

healthpolicybrief

Health insurance marketplaces

What Ohioans can expect



Under the Patient Protection and Affordable Care Act (ACA), states have the choice to establish a state-based marketplace, a federally facilitated marketplace (FFM), or a hybrid/partnership marketplace to assist qualified individuals and small employers with selecting and purchasing health insurance coverage. The ACA requires only “Qualified Health Plans (QHPs)” be offered to consumers via health insurance marketplaces (formerly known as exchanges) beginning in 2014. This paper explores how marketplaces will operate in Ohio and describes QHPs. The paper also describes the benefits that will be included in plans available through the individual market, the small group market and Medicaid.

Ohio’s Federally Facilitated Marketplaces (FFM)

Earlier in 2013, Ohio decided not to pursue a state-based marketplace, but indicated that Ohio would continue to perform insurance regulatory functions through the Ohio Department of Insurance (ODI). Ohio stopped short of referring to this as a partnership or hybrid approach, although the functions mirror those required in a plan management partnership (see HPIO’s *Ohio’s options for health insurance exchanges brief* at <http://bit.ly/Xjxd88>). The Centers for Medicare and Medicaid Services (CMS) described the details of a federally facilitated marketplace with the state performing plan management in a February 2013 publication.¹ This arrangement is similar to those proposed in Kansas, Maine, Montana, Nebraska, South Dakota and Virginia.

There will be two separate federally facilitated marketplaces (FFMs) offered in Ohio: a marketplace for individuals and a Small Group Health Options Program (FF-SHOP) marketplace for small groups (50 or fewer full-time employees). Both marketplaces will be available via open enrollment beginning October 2013 for effective coverage dates beginning January 1, 2014. The two marketplaces will operate separately and will maintain separate and distinct risk pools.

By retaining its regulatory authority over the business of insurance in Ohio, ODI will oversee the certification of QHPs. In addition, ODI will continue to collect and analyze information on plan rates, covered benefits, and cost-sharing requirements; ensure ongoing plan compliance; resolve consumer complaints; provide issuer technical assistance; and help manage

Who will enroll in Qualified Health Plans?

According to initial projections, by 2017 Ohio’s individual health insurance market may more than double in size from 350,000 to 735,000, (assuming Medicaid expansion to 138% of the Federal Poverty Level [FPL].)² While this represents sizeable growth, it is important to consider that 735,000 represents 7.3 percent of all Ohioans ages 0-64. The majority of non-elderly Ohioans will continue to be covered through employer-sponsored insurance.³

Because premium and cost-sharing subsidies are only available through the marketplace, 71 percent (524,000) of those in the individual market are expected to enroll in a QHP through the federally facilitated marketplace; 29 percent (211,000) are projected to enroll outside the federally facilitated marketplace.

Much of the growth in the individual market is expected to come from the currently uninsured who likely will enroll because of the individual mandate, guaranteed issue and premium tax credits and cost-sharing subsidies.⁴ Other growth is expected to come from individuals who were previously enrolled in employer-sponsored insurance that is either terminated or determined not to meet minimum requirements of covered benefits or affordability. Many of these enrollees will come from small employers that do not face a tax penalty for dropping or not offering coverage, generally offer lower benefit levels, and often require higher employee premium contributions.⁵

As many as 170,000 additional Ohioans (1.7 percent of all Ohioans 64 and younger) are projected to get their coverage through the Small Group Health Options Program, or SHOP, exchange.⁶

decertification of issuers and associated appeals.⁹ However, the federal government has final authority to approve QHPs.

Small group Health Options Program (SHOP)

As originally conceptualized, the SHOP would have enabled employers to offer and employees to choose from multiple insurance products. However, given the challenge of meeting tight operational deadlines, the Department of Health and Human Services (HHS) recently instituted a one-year delay for this employee choice component of the SHOP for all 33 federally facilitated and partnership marketplaces, including those in Ohio.⁷ As a result, in 2014, an employer participating in the SHOP can offer only one plan to its employees. Reports suggest that, while optional, many of the state-based SHOPS intend to enable employee choice beginning in 2015.

Even with the limitations on employee choice, the SHOP marketplace will provide a number of benefits including:

- A standardized method of plan comparison
- Only plans that are certified as QHPs
- The potential for employers to earn small business tax credits

These tax credits have been available since 2010 to small businesses with no more than 25 employees who have average annual wages of \$50,000 or less, and who contribute at least 50 percent toward the health insurance plan premium for its employees. For 2010 through 2013, the tax credit covers up to 35 percent of an eligible, for-profit small employer's contribution to health insurance, and 25 percent of a nonprofit employer's premium contribution. Beginning in 2014, the small business tax credits are increased to up to 50 percent of premium for for-profit businesses and up to 35 percent for eligible non-profits; however, tax credits will only be available to employers who purchase via the FF-SHOP marketplace.

Notably, issuers that have greater than 20 percent small group market share must offer at least one silver-level QHP and one gold-level QHP through the FF-SHOP as a condition of participation in the federally facilitated individual market marketplace.⁸

Qualified Health Plans (QHPs)

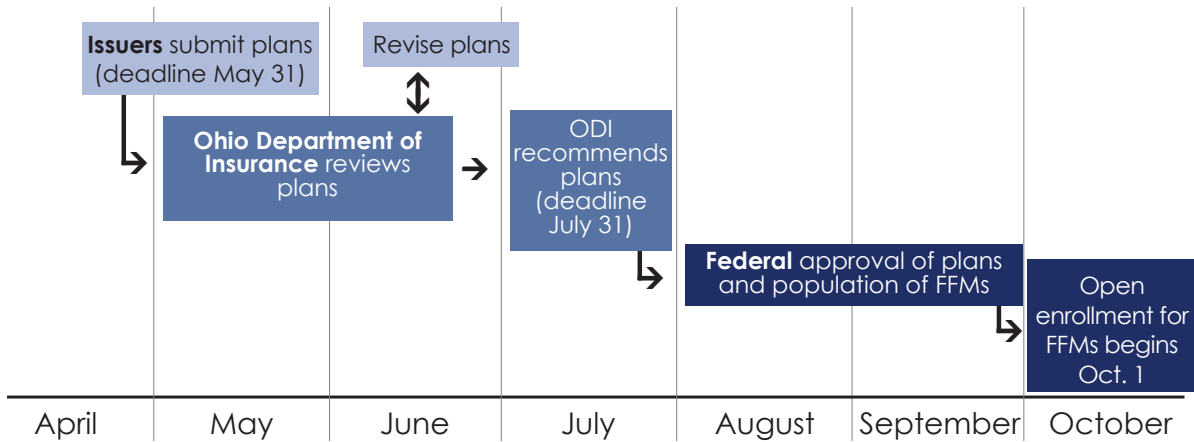
The ACA requires only "Qualified Health Plans (QHPs)" be offered to consumers on health insurance marketplaces beginning in 2014. A QHP is a health plan that meets certain certification requirements and minimum standards of quality, value, and benefit design. Specifically, QHPs are required to:

- Be offered by a health insurance issuer that is "licensed and in good standing" with the state
- Offer plans that fall within the bronze, silver, gold, platinum or catastrophic cost sharing tiers
- Offer at least one silver and one gold QHP through the marketplace
- Include a comprehensive package of covered items and services known as "essential health benefits" (EHB)
- Include an adequate provider network including "essential community providers" (ECPs)
- Limit out of pocket spending by consumers to \$6,350 for single coverage and \$12,700 for family coverage in 2014

QHP certification process

In Ohio, issuers were required to submit plans for QHPs to ODI by May 31, 2013, to allow sufficient time for review and revisions. All rate and product filings and reviews between issuers and ODI must be conducted through the System for Electronic Rate and Form Filing (SERFF) established by the National Association of Insurance Commissioners. Approved QHPs must be submitted to CMS by July 31, 2013, via CMS' Health Insurance Oversight System (HIOS).

The following chart depicts the timeline and interplay between issuers filing new benefit plans, ODI's review, and the federal government's final approval in order for plans to be ready for the opening of the marketplaces to Ohio consumers on October 1, 2013.



Impact on Ohio market

In a press release dated June 6, 2013, ODI indicated 14 issuers submitted 214 individual product plans for review.¹⁰ Along with Michigan, which also recently announced 14 issuers, this represents more carriers than other states (AR-5; CA-13; CO-10; CT-9; IL-6; MD-13; MN-9; OR-12; RI-6; VT-2; WA-9) that have released similar data. According to ODI's press release, the plans filed with ODI to be sold in the individual market had an average "index rate" of \$420 and a spread of \$282.51 to \$577.40.

The index rate is the average allowed claim costs per member per month submitted by health care providers (i.e., doctors and hospitals) for payment and includes not only claims to be paid by insurers, but also out-of-pocket expenses to be paid by consumers. Because of this, the index rate will tend to be higher than premium rates charged to consumers in 2014.

For example, a review of two individual market plan submissions found gross average premium rates of \$353 and \$386 per member per month, with index rates of \$456 and \$509, respectively. These 2014 average premium rates do not take into account premium subsidies that consumers with incomes below 400% of the federal poverty line will receive. Also, these are "average" rates. Insurers will take into account the following factors when determining a specific premium for a specific person: age, tobacco use, regional characteristics and whether the plan will cover one person or a family.

As noted earlier in this brief, ODI will review and approve rates by July 31, 2013. Further analysis of final approved premium rate filings will be required to fully understand the premium rates that consumers can expect to pay in the 2014 market. The federal government has indicated that all rates for plans in the federal exchange will be made public in September 2013. When making direct comparisons to previous years, it is important to consider that plans now are required to provide essential health benefits in the 2014 market and many other insurance regulations have changed as well.

Although not a comprehensive list, ODI has released publicly the names of the following health issuers interested in operating in Ohio's marketplaces:

Individual marketplace	SHOP
Aetna	AultCare
AultCare	Community (Anthem)
Community (Anthem)	Coordinated Health Mutual
Coordinated Health Mutual	Kaiser Foundation Health Plan
Coventry	Medical Insuring Corp of OH (MMO)
Medical Insuring Corp of OH (MMO)	Summa
Summa	

Required levels of coverage

Under the ACA, health plans may offer four levels of coverage, known as “metal tiers”: bronze, silver, gold and platinum. Platinum-level coverage provides the most generous coverage (rated at 90 percent of medical expenses) with the least cost sharing, while bronze-level coverage is the least generous coverage (60 percent of expenses) with the highest cost-sharing. A QHP issuer must offer at least one silver level (70 percent) QHP and one gold level (80 percent) QHP through the marketplace.

Essential health benefits (EHB)

The ACA requires small group and individual health insurance plans offer a comprehensive package of covered items and services known as “essential health benefits”(EHB). This provision pertains to plans offered both inside and outside the marketplaces, with the exception of “grandfathered” plans. Grandfathered plans are those plans established prior to the passage of the ACA on March 23, 2010 which have not been substantially modified as to covered services.¹¹ The intent of the EHB provision is to ensure health plans purchased by consumers and small businesses cover a comprehensive set of health services.

10 statutory essential benefits categories

- Ambulatory patient services
- Emergency services
- Hospitalization
- Maternity and newborn care
- Mental health and substance abuse treatment
- Prescription drugs
- Rehabilitative and habilitative services and devices
- Laboratory services
- Preventive and wellness services and chronic disease management
- Pediatric services, including oral and vision care

In addition to the ten statutory categories dictated by the ACA (see box insert), the U.S. Department of Health and Human Services (HHS) provided direction to states to establish a benchmark that sets a minimum level of benefit coverage for each QHP. If a state did not choose a benchmark, the largest small group plan in the state’s commercial market would be the default. In Ohio, the state defaulted to the largest small group plan sold in the state, *Anthem’s Blue 6.0 – Blue Access PPO – Medical Option #D4/Rx Option G*. For dental and vision benchmark plans, Ohio defaulted to the *MetLife Federal Dental* plan and the *Federal Employee Program Blue Vision* plan.¹²

Additional guidance offered by the Ohio Department of Insurance on EHB requires that QHPs adhere to the following:^{13,14}

- Coverage must be substantially equal to coverage in the Ohio EHB Benchmark Plan, and cannot include more restrictive quantitative limits or exclusions for EHB benefits and services than the Ohio EHB Benchmark Plan.
- No annual or lifetime dollar limits are permitted on EHB benefits and services.
- Except for prescription drug benefits, a plan may substitute benefits, or sets of benefits, that are actuarially equivalent to the EHB Benchmark Plan benefits being replaced, but only within an EHB benefit category, not between different categories.

Prescription drug coverage

- Each plan must cover the greater of (i) one drug in each United States Pharmacopeia (“USP”) category or class, or (ii) the same number of prescription drugs covered in each USP category or class as the Ohio EHB Benchmark Plan.
- A plan may substitute a prescription drug(s) covered under the Ohio EHB Benchmark Plan provided that the substitution is in the same USP category or class as the drug covered under the Ohio EHB Benchmark Plan. Substitutions must be identified in a separate document along with verification that the USP category or class of the substituted drug is the same as the drug covered under the Ohio EHB Benchmark Plan.

Dental, vision, and mental health coverage

- Plans offered in the marketplaces may exclude required EHB pediatric dental services if a stand-alone dental plan providing the required EHB pediatric dental services is also offered in the marketplace.
- Plans offered outside the marketplace must cover the pediatric dental services covered by the Ohio EHB Benchmark Plan (the *MetLife Federal Dental* plan), for enrollees up to 19 years of age, unless the issuer can determine, after reasonable inquiry, that the policyholder is covered under a dental insurance plan that covers the required EHB pediatric dental services.

- Plans must include adult eye exam and pediatric vision services covered under the Ohio EHB Benchmark Plan (Federal Employee Program Blue Vision) for enrollees up to age 19 for products sold inside and outside the marketplace.
- Plans must comply with federal Mental Health Parity law.

Habilitative services

- As outlined in a December 26, 2012 letter from Governor Kasich to CMS,¹⁵ “Habilitative services benefits shall be determined by the individual plans and must include, but shall not be limited to, Habilitative Services to children (0 to 21) with a medical diagnosis of Autism Spectrum disorder which at a minimum shall include:
 1. Out-Patient Physical Rehabilitation Services including:
 - (a) Speech and Language therapy and/or Occupational therapy, performed by a licensed therapists [sic], 20 visits per year of each service; and
 - (b) Clinical Therapeutic Intervention defined as therapies supported by empirical evidence, which include but are not limited to Applied Behavioral Analysis, provided by or under the supervision of a professional who is licensed, certified, or registered by an appropriate agency of this state to perform the services in accordance with a treatment plan, 20 hours per week;
 2. Mental/Behavioral Health Outpatient Services performed by a licensed Psychologist, Psychiatrist, or Physician to provide consultation, assessment, development and oversight of treatment plans, 30 visits per year total.”

The initial EHB benchmark plan selected by the state is in effect for benefit years 2014 and 2015. HHS intends to revisit benchmark selection beginning in 2016.

Essential Community Providers (ECPs)

Issuers offering plans through marketplaces are required to ensure QHP and Stand Alone Dental Plan networks include a sufficient number and geographic distribution of providers that serve predominantly low-income, medically underserved individuals, referred to as Essential Community Providers (ECPs). For federally facilitated and hybrid marketplaces, CMS directed potential issuers to use the non-exhaustive database of ECPs via a published link¹⁶ as the basis for determining the number of available ECPs in the QHP’s service area. Potential ECPs were sent letters from the Center for Consumer Information and Insurance Oversight (CCIIO) on May 13, 2013 strongly encouraging them to consider joining issuers’ networks.

According to ODI, while QHP issuers in Ohio are required to make provider directories available for publication online and to potential enrollees in hard copy upon request, the issuer is not required to denote which providers are ECP. However, the QHP issuer must identify providers that are accepting new patients.

ODI has indicated it will approve a QHP’s ECP certification requirements as long as one of the following standards is satisfied:

- If the plan contracts with 20 percent of ECPs in their service area, it falls within a “safe harbor.”
- Where the plan has the participation of at least 10 percent of ECPs in their service area, it meets a “minimum expectation” standard.
- If an issuer submits a letter of evidence as to why 10 percent could not be met, and how the issuer plans to increase ECP participation in the future, it may be allowed to meet an alternative standard.¹⁷

EHB: Stakeholder concerns

Some stakeholders are concerned by the flexibility of substitution allowed to issuers in complying with EHB criteria. Further, while mental health professionals are pleased parity is extended to the individual and small group markets, they are worried Ohio’s benchmark EHB plan (i.e., Anthem’s PPO product) may neither cover specific behavioral health screenings nor the full continuum of mental health care treatments and medications.

Dental and eye care professionals are optimistic about their primary services being included as part of the EHB, but remain wary of the unknown form in which these services will be marketed to consumers. Some wonder how well the marketplace will allow consumers to compare dental and vision benefits from product to product, especially if such benefits are buried in the medical plan coverage. Some consumers may be accustomed to looking for these types of coverage in standalone benefit plans. While the EHB specifically allows for freestanding dental plans, the same stipulation is not made for vision.

Alternative benefit plans and EHB in Medicaid

Since 2006, through authority granted by Section 1937 of the Deficit Reduction Act of 2005, states have had increased flexibility to design Medicaid benefit packages in their state plan.¹⁸ Broadly speaking, state Medicaid programs have the option to provide certain groups of Medicaid enrollees with “benchmark” or “benchmark-equivalent” coverage based on one of three commercial insurance products, or a fourth, “Secretary-approved” coverage option.

“Benchmark” means that the benefits are at least equal to one of the specified benchmark plans, and “benchmark-equivalent” means that the benefits include certain specified services and the overall benefits are at least actuarially equivalent to one of the specified benchmark coverage packages.^{19,20} A state may design different benefit packages for different populations.

The four benchmark options are:

1. The Standard Blue Cross/Blue Shield Preferred Provider Option offered through the Federal Employees Health Benefit program (FEHBP)
2. State employee coverage that is offered and generally available to state employees
3. The commercial HMO with the largest insured commercial, non-Medicaid enrollment in the state
4. Secretary-approved coverage, which can include the state's full Medicaid benefit package

Under the ACA, states that opt to expand Medicaid coverage to 138% FPL must provide the newly-eligible low-income adult group with an Alternative Benefit Plan (formerly called the Medicaid benefit benchmark).

Any Alternative Benefit Plan must²¹:

- Cover the ten essential health benefits as described in the ACA (refer to box on page 4)
- Comply with the Mental Health Parity and Addiction Equity Act
- Include coverage for family planning services and supplies
- Include transportation to and from medically necessary covered Medicaid services
- Assure access to Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services²²

The ACA modified Section 1937 of the Social Security Act to implement two standards for minimum coverage provisions: (1) not only must EHBs, as defined by the Secretary, be provided, but (2) all requirements of Section 1937 of the Social Security Act continue to apply.²³

Certain populations, such as blind, disabled, medically-frail, former foster care children, certain pregnant women, and those also enrolled in Medicare, are exempt from mandatory enrollment in an Alternative Benefit Plan.²⁴ States may, however, offer voluntary enrollment in an Alternative Benefit Plan to those exempt groups. In addition, Alternative Benefit Plans must comply with the standards and conditions under which states may impose premium and cost-sharing within the Medicaid program.²⁵

Similar to the EHB benchmark in the commercial market, the approved Alternative Benefit Plan will be in effect for two years through 2015.

Approval process for the Alternative Benefit Plan

States are required to submit to CMS State Plan Amendments (SPAs) describing the Alternative Benefit Plan for the newly-eligible adult group. SPAs may be submitted starting in the first quarter of 2013 for coverage beginning January 1, 2014. Prior to submitting a State Plan Amendment to establish or substantially modify an Alternative Benefit Plan, a state must have provided the public with advance notice of the amendment and reasonable opportunity to comment for such amendment.²⁶

Status in Ohio

As of the publication of this paper, the Ohio General Assembly still is considering whether or not to expand Medicaid coverage to adults with incomes up to 138% FPL. If the decision is no, then no further action is required by Ohio regarding establishing an Alternative Benefit Plan. If the decision is yes, then Ohio will need to decide which of the four benchmark options outlined above will be adopted for the newly-eligible population.

Conclusion

The criteria QHPs must meet to be offered to consumers, coupled with the metal tiers of the marketplace, are intended to ensure that consumers can shop, compare and purchase standardized health plans that include a broad scope of covered benefits on the individual or SHOP marketplaces. There remains, however, the daunting challenge for issuers and state and federal government agencies to file, review and approve adequate numbers of health plans within the aggressive time frames required to be ready for open enrollment on Oct. 1, 2013. In addition, if the Ohio General Assembly decides to expand Medicaid coverage to adults with incomes up to 138% FPL, the state will have to decide which benchmark benefit package will be adopted for the newly eligible population.

Glossary

Actuarial value — The percentage of total average costs for covered benefits that a plan will cover. For example, if a plan has an actuarial value of 70%, on average, a consumer would be responsible for 30% of the costs of all covered benefits. A consumer could be responsible for a higher or lower percentage of the total costs of covered services for the year, depending on actual health care needs and the terms of the insurance policy.

Essential community providers — Essential Community Providers (ECPs) serve predominantly low-income, medically underserved populations and include, but are not limited to, safety net providers who are eligible to participate in the 340B drug purchase program in these six categories: Federally Qualified Health Centers (FQHCs), Ryan White providers, family planning providers, Indian providers, specified hospitals, and others.

Essential health benefits (EHB) — The ACA requires small group and individual health insurance plans offer a comprehensive package of covered items and services known as “essential health benefits” (EHB). Essential health benefits must include items and services within at least the following 10 categories: ambulatory patient services; emergency services; hospitalization; maternity and newborn care; mental health and substance use disorder services, including behavioral health treatment; prescription drugs; rehabilitative and habilitative services and devices; laboratory services; preventive and wellness services and chronic disease management; and pediatric services, including oral and vision care. This provision pertains to plan offered both inside and outside the marketplaces, with the exception of “grandfathered” plans.

Grandfathered plan — A group health plan that was created or an individual health insurance policy that was purchased on or before enactment of the ACA, March 23, 2010. Grandfathered plans are exempt from many of the changes implemented by the ACA.

Health insurance marketplaces — Established in the ACA, the American Health Benefit Exchange (now known as the Health Insurance Marketplace) facilitates the purchase and sale of qualified health plans in the individual market in states. Likewise, the Small Business Health Options Program Exchange (now known as the SHOP Marketplace) enables small businesses with up to 100 employees to purchase qualified health coverage. The aim of the marketplaces is to reduce the number of uninsured, increase transparency in the insurer marketplace, provide consumer education and assist individuals with access to publicly-funded insurance programs, premium assistance and cost-sharing reductions.

Patient Protection and Affordable Care Act — The federal health care reform law enacted in March 2010. The law was enacted in two parts: the Patient Protection and Affordable Care Act was signed into law on March 23, 2010 and was amended by the Health Care and Education Reconciliation Act on March 30, 2010. The name “Affordable Care Act” or “ACA” refers to the final, amended version of the law.

Qualified health plan — A qualified health plan (QHP) is a health plan certified by an Exchange and that meets minimum standards of quality, value, and benefit design.

Notes

1. www.cms.gov/CCIIO/Resources/Files/Downloads/plan-management-faq-2-20-2013.pdf
2. Milliman Client Report, "Assist with the first year of planning for design and implementation of a federally mandated American Health Benefit Exchange." August 31, 2011. Prepared for Ohio Department of Insurance, by Milliman, Inc. <http://www.ohioexchange.ohio.gov/Documents/MillimanReport.pdf>
3. Ibid.
4. Ibid.
5. Ibid.
6. Ibid. The Milliman report includes, based on a series of factors and assumptions, a "lower SHOP enrollment" projected enrollment of between 30,000 and 70,000 and a "higher SHOP enrollment range" projected enrollment of between 100,000 and 170,000.
7. www.ofr.gov/OFRUpload/OFRData/2013-13149_PL.pdf
8. Ibid.
9. www.ohiomarketplace.ohio.gov/
10. <http://www.insurance.ohio.gov/Newsroom/Pages/06062013ACAProposedRates.aspx>
11. www.healthreform.gov/about/grandfathering.html
12. www.insurance.ohio.gov/Company/Pages/planmanagementtoolkit
13. www.insurance.ohio.gov/Company/Pages/planmanagementtoolkit
14. <http://insurance.ohio.gov/Company/Pages/ACASampleGuidanceandChecklist>
15. www.insurance.ohio.gov/Company/Documents/Habilitative%20Services%20Letter.pdf
16. <https://data.cms.gov/dataset/Non-Exhaustive-List-of-Essential-Community-Provider-ibay-mswq>
17. www.insurance.ohio.gov/Company/Pages/planmanagementtoolkit.aspx
18. See §1937 of the Social Security Act, enacted as part of the Deficit Reduction Act of 2005
19. State Medicaid Director Letter # 12-003, "Essential HealthBenefits in the Medicaid Program," November 20, 2012.
20. Benchmark-equivalent health benefits coverage must include coverage for 1) inpatient and outpatient hospital services, 2) physicians' surgical and medical services, 3) laboratory and x-ray services, 4) well-baby and well-child care, including age-appropriate immunizations, 5) emergency services, and 6) family planning services. See CFR Title 42 §440.335.
21. See CFR Title 42 §440.345 and §440.390.
22. The EPSDT requirement applies to 19 and 20 year olds in the newly-eligible group. See CFR Title 42 §440.345.
23. See introduction to proposed rules, Federal Register/ Vol. 78, No. 14/Tuesday, January 22, 2013/Proposed rules, page 4630.
24. See CFR Title 42 §440.315.
25. The Affordable Care Act grants states the authority to require certain beneficiaries to share in the costs of the Medicaid program through premiums and cost sharing. See Sections 1902(a)(14), 1916, and 1916A, and CFR Title 42 §447.50 through 447.57
26. See CFR Title 42 §440.386.

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