff Attorneys

RE: Powers and Duties of Health Exchanges from Utah, California, and Massachusetts

DATE: December 7, 2010

This Memo summarizes the powers and duties of the health exchanges that have been created in California, Utah, and Massachusetts, for consideration by the Special Committee on Health Care Reform Implementation.

The California State Exchange has the power to do all of the following:

1. Bargain and selectively contract with insurance carriers to offer plans through the exchange.

2. Establish and use a competitive process to select participating carriers.

3. Collect premiums and assists with subsidies in respect to individual coverage.

4. Create a directory of providers contracting with carriers in the exchange indicating which carriers with whom the providers contract.

5. Place the same coverage requirements on all carriers regardless of their participation in the exchange.

Utah's Office of Consumer Health Services is required to do all of the following:

1. Create an Internet portal that is capable of providing access to private and government health insurance websites and their electronic applications forms and submissions procedures.

2. Facilitate a private sector method for the collection of health insurance premium payments made for a single policy by multiple payers, including the policyholder, one or more employers of one or more individuals covered by the policy, government programs, and

others by educating employers and insurers about collection services available through private vendors, including financial institutions.

3. Assist employers with a free- or low-cost method for establishing mechanisms for the purchase of health insurance by employees using pre-tax dollars.

Utah's strategic plan includes consideration of the following:

1. Legislation necessary to allow a health insurer in the state to offer plans that meet a number of specified coverage requirements.

2. Current rating and issue practices by health insurers.

3. Methods to decrease cost-shifting from uninsured and underinsured to the insured, health care providers and taxpayers.

4. Providing public employees an option for greater control of their health care benefits.

5. Giving public employees access to individually selected and owned policies.

6. Encouraging the use of health care quality measures and the adoption of best practice protocols by health care providers.

7. Providing some protection from liability for health care providers who follow best practice protocols.

8. Promoting personal responsibility through obtaining health insurance, achieving self-reliance, making healthy choices, and encouraging healthy behaviors and lifestyles.

9. Studying the costs and benefits associated with different forms of mandates for individual responsibility and potential enforcement mechanisms for individual responsibility.

10. Increasing the number of affordable health insurance policies available by creating and funding a system of subsidies, and creating Medicaid waivers, which bring more people into the private insurance market. Funding may include: imposing assessments on health care facilities, health care providers, health care services, and health insurance products; and relying on other funding sources.

11. Investigating and applying for Medicaid waivers that will promote the use of private sector health insurance.

12. Identifying federal barriers to state health system reform and seeking collaborative solutions to those barriers.

13. Maximizing the use of pre-tax dollars for health insurance premium payments.

14. Requiring employers in the state to adopt mechanisms that allow an employee to use tax-exempt earnings, other than pre-tax contributions by the employer, to purchase a health insurance product.

15. Extending a preference under the state procurement code for bidders who offer goods or services to the state if the bidder provides health insurance benefits or a defined contribution for health insurance to the bidder's employees.

16. Requiring insurers to accept premium payments from multiple sources, including state-funded subsidies.

The Massachusetts Health Exchange, known as the Connector, is charged with developing policy and regulatory components of the state health reform measure, including establishment of the benefits packages and premium contributions schedules, development of regulations defining what constitutes minimum creditable coverage, and construction of an affordability schedule. The Connector is also responsible for outreach and education regarding the programs. The board of the Connector is authorized and empowered to:

1. Develop a plan of operation for the Connector. This shall include, but not be limited to, establishing:

    a. Procedures for operations of the Connector;

    b. Procedures for communications with the executive director;

    c. Procedures for the selection of and the seal of approval certification for health benefit plans to be offered through the Connector;

    d. Procedures for the enrollment of eligible individuals, groups and commonwealth care health insurance program enrollees;

    e. Procedures for granting an annual certification upon request of a resident who has sought health insurance coverage through the Connector, attesting that, for the purposes of enforcing the law, no health benefit plan which meets the definition of creditable coverage was deemed affordable by the Connector for said individual. The Connector shall maintain a list of individuals for whom such certificates have been granted;

    f. Procedures for appeals of eligibility decisions for the commonwealth care health insurance program, established by law;

    g. Appeals procedures for enforcement actions taken by the Department of Revenue (DOR) under the law, including standards to govern appeals based on the assertion that imposition of the penalty under the law would create extreme hardship;

    h. A plan for operating a health insurance service center to provide eligible individuals, groups, and commonwealth care health insurance program enrollees, with information on the Connector and manage Connector enrollment;

    i. Managing a system of collecting all premium payments made by, or on behalf of, individuals obtaining health insurance coverage through the Connector, including any premium payments made by enrollees, employees, unions, or other organizations;

j. Managing a system of remitting premium assistance payments to the carriers;

k. A plan for publicizing the existence of the Connector and the Connector's eligibility requirements and enrollment procedures;

l. Criteria for determining that certain health benefit plans shall no longer be made available through the Connector, and to develop a plan to decertify and remove the seal of approval from certain health benefit plans;

m. A standard application form for eligible individuals, groups seeking to purchase health insurance through the Connector, and commonwealth care health insurance program enrollees, seeking a premium assistance payment which shall include information necessary to determine an applicant's eligibility, previous health insurance coverage history, and payment method; and

n. Criteria for plans eligible for premium assistance payments through the commonwealth care health insurance plan, initially publishing said criteria by July 1, 2006 for plans to be procured and implemented no later than October 1, 2006.

2. Determine each applicant's eligibility for purchasing insurance offered by the Connector, including eligibility for premium assistance payments.

3. Seek and receive any grant funding from the federal government, departments or agencies of the commonwealth, and private foundations.

4. Contract with professional service firms as may be necessary in its judgment, and to fix their compensation.

5. Contract with companies which provide third-party administrative and billing services for insurance products.

6. Charge and equitably apportion among participating institutions its administrative costs and expenses incurred in the exercise of the powers and duties granted by this chapter.

7. Adopt by-laws for the regulation of its affairs and the conduct of its business.

8. Adopt an official seal and alter the same.

9. Maintain an office at such place or places in the commonwealth as it may designate.

10. Sue and be sued in its own name, plead and be impleaded.

11. Establish lines of credit, and establish one or more cash and investment accounts to receive payments for services rendered, appropriations from the commonwealth, and for all other business activity granted by this chapter except to the extent otherwise limited by any applicable provision of the Employee Retirement Income Security Act of 1974.

12. Approve the use of its trademarks, brand names, seals, logos, and similar instruments by participating carriers, employers, or organizations.

13. Enter into interdepartmental agreements with the DOR, the executive office of health and human services, the division of insurance, and any other state agencies the board deems necessary to implement the law.

14. Create and deliver to the DOR a form for the department to distribute to every person to whom it distributes information regarding personal income tax liability, including, without limitation, every person who filed a personal income tax return in the most recent calendar year, informing the recipient of the requirements to establish and maintain health care coverage.

15. Create for publication, by September 30 of each year, the commonwealth care health insurance program consumer price schedule.

16. Create for publication by December 1 of each year, a premium schedule, which, accounting for maximum pricing in all rating factors with an exception for age, shall include the lowest premium on the market for which an individual would be eligible for "creditable coverage" as defined in statute. The schedule shall publish premiums allowing variance for age and rate basis type. The premium schedule shall be delivered to the DOR for use in establishing compliance with relevant statutes.

17. Review annually the publication of the income levels for the federal poverty guidelines and devise a schedule of a percentage of income for each 50% increment of the federal poverty level at which an individual could be expected to contribute said percentage of income towards the purchase of health insurance coverage. The report shall be published annually beginning on June 1, 2007. Prior to publication, the schedule shall be reported to the House and Senate Committee on Ways and Means and the Joint Committee on Health Care Financing.

18. Establish criteria, accept applications, and approve or reject licenses for certain sub-connectors which shall be authorized to offer health benefit plans offered by the Connector. The board shall establish and maintain a procedure for coordination with said sub-connectors.

19. Define and set by regulation minimum requirements for health plans meeting the requirement of creditable coverage.

20. Establish and evaluate requirements for plans issued under item 5 with regard to health care delivery network design.

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