



South Dakota's Health Insurance Exchange Planning Effort

Report for Governor Dennis Daugaard

November 3, 2011

This document is intended to provide an overview of PPACA requirements relating to a South Dakota health insurance exchange, South Dakota's efforts to plan for an exchange, and the challenges facing the state as it decides whether to pursue a state based health insurance exchange.

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I. Requirements of the Patient Protection and Affordable Care Act

A. Passage of the Bill

The President's health reform law, officially entitled the Patient Protection and Affordable Care Act (hereinafter PPACA), passed the Senate on December 24, 2009 by a 60-39 margin.

House and Senate Democrats disagreed about the specifics of the law, but due to the death of Senator Ted Kennedy and subsequent results of the special election to name his successor, were unable to pass a new version in the Senate to resolve their differences. The election of Republican Scott Brown meant that the Democrats lost their 2/3 majority in the Senate by one vote. Because Democrats no longer maintained a 2/3 majority, Republicans could block a vote on any new bill by continuing an endless discussion of it through a tactic called a filibuster.

In order to pass the Senate version of PPACA in the House, the Democrats agreed to amend the bill through the budget reconciliation process, which limits debate on budget bills to 24 hours. As a result of this agreement, PPACA passed the House of Representatives by a vote of 219-212 on March 21, 2010. PPACA was signed into law by President Obama on March 23, 2010. The Health Care and Education Reconciliation Act subsequently passed both Houses of Congress and was signed by President Obama on March 30, 2010.

B. Health Insurance Requirements Under PPACA

PPACA includes a number of provisions that affect the health insurance industry. Some important provisions of the law include the requirement that insurance companies allow children to maintain coverage through their parents policy until age 26, an expansion of Medicaid in 2014, an individual mandate which requires nearly every American purchase insurance or pay a penalty, a requirement that insurance companies issue insurance to anyone regardless of pre-existing conditions, a requirement that businesses with over 50 employees make insurance coverage available to their employees or face a penalty, and the creation of health insurance exchanges in all 50 states, all US territories, and the District of Columbia.

PPACA requires that a health insurance exchange is operated in every state. A health insurance exchange is best defined as a one-stop shopping place where individuals can purchase health care coverage. Users of an exchange are typically able to enroll in health insurance coverage by visiting a website, calling a toll free hotline and signing the appropriate documents, or visiting an office.

PPACA requires the creation of two exchanges in each state, one where individuals can purchase plans, and another where employees of small businesses will be able to purchase

group health insurance plans. The two exchanges can use the same resources for daily operations including the same website and technology, or each can operate separately. In addition, exchange users can be combined into one pool or separated into two for insurance risk adjusting purposes.

Beginning on January 1, 2014, PPACA requires every employer with more than 50 employees to provide each employee that works more than 30 hours per week with access to affordable health insurance coverage. Affordability is defined as a premium that is less than a certain percentage of an individual's income, as defined by federal law. In addition, the insurance offered must provide adequate coverage as defined by PPACA. If an employer does not offer affordable coverage that meets minimum quality standards, the employer will be assessed a penalty of \$750 per employee per year. Employers with fewer than 50 employees are not required to make health insurance coverage available to their employees.

Health insurance exchanges must be certified for operation by the United States Department of Health and Human Services by January 1, 2013, become fully operational by January 1, 2014, and become self-sustaining by charging fees to users or plan issuers by January 1, 2015.

1. Eligibility and Enrollment

PPACA sets forth several broad requirements on how an exchange must be operated. The law provides federal tax credits to low income individuals and families to apply toward the purchase of insurance on an exchange. Individuals and families earning between 139% and 400% of the federal poverty level (FPL) will be eligible for federal tax credits. To put this figure into perspective 139% FPL is \$31,066 annually for a family of four and 400% FPL is \$89,400 annually for a family of four. However, only those without affordable coverage from another source, such as an employer, will be eligible to purchase health insurance on an exchange. Every exchange must also be able to determine whether the applicant is eligible to receive the tax credit. In addition, every exchange must determine whether an applicant qualifies for federal entitlement programs, to include Medicaid and the Children's Health Insurance Program (CHIP).

Each exchange must host a website where users apply for health insurance coverage. The website is required to provide information about the cost and quality of plans so users can compare different coverage and choose the best alternative. The site must also include a calculator that will help those receiving financial assistance determine their out-of-pocket costs for different health insurance plans.

To allow access to the exchange by those that do not have easy access to a computer, PPACA requires each exchange to allow users to enroll by visiting an office or calling a 1-800 number and filling out the appropriate paperwork.

To assist all enrollees, PPACA requires each exchange to hire navigators. Navigators will provide basic information to users about plans, educate them about the exchange enrollment process, and assist them with any difficulties they have applying for coverage.

2. Minimum Coverage and Qualified Health Plans

PPACA also outlines minimum coverage standards for policies sold on an exchange. Every health plan sold on the exchange must offer certain minimum essential health benefits as defined by the law. A specific definition of minimum essential health benefits has not been provided by the United States Department of Health and Human Services. A more detailed definition is expected to be offered in future regulations, but, to date, the department has not offered a specific date for the release of regulations on this topic. If a plan is found to offer minimum essential benefits, it can be certified for sale on the exchange as a qualified health plan.

The exchange will be responsible for certifying plans sold on it, recertifying them, and decertifying them if they no longer meet the minimum requirements. Exchanges must also provide an open enrollment period, or a time each year when individuals can change their coverage, choose a different plan, or add dependents to their plan. Native Americans are provided with a special monthly enrollment period, wherein they can enroll in a qualified health plan outside the annual open enrollment period. Open enrollment is new to the individual health insurance policy market, but common in the group health insurance industry.

3. SHOP (Small Business) Exchanges

PPACA requires that each exchange sell insurance plans to employees of small businesses through a SHOP (small business) exchange. Exchanges must make coverage available to employers with fewer than 50 employees beginning in 2014. In 2017, exchanges are required to make coverage available to small businesses with fewer than 100 employees. A SHOP exchange can be operated in conjunction with an individual exchange, or each can be operated separately. Each small business exchange must offer a defined contribution plan to users. A defined contribution plan allows the employer to provide a set amount of money to an employee to purchase a plan of their choice on the exchange.

4. The Role of the States in Exchange Development

PPACA requires that an exchange is operated in every state, but it does not require states to run their own exchanges. If a state chooses not to operate an exchange, the federal government will operate one for them. So far, states have been offered three choices for the operation of an exchange in their state by 2014. A state can allow the federal government to run an exchange, create and operate a state exchange with the help of federal grant money, or

partner with the federal government to run certain aspects of an exchange. States are also allowed to partner with each other to create regional exchanges, though little progress has been seen on this front to date. Federal grant money will also be available to states seeking to establish federal and partnership exchanges.

a. Core Exchange Functions

PPACA has defined five core functions of an exchange that a state must operate in order to run a state exchange. These include consumer assistance, plan management, eligibility, enrollment, and financial management. If a state exchange does not conduct all of these functions, it will not be certified by the federal government. Consumer assistance includes functions such as managing call centers, assisting consumers through education and outreach, and managing navigators.

Plan management includes monitoring and overseeing plan issuers, outreach and training, data collection, analysis of quality, and choosing a plan selection approach. The two most common approaches to plan selection are the active purchaser and market facilitator approaches. A market facilitator allows any plan that meets the minimum essential benefit requirements to be sold on the exchange and relies on market competition to control premium rates. An active purchaser negotiates with insurers over rates and then chooses which insurers are allowed to sell qualified plans on the exchange.

Eligibility includes accepting applications, verifying the information on the applications, determining eligibility for enrollment in a Qualified Health Plan and for tax credits, determining eligibility for Medicaid, connecting eligible users to Medicaid and CHIP programs, and conducting redeterminations and appeals.

Enrollment includes enrolling consumers into qualified health plans, transactions with qualified health plans, and transmitting the information necessary to advance payments of the premium tax credit and cost-sharing reductions.

Financial management includes user fees, maintaining financial integrity requirements and managing risk adjustment, reinsurance, and risk corridor programs. Financial management essentially includes the background functions of the exchange such as accounting, managing insurance risk, creating a system for transmitting fees to insurers, and ensuring that the exchange is self-sustaining through fees.

In order to manage the core functions of the exchange, each state has the authority to choose the governance structure of a state run exchange. An exchange can be operated by an existing state agency, the state can contract with a non-profit agency, or the exchange can be run by a quasi-government entity such as a board or commission.

b. Federal Exchange

Under a federal exchange, the United States government would run all of the core exchange functions and be responsible for choosing the governance structure. This includes determining certain categories of Medicaid eligibility for exchange users. Currently, all Medicaid eligibility determinations are made by the states. In addition, the federal exchange would be responsible for ensuring the financial integrity of an exchange by charging fees to users or plan issuers. The federal government has still not decided how fees will be charged or how they will be shared with states. This could be problematic considering that state insurance departments, Medicaid programs, and other state entities will be required to expend resources to help get a federal exchange up and running and when interacting with an exchange after it is established.

To date, it is still unclear exactly what a federal exchange will look like, as no regulations have been released defining its parameters. Especially concerning is the fact that no decision has been made concerning whether a federal exchange will be an active purchaser negotiating with insurers to provide eligible plans for sale on the exchange, or a market facilitator allowing all qualified plans to participate in the exchange. This decision is important, because it could have an effect on the insurance market outside the exchange in South Dakota. The United States Department of Health and Human Services is currently in the process of soliciting contracts with private vendors to establish various exchange functions to include a web portal, standard operating procedures for plan certification, and developing back office financial transactions, among other efforts by the federal government to create a model for a federal exchange.

The federal government has expressed a desire to work with states that choose to have a federal exchange in order to collect adequate data and prevent the overlap of federal and state regulations relating to the exchange. It is still unclear how any collaboration process will be structured at this time.

c. Proposed Federal/State Partnership

In September, 2011, the federal government released an outline for a proposed federal/state exchange partnership. Under the partnership, the federal government would operate the eligibility, enrollment, and financial management functions of the exchange. States would be allowed to operate consumer assistance and plan management functions. Part of the federal government's responsibility under a partnership model would be to determine certain categories of Medicaid eligibility under the exchange. In addition, the federal government would develop the web portal and back office financial management functions.

States would be allowed to do consumer assistance functions, plan management functions, or both. This means that the state could choose whether an exchange was an active purchaser or market facilitator and also run navigator programs. The US Department of Health and Human

Services is still accepting comments on the federal/state partnership and the current partnership approach is not in final form.

5. South Dakota's Opposition to PPACA

Since the debate over health care reform began, the State of South Dakota has been opposed to PPACA. In March, 2010, at the direction of then Governor Mike Rounds, the State of South Dakota joined twenty-five other states in multi-state litigation challenging the constitutionality of PPACA. Governor Daugaard is also an opponent of PPACA and supports the decision to enter the lawsuit. He believes PPACA is unconstitutional and should be repealed.

In August of 2011, the United States Court of Appeals for the 11th Circuit held that the individual mandate portion of the law was unconstitutional, but upheld its other provisions.

The 11th Circuit decision created a split among federal courts on the constitutionality of the individual mandate. In June of this year, the 6th Circuit Court of Appeals upheld the individual mandate.

The Department of Justice appealed the 11th Circuit decision to the United States Supreme Court. The United States Supreme Court recently agreed to an expedited review of the case, setting the stage for it to be heard during the court's current term. It is anticipated that the case could be heard as soon as the early part of 2012.

As of today, the individual mandate is unconstitutional in South Dakota and the twenty-five other states that were part of the lawsuit. The other portions of the law remain effective in South Dakota, including the requirement that a health care exchange is established in each state. Unless the Supreme Court rules that the entire health law is unconstitutional, the other provisions of the law will remain in effect.

II. The South Dakota Exchange Planning Process

A. *Planning Grant*

In September, 2010 the federal government awarded \$49 million for the planning of state run health insurance exchanges in 48 states and the District of Columbia. Only Alaska and Minnesota did not apply for and receive federal planning grant dollars.¹ Each state was awarded \$1 million to plan for a state based exchange. As a condition of receiving the \$1 million planning grant, states were required to meet with and solicit input from key stakeholders in the health and insurance industries, conduct background research to gather

¹ *Health Insurance Exchanges: State Planning and Establishment Grants*. Center for Consumer Information & Insurance Oversight. September, 2010. http://cciio.cms.gov/resources/files/grant_award_faq.html.

more information about their state's insurance industry, and study the feasibility and cost of implementing a state based exchange.

In 2010, under the direction of Governor Rounds, the State of South Dakota applied for and received a \$1 million planning grant to determine whether South Dakota should implement an exchange and if the state were to do so, what it should look like. Grant funding was received by the state in September, 2010 and was good for one year. The State of South Dakota recently applied for and received an extension to continue using planning grant funding through September, 2012. Any money that is not used by then will be returned to the federal government.

B. South Dakota Health Insurance Exchange Task Force

In order to properly plan for the possibility of a state based exchange, the Governor assembled a task force composed of legislators, state officials, and individuals from key private industries, including insurance and health care, to prepare recommendations on a state health insurance exchange. Lieutenant Governor Matt Michels was selected by the Governor to serve as the chair of the task force.

The purpose of the group was to make recommendations concerning how a South Dakota health insurance exchange should be organized and operated, should the Governor decide to pursue one. No recommendation was made regarding whether the state should run a health care exchange or not. The Governor set forth seven key parameters that were non-negotiable with respect to any health insurance exchange the State of South Dakota would consider pursuing.

1. An Exchange must be a "Market Facilitator";
2. An Exchange must provide for benefit eligibility interconnection/interface for state benefit assistance determination such as CHIP and Medicaid;
3. An Exchange shall not be operated with state taxpayer funds, but the state will continue to fund expenses related to Medicaid and CHIP eligibility determinations;
4. One statewide exchange will be created to serve both the individual and small group markets, but the two may be separated for risk adjustment purposes;
5. The state should pursue opportunities to share functionality and technology with other states;
6. An exchange should provide more insurance options for consumers, rather than replace the current private market. South Dakotans must be able to purchase policies outside of an exchange just as they are able to today; and
7. The decision on any exchange governance structure will be within the sole discretion of the Governor.

The task force began meeting in May, 2011 and continued holding regular meetings through August, 2011. To improve efficiency, the group was divided into three subgroups to include Insurance Plan and Market Organization, Outreach and Communication, and Operations and Finance. Subgroups met on their own between task force meetings as needed to complete their work. Recommendations were first approved by consensus in each subcommittee and then brought to the full task force for approval by consensus. Because of the consensus format, not every member of the taskforce necessarily agreed with every recommendation.

Please see attached *Health Insurance Exchange Task Force Recommendations*.

1. *Insurance Plan and Market Organization*

The Insurance Plan and Market Organization subgroup was co-chaired by Randy Moses from the Division of Insurance and Eric Matt from the Governor's Office. The subgroup was tasked with examining the ramifications of a South Dakota Exchange on the health insurance market and the current state regulatory environment in South Dakota. A particular focus of the group was to ensure that any recommendations honored the Governor's belief that any exchange should increase choices for consumers and protect the private insurance market. The group was tasked with making recommendations regarding the following topics:

- Methods and rules under which insurance agents can participate in the placement of coverage through the exchange,
- The carrier certification process and role of the Division of Insurance,
- Standards for marketing of products within the exchange for agents and carriers,
- Methods for employers and employees to enroll and purchase health insurance in an exchange,
- Requirements for network adequacy within and outside the exchange, and
- An outline of the ways in which adverse selection can occur.

2. *Outreach and Communication*

The Outreach and Communication subgroup was co-chaired by Secretary Kim Malsam-Rysdon of the South Dakota Department of Social Services and Secretary Doneen Hollingsworth from the South Dakota Department of Health. The group was tasked with developing an outreach and education plan for a potential South Dakota health care exchange, developing recommendations for implementing a navigator program as required by PPACA, and recommending strategies for parts of the exchange such as the call center and website to ensure effective assistance for targeted populations such as the uninsured, small businesses, tribal members, tribal leaders, and Indian Health Services.

3. *Operations and Finance*

The Operations and Finance subgroup was co-chaired by Lieutenant Governor Matt Michels and Rachel Byrum of the South Dakota Bureau of Finance and Management. This subgroup was tasked with identifying and making recommendations related to back office functions and capabilities necessary for the operation of a South Dakota exchange. Among the functions examined by the group were accounting and financial systems to ensure the financial integrity of a potential exchange, technical requirements for a web portal, technical requirements for enrollment and eligibility determinations, and staffing requirements. Objectives of the group included examining resources and capabilities, existing technical infrastructure and anticipated technical needs, regulatory or policy actions and legislation necessary for an exchange, and identifying business operations requirements and resources necessary to comply with them.

Task Force Members

IPMO stands for Insurance Plan and Market Organization and Outreach & Comm. stands for Outreach and Communication

<u>Name</u>	<u>Organization</u>	<u>Subcommittee</u>
Lt. Governor Matt Michels	Governor's Office	Operations & Finance
Kea Warne	Governor's Office	Operations & Finance
Eric Matt	Governor's Office	IPMO
Kim Olson	Governor's Office	Operations & Finance
Secretary Pam Roberts	Department of Labor and Regulation	Operations & Fiance
Randy Moses	Division of Insurance	IPMO
Jim Edman	Bureau of Information and Technology	Operations & Finance
Secretary Kim Malsam-Rysdon	Department of Social Services	Outreach & Comm.
Lynne Valenti	Department of Social Services	IPMO
Carrie Johnson	Department of Social Services	Operations & Finance
Teresa Bray	Department of Social Services	Operations & Finance
Commissioner Sandy Zinter	Bureau of Personnel	IPMO
Secretary Doneen Hollingsworth	Department of Health	Outreach & Comm.
Joan Adam	Department of Health	Outreach & Comm.
Commissioner Jason Dilges	Bureau of Finance & Management	Operations & Finance
Rachel Byrum	Bureau of Finance & Management	Operations & Finance
Commissioner Merle Scheiber	Division of Insurance	Outreach & Comm.
Larry Kucker	Bureau of Personnel	IPMO
Cristine Vogel	Navigant	Outreach & Comm.
Catherine Sreckovich	Navigant	IPMO
Ken Barrette	Optimty Advisors	Operations & Finance

Representative Spencer Hawley	SD Legislature	Outreach & Comm.
Representative Fred Romkema	SD Legislature	Operations & Finance
Senator Jim Hundstad	SD Legislature	IPMO
Senator Phyllis Heinemann	SD Legislature	Operations & Finance
Chuck Sherman	Human Service Agency	Operations & Finance
Kevin Van Dyke	Wellmark	Operations & Finance
Deb Fischer-Clemens	Avera Health	Operations & Finance
James Reynolds	North Central Heart Institute	Operations & Finance
Mark Thompson	Regional Health	Operations & Finance
Amy Olson-Miller	Big I (IIASD)	IPMO
Sarah Folsland	Black Hills Power	Outreach & Comm.
Dave Hewett	SD Assn. of Healthcare Orgs	Outreach & Comm.
Shawn Lyons	SD Retailers Association	Operations & Finance
Rob Bates	Avera Health	IPMO
Randy Hanson	Mills Construction	Outreach & Comm.
Sam Wilson	AARP	Outreach & Comm.
Elaine Roberts	South Dakota Parent Connection	Outreach & Comm.
Jennifer Stalley	American Cancer Society	Operations & Finance
Tom Bohnet	Applied Engineering, Inc.	IPMO
Darla Pollman-Rogers	America's Health Insurance Plans	IPMO
Bob Clark	NAIFA Agent	Operations & Finance
Terry Dosch	SD Council of Mental Health Centers	Outreach & Comm.
Bob O'Connell	Sioux Falls Chamber of Commerce	Outreach & Comm.
Lisa Carlson	Sanford	IPMO
Frank Stork	Wellmark	IPMO
Kirk Zimmer	Dakotacare	IPMO
Cecilia Fire Thunder	Great Plains Tribal Health Board	Outreach & Comm.
Joseph Sluka	Rapid City Regional Health	Outreach & Comm.
Ruth Krystopolski	Sanford Health Plan	IPMO
Rita Wishard	NAIFA Agent	Outreach & Comm.
Sue Schaefer	SD Pharmacists Association	IPMO
Scott Graff	Community Healthcare Association of the Dakotas	Operations & Finance
Barb Smith	SD State Medical Association	Operations & Finance
Sarah Perry	Falcon Plastics, Inc.	IPMO
Kim Perry	First Premier Bank	IPMO
Lila Caspers	LK Caspers Insurance	IPMO
Scott Jones	Delta Dental	IPMO
Paula Pourier	Little Wound School	IPMO

Subcommittee Staff

<u>Name</u>	<u>Agency</u>	<u>Subcommittee</u>
Melissa Klemann	Division of Insurance	Operations & Finance
Geraldine Ray	Bureau of Information and Telecomm.	Operations & Finance
Karrie Geffre	Bureau of Information & Telecomm.	Operations & Finance
Beverly Wilson	Department of Social Services	Outreach & Comm.
Denise Luckhurst	Bureau of Information & Telecomm.	Outreach & Comm.
Jill Kruger	Division of Insurance	IPMO
Randy Johnson	Bureau of Information & Telecomm.	IPMO
Emily Currey	Department of Social Services	Outreach & Comm.
Susan Sporrer	Department of Health	Outreach & Comm.

C. Market Decisions Survey

As part of the planning grant awarded to the State of South Dakota, the state was required to conduct background research to learn more about the demographics of the state's insured and uninsured populations. On April 1, 2011, the state awarded a contract to Market Decisions, LLC out of Portland, Maine to conduct a phone survey to gather this information. Market Decisions conducted telephone interviews with 2,530 randomly selected South Dakota households and obtained data from 6,157 South Dakota residents during the interviews.

Market Decisions is a leader in conducting research on insured and uninsured populations. Their survey uses rostering to identify members of a household and then determine the health coverage of each member. Market Decisions does research for private and public entities across the United States and has more recently conducted studies on the uninsured populations in Vermont and Pennsylvania.

The results of the survey showed that 62% of South Dakotans (503,327 people) are covered by private insurance, 13% are covered by Medicaid or South Dakota Medical Benefits, including those that have coverage in Medicaid combined with coverage from another source (109, 121 people), 16% are covered by Medicare (132, 756 people), and 5% are covered by military health insurance (43,662 people).

The survey also determined that 8.8% of South Dakotans are uninsured (71,204 people). Individuals aged 19-24 were most likely to choose not to purchase insurance, followed by individuals age 25-34. At the time of the survey, 26% of individuals age 19-24 were without insurance and 17% of adults age 25-34 did not have insurance. Native American adults were also uninsured at a high rate. 42% of this population was uninsured at the time of the survey. It is important to note that Indian Health Services was not considered health insurance for the purposes of the survey. The top reasons cited by the uninsured for not purchasing insurance were cost, job loss by a member of the family, an employer that stopped offering coverage, and a denial of coverage by an insurer because of a pre-existing condition.

In addition, the survey estimated the number of individuals that would be eligible, based on their income, to receive tax credits to purchase insurance on the exchange, and those that would be eligible to receive Medicaid under the new federally mandated Medicaid eligibility standards. Beginning on January 1, 2014, most adults with an income up to 138% of the Federal Poverty Level will be eligible for Medicaid. The survey found that 31% of the individuals with only private health insurance or 147,804 people will be eligible for tax credits to purchase insurance on the exchange. It is estimated that 48,564 individuals will be newly eligible to enroll in Medicaid in 2014. In addition, there are approximately 5,500 individuals in South Dakota that are currently eligible for, but not enrolled in Medicaid.

D. Labor Market Information Center Business Survey

As an additional requirement of the exchange planning grant, the State of South Dakota was required to collect information about employer sponsored health insurance in the state. In April, 2011, the Labor Market Information Center, a part of the South Dakota Department of Labor and Regulation, was asked to conduct a survey of businesses to gather this information.

The Labor Market Information Center (hereinafter LMIC) sent out a survey to all businesses in South Dakota that reported that they offered health insurance to their employees in a 2009 survey conducted by the LMIC. In total, the 2011 survey was sent to 709 companies. A response was received from 85% of these businesses. Of the 605 businesses that responded to the survey, 447 offered private health insurance to full time employees, defined as individuals that work 40 hours per week, and 74 offered private health insurance to part time employees. A total of 556 companies offered dependent health insurance to full-time employees and 136 offered dependent health coverage to part time employees.

Only 2% of the companies that responded to the survey indicated that they had stopped providing health insurance for their employees since 2009. The survey found that 25% of the companies that responded self-funded health insurance coverage, while 75% provided

coverage through a private insurer. Companies that self-fund their insurance policies set aside funds to pay claims rather than paying premiums to insurers.

The survey provided additional information about the contribution made by employers to cover the cost of their employees' health insurance coverage. Of the responding businesses, 39% contributed 100% toward the cost of their full time employees' health insurance premiums, 51% contributed 50-99%, 7% contributed 1-49%, and only 3% of firms contributed 0%. The average employer contributed 73% toward the cost of each full-time employee's health insurance coverage.

Employers are also contributing to the cost of insurance coverage for part time employees. The survey showed that 32% of responding businesses contributed 100% toward the cost of their part time employees' health insurance coverage, 51% contributed 50-99%, 7% contributed 1-49%, and 3% contributed 0%. The average employer also contributed 73% toward the cost of each part time employee's health insurance coverage.

In addition, the survey showed that many employees that are offered health insurance coverage from their employer choose not to enroll in it. Of the 60,093 full time employees offered health insurance benefits, 40,804 or 68% enrolled. Of the 6,493 part time employees offered employer sponsored health insurance coverage, 1,619 or 25% enrolled.

E. Navigant

In June, 2011 the State of South Dakota contracted with Navigant Consulting, Inc. to assess the policy, technology, operational, and cost implications of implementing a state exchange as required by provisions of PPACA. These findings will be used to help decide whether South Dakota should establish a state-based exchange and to make decisions related to the next steps of planning an exchange. A key part Navigant's assessment was the development of a cost model to understand and quantify the financial commitment required to develop a state based exchange. Over a ten-week period, Navigant developed an exchange cost model in close collaboration with state agencies to define and understand the start-up and ongoing operational costs of a South Dakota exchange.

To arrive at cost estimates, Navigant conducted background research, reviewed South Dakota demographic information, and performed an assessment of current operations and technology. Navigant also worked with the co-chairs of the task force subcommittees and conducted more than 20 interviews with state agencies to obtain information about current processes, capabilities, and systems.

Navigant estimates that it will cost \$45,233,699 to implement a hosted exchange in South Dakota. A hosted exchange is one where the state would contract with a third-party vendor to

“host” the state’s exchange on the vendor’s information architecture on a subscription-basis, rather than create the information technology infrastructure required to host an exchange on its own. It is estimated that approximately \$23 million of the cost will be needed to replace the state’s person master index. A person master index is a data warehouse center that handles important information related to eligibility determinations. The current person master index is outdated and currently incapable of providing the necessary functionality for an exchange. The Level I Establishment Grants from the federal Department of Health and Human Services (HHS) may cover the majority of the implementation costs. The state may be able to secure additional funding for the person master index from federal 90/10 Medicaid matching funds, where the federal government pays 90% of costs and the state pays 10%. This funding is available for the enhancement or replacement of Medicaid eligibility systems.

The annual operating costs of an exchange are estimated at between \$6,376,985 and \$7,782,382. Federal funding from the US Department of Health and Human Services is **not** available to cover operating expenses. If the state operates an exchange, it has the authority to charge fees to cover these costs. The task force made no recommendation concerning how the state would fund ongoing exchange costs.

Navigant, in a joint effort with the Department of Social Services, Department of Labor and Regulation, Department of Revenue, and Governor’s Office, also estimated the number of individuals expected to enroll in health insurance through a South Dakota exchange. It is estimated that between 97,070 and 166,767 individuals will enroll in health care in the small business and individual insurance markets. Because an exchange must also determine Medicaid eligibility, the number of Medicaid users expected to enroll through an exchange was estimated at between 99,674 and 168,059 individuals. Of these Medicaid enrollees, it is expected that 48,564 will be newly eligible for Medicaid under PPACA’s Medicaid expansion.

The State of South Dakota is also examining its Medicaid eligibility system to determine if additional upgrades are needed to support business functions for Medicaid enrollees both inside and outside an exchange. The current Medicaid enrollment and eligibility system is outdated and will require radical modification or replacement to meet South Dakota’s Medicaid eligibility and enrollment needs.

III. Next Steps

A. *Federal Establishment Grants*

The next step in the exchange planning process, regardless of whether South Dakota decides to create a state based health insurance exchange or not, is deciding whether or not to apply for additional federal grant funding related to health insurance exchange development. The next

level of funding South Dakota is eligible to apply for is Level I Establishment Grant Funding. This funding is used to do more in-depth planning concerning a health insurance exchange. Level I Establishment Grant Funding is available to states that have shown progress in planning for an exchange, but have not yet obtained enough progress toward a state based exchange to apply for Level II Establishment Grant Funding. A state is not required to commit to creating a state based health insurance exchange in order to receive Level I Funding. This funding is good for one year and the deadline for states to apply for Level I funding is December 30, 2011. The Department of Health and Human Services will be employing teams to closely monitor the progress of states that accept Level I funding and is authorized to rescind funding to states that do not show progress toward either helping the federal government establish a federal exchange in their state, establishing a partnership exchange in their state, or establishing a state based health insurance exchange.

Level II funding provides additional money for states that choose to implement a state based health insurance exchange and show progress toward doing so. In order to apply for Level II funding, a state must commit to establishing a state based exchange. To show a commitment to a state based exchange, any state applying for Level II funding must put in place the appropriate legal authority, such as legislation, authorizing it to implement a state run health insurance exchange. The deadline for applying for Level II funding is June 29, 2012 and the funding is available to states through December, 2014.

If a state does not apply for Level II Establishment Grant Funding by the deadline, and later decides to implement a state based exchange, it will not be eligible for federal funding through 2013 to finish establishing a plan for a state based exchange. In addition, it will not be eligible for federal funding to implement the exchange in 2014.

Therefore, if a state does not have legal authority to establish an exchange before June 29, 2012 it will not be able to obtain federal funding for the full costs of establishing and implementing a health insurance exchange through 2014. In that instance, state resources would have to be expended to complete the establishment and implementation process for a state based exchange.

The lack of direction from the US Department of Health and Human Services concerning state based exchanges makes it unwise to pursue legislation during the 2012 legislative session. Because level II funding requires legal authority and the deadline for applying is in June, 2012, well before the 2013 legislative session, the State of South Dakota is precluded from applying for Level II Establishment Grant Funding.

B. Regulations

Many important decisions related to the implementation of PPACA are still unclear due to the release schedule of federal regulations from the Department of Health and Human Services. It took the department over one year and one half to release some regulations. Many important regulations are yet to be released including but not limited to those that define the meaning of essential health benefits and regulations related to navigators. There are also questions about how the federal government will compute error rates and determine liability under the new approaches for on-line eligibility determinations related to the retrospective reconciliation of inaccurate determinations of Medicaid and exchange plan subsidy eligibility. Further concern exists over the readiness of the federal data hub by October 2013. The federal data hub is being developed by the federal government to provide real-time eligibility data such as income verification through links to the Internal Revenue Service and other federal agencies. The Department of Health and Human Services has not clearly defined when further regulations will be forthcoming.

The lack of clear direction from the Department of Health and Human Services has created a barrier for states as they decide whether to implement an exchange. It makes it more difficult to commit to a state exchange when important requirements are still unknown.

C. Political and Legal Uncertainty

Further complicating the decision whether South Dakota should pursue a state based exchange is the current political environment. The Republican Party is strongly opposed to PPACA and has pledged to work to repeal it. If a Republican President is elected and the party gains control of the Senate after the 2012 elections, it is possible that a bill to repeal some or all of the provisions of PPACA could be successful in 2013.

Besides the current political environment, the legal status of PPACA adds additional uncertainty to the fate of the law. As provided above, one federal court of appeals has upheld the individual mandate portion of the law and the other court has found the individual mandate unconstitutional while upholding the rest of the law. The Supreme Court is set to hear the case during the upcoming term, but it is unclear how the court will rule.

D. 2012 South Dakota Exchange Legislation

Because of all the uncertainty surrounding PPACA, the Governor will not pursue enabling legislation to establish an exchange during the 2012 legislative session. Considering the lack of guidance from the federal government concerning what a state exchange should look like and the political and legal uncertainty surrounding the law, it is unwise to commit to a state based exchange at this time. It is still unclear what a state exchange is required to look like or

whether it will exist on January 1, 2014 when the law is set to be implemented. Such a massive undertaking of time and resources should be entered into carefully with a clear idea of the end product in mind. Currently, adequate information is not available to make such a commitment through legislation.

E. The Options for South Dakota

1. Federal Exchange-Important Considerations

Without legislation in 2012, one option for the State of South Dakota is to let the federal government run an exchange in South Dakota. The prime advantage of doing so is that the federal government would be solely responsible for developing and implementing the costly technical infrastructure and back office functions necessary to establish an exchange and the integrated eligibility system for the exchange and Medicaid. The state would also free up time and resources to devote to other projects and would not be responsible for the operating costs associated with maintaining an insurance exchange. The state would not be completely free from involvement in the planning process, however. State experts would need to work with federal officials to gather South Dakota specific information necessary to implement a federal exchange and to ensure that federal and state insurance and Medicaid rules do not conflict.

A major disadvantage of allowing the federal government to run every aspect of a South Dakota health insurance exchange is the loss of control of certain Medicaid eligibility determinations and increased federal regulation of South Dakota's insurance industry. Currently, the State of South Dakota is solely responsible for all Medicaid determinations. Under a federal exchange, those individuals that apply for Medicaid through the exchange would be screened for eligibility by the federal system.

With regards to insurance regulation, the federal government, rather than the state, would be responsible for risk adjustment, adverse selection mitigation, consumer protection, and other important considerations that could affect the insurance market inside and outside the exchange. The federal government could also choose to determine which plans can be sold on the exchange by using an active purchaser model, which could have a negative impact on the private insurance industry.

In order to pay for the operating costs of a federal exchange, the federal government will likely have to charge fees to users or insurers or choose another method of collecting funds to ensure that the exchange can maintain itself. The method used for sustaining the exchange is still unknown and it is unclear how the state would be reimbursed for any costs incurred assisting federal officials and interacting with the exchange.

2. Partnership Exchange-Important Considerations

The major advantage of partnering with the federal government, as opposed to allowing for the federal government to run every exchange function is that the state could maintain authority to do customer service and/or plan management. The federal government would still be responsible for establishing the technical infrastructure and back office functions required to operate an exchange and create an integrated eligibility system for the exchange and Medicaid. However, the state could choose to provide customer service to those enrolling on the exchange by running the navigator program. In addition, the state could retain more control over insurance regulation and have an opportunity to better protect the private market by allowing any plan that meets minimum standards to be sold on the exchange.

While possibility mitigating some aspects of the loss of state insurance regulatory authority, the major disadvantages of the partnership model are essentially the same as the federal exchange model. The one major difference is that it may be difficult for the state to provide consumer assistance for a system it did not create and has no control to alter.

3. Regional Exchange

South Dakota is discussing the option of sharing exchange functions with other rural, neighboring states. A major barrier to creating a state run exchange in a rural state such as South Dakota is enrolling enough participants to make the exchange cost effective. A potential partnership could be designed to assemble and share back office functionality such as web portal technology, database technology, and other business functions to spread costs over a larger population. Despite the potential cost benefits of sharing functionality, establishing a regional exchange in time for implementation by 2014 will be very difficult. Policy decisions in neighboring states have already limited South Dakota's ability to establish partnerships and, no rural state in our region is far enough along in the planning process to determine how a regional partnership might function.

After legislation to create a state run exchange in Montana failed in the 2011 Montana legislative session, it appeared that the federal government would be left to run a Montana insurance exchange, eliminating the need for a partnership.² This fall, however, the Governor of Montana requested flexibility from PPACA requirements in order to set up a universal health insurance program in the state.³ Nebraska Governor Heinemann recently decided that his state will not pursue legislation authorizing the creation of a state based exchange until the U.S.

² Federal Officials Left to Set Up Montana Health Insurance Exchange, Lindeen Says. Missoulian. July 14, 2011. http://missoulian.com/news/state-and-regional/article_5527e210-ae6e-11e0-a447-001cc4c002e0.html

³ Montana Governor Calls for Universal Health Care. Associated Press. Bloomberg Businessweek. September 29, 2011. <http://www.businessweek.com/ap/financialnews/D9Q27RJG0.htm>.

Supreme Court rules on the constitutionality of PPACA. In the meantime, Nebraska is still planning for a state based exchange, and applied for Level I Establishment Grant Funding on September 30, 2011.⁴ North Dakota passed legislation during its 2011 legislative session concerning the state's intent to create a state run health insurance exchange. The legislation also delegated the planning of the exchange to the North Dakota Insurance Commissioner and North Dakota Department of Human Services. In July, the state issued a request for proposals (RFP) to identify a subcontractor to conduct research and recommend a plan for developing and sustaining a North Dakota health insurance exchange. The North Dakota legislature is holding a special session for redistricting in November, where they will likely discuss proposed legislation to create a state based exchange.⁵ It is uncertain whether or not this legislation will pass. North Dakota is not in a position to discuss a potential partnership until after this year's special session.

Wyoming Governor Matt Mead has endorsed creating at least some of the components of a state run exchange in Wyoming, as per the recommendations of Wyoming's Health Benefit Exchange Steering Committee. Wyoming has not yet passed legislation to create an exchange, and their Governor is leaving the decision on whether or not to move forward with a Wyoming exchange to the Wyoming legislature. Legislators are currently deciding whether or not to draft legislation for consideration during the 2012 session. Governor Mead also believes that Wyoming should retain as much flexibility as possible in the exchange planning process. This means waiting to decide on whether to run a state based health insurance exchange until it is absolutely necessary.⁶

In Iowa, several bills introduced during the 2011 legislative session to establish a state run health insurance exchange failed. The State of Iowa created an interagency workgroup to plan and make recommendations for an exchange. In addition, the state met with stakeholders in public meetings to solicit input. The Iowa Department of Human Services has initiated a project to develop a new Medicaid and CHIP enrollment system with exchange interoperability and has released a request for information (RFI) seeking potential solutions from information technology contractors.⁷

⁴ Wait-and-see Plan Urged for Exchange. Omaha World Herald. October 4, 2011.

<http://www.omaha.com/article/20111004/LIVEWELL03/710049906/1161>.

⁵ Implementing Health Insurance Exchanges: North Dakota, Focus on Health Reform. The Henry J. Kaiser Family Foundation, August 9, 2011. <http://www.kff.org/healthreform/upload/8223-ND.pdf>.

⁶ Wyoming Gov. Mead Supports State Health Insurance Recommendation. Casper Star Tribune, October 11, 2011. http://trib.com/news/state-and-regional/mead-supports-state-health-exchange-recommendation/article_3f3d6b73-af00-5a86-8193-bc34eb10e31d.html.

⁷ Implementing Health Insurance Exchanges: Iowa, Focus on Health Reform. The Henry J. Kaiser Family Foundation, August 16, 2011. <http://www.kff.org/healthreform/upload/8223-IA.pdf>.

4. Level I Establishment Grant Funding Opportunities for South Dakota

As mentioned above, the state will not be eligible to pursue Level II Establishment Grant Funding without passing legislation in the 2012 session. South Dakota will be able to pursue Level I Establishment Grant Funding without enabling legislation regardless of whether a decision is made to pursue a federal, partnership, or state based exchange.

Level I Establishment Grants are available to allow states to do additional planning in 11 core areas. Of these 11 core areas, South Dakota is positioned to pursue additional background research on topics such as risk corridor analysis and the market impact of a potential exchange, develop exchange interfaces to share information between state agencies, qualified health plans, the federal data plan, and the person master index, develop information technology systems, provide assistance to individuals and small business, coverage appeals, and complaints by doing further research on a potential navigator program and assessing and planning an outreach and communications plan, and to further identify and develop systems necessary to conduct the business operations of an exchange.

If South Dakota decides to pursue a federal exchange, at this time, no federal funding will be available after 2012. If the state pursues a federal partnership, funding will be available in 2013 and 2014, but only for the functions the state will be operating, which, under the current federal proposal are limited to plan management (market facilitator vs. active purchaser and the like) and consumer assistance functions (navigator program). The federal government has not set forth what a state would need to do to help the federal government establish an exchange. There are also no timelines or information concerning the requirements for applying for additional funding to pursue a partnership exchange after level I funding expires.

If South Dakota decides to pursue a state exchange or develop selected functions of an exchange outside of the proposed partnership model without legislation in 2012, level I funding will be available for up to one year. South Dakota could decide to apply for level I funding in each of the core areas listed above and develop some or all of the systems required to establish an exchange during a one year period. The state's grant application, including a budget and plan for spending the federal funding, would have to be approved by the US Department of Health and Human Services and the funding could be eliminated if the federal government determined that a federally facilitated exchange would have to be operated in South Dakota despite the state's efforts.

A potential benefit of applying for level I establishment grant funding is the opportunity to leverage federal grant dollars, in addition to enhanced federal Medicaid matching funds (FMAP) at a rate of 90% federal contribution to 10% state contribution to support key functionality in the state Medicaid eligibility system, as opposed to relying only on federal 90-10 funding. It is

important to note that regardless of South Dakota's decision to apply for Level I Establishment Grant Funding or to pursue a state run exchange, the state will be eligible to receive the enhanced 90-10 FMAP funding to support key functionality in the South Dakota Medicaid eligibility system.