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hpio health policy institute of ohio

Federal rules for establishing health insurance exchanges

Introduction

Under the Patient Protection and Affordable Care Act (ACA), individuals and qualified small businesses will be able to purchase private health insurance through Affordable Insurance Exchanges (exchanges) beginning on Jan. 1, 2014.[1] An exchange is a marketplace where consumers and small businesses can shop for, select, and enroll in private health insurance. The Centers for Medicare & Medicaid Services (CMS) estimates more than 22 million individuals will be enrolled in coverage sold through exchanges by 2016.[2]

Exchanges sit at the cornerstone of the ACA and are aimed at providing affordable health care coverage to individuals and small businesses. Implementation of exchanges under the ACA is intended to increase consumers' choice of health plans, provide consumers with accessible information on health plan benefits, price, and quality, and increase the purchasing power of small businesses.

Under the ACA, the Department of Health and Human Services (HHS) is charged with implementing exchanges and has begun to do so through rulemaking.[3] On July 11, 2011, HHS released two proposed rules regarding exchanges for public comment. The first set of proposed rules set forth (1) requirements states must meet if they choose to establish and operate an exchange, (2) standards regulating the participation of insurers and qualified health plans (QHPs) in exchanges, and (3) standards regulating employer participation in the Small Business Health Options Program (SHOP).[4] The second set of proposed rules provides guidance on the reinsurance, risk corridor, and risk adjustment mechanisms related to coverage sold through exchanges.[5] Public comment on ***both*** rules is due by **Sept. 28, 2011**.

This paper summarizes key provisions of the proposed rules on exchanges and highlights key issues and considerations regarding establishment of an exchange in Ohio.

Where is Ohio in the exchange process?

Ohio has not pushed full throttle on exchanges. Given the fluid policy environment at both the state and federal levels, many policymakers are taking a "wait and see" stance before moving forward. A number of factors have contributed to this, including pending results of the Ohio ballot initiative to opt out of the federal individual health insurance mandate, a possible ruling from the U.S. Supreme Court on the constitutionality of the insurance mandate, and the presidential election of 2012.

Ohio was among 49 states to receive a $1 million exchange planning grant that allows for state research and planning of exchanges.[6] Earlier this year, the Ohio Department of Insurance (ODI) contracted with Milliman, a health actuarial consulting firm, to conduct research and analysis of the Ohio health insurance market and its implications for exchanges.[7] ODI also contracted with KPMG to perform an information technology "gap analysis" related to the requirements of an exchange.[8] Results from the Milliman and KPMG analyses are expected to be reported this fall and will inform the choices Ohio makes in terms of moving forward.

Ohio has not applied for an exchange establishment grant, which is directed at helping states continue implementation of exchanges. Establishment grant applications will be accepted quarterly until June 29, 2012.[9] The District of Columbia and 16 states, including West Virginia, Kentucky, and Indiana, have been awarded establishment grants.[10] The next round of establishment grant applications is due by **Oct. 31, 2011**.

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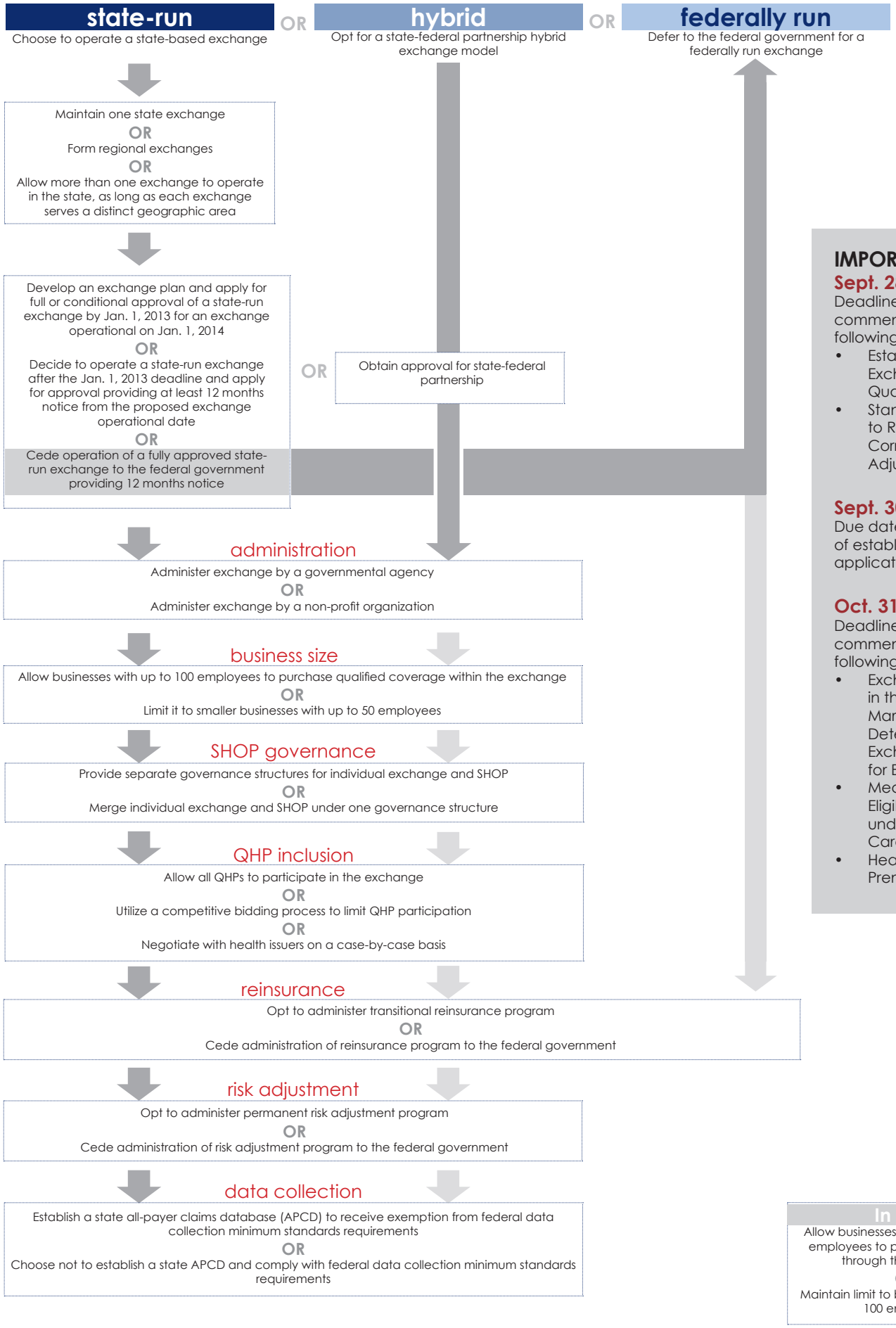
Thanks to **Doug Anderson,** of Counsel, Bailey Cavalieri LLC (www.baileycavalieri.com), who provided legal review, editing and technical assistance

What key choices will Ohio have to make on exchanges?



IMPORTANT DATES

Sept. 28, 2011
Deadline for public comments on the following proposed rules:

- Establishment of Exchanges and Qualified Health Plans
- Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

Sept. 30, 2011
Due date for next round of establishment grant applications

Oct. 31, 2011
Deadline for public comments on the following proposed rules:

- Exchange Function in the Individual Market: Eligibility Determinations; Exchange Standards for Employers
- Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010
- Health Insurance Premium Tax Credit

In 2017
Allow businesses with more than 100 employees to purchase coverage through the exchange
OR
Maintain limit to businesses with up to 100 employees

Further guidance on proposed rules for exchanges

What are Affordable Insurance Exchanges?

Under the ACA, states can elect to establish and operate Affordable Insurance Exchanges for individual and small group health insurance coverage by Jan. 1, 2014 or can cede establishment and operation of exchanges to the federal government.[11] Exchanges are designed to be competitive marketplaces where health insurance coverage is affordable and easy to purchase for individual consumers and small businesses. They are structured as "one-stop shops" or "clearinghouses" — where consumers and small businesses can compare, select, and enroll in qualified health plans (QHPs). Exchanges serving individuals and families will also determine individual eligibility for health programs such as Medicaid and CHIP and identify individuals qualified for federal subsidy assistance in paying for private insurance.[12]

The ACA provides for the creation of "American Benefit Exchanges" that will serve individuals and "Small Business Health Option Programs" (SHOPs) that will serve small businesses in each state.[13] SHOP exchanges allow small businesses (with up to 100 employees) to provide health insurance benefits to their qualified employees through QHPs. Through participation in SHOPs, certain small business owners and the self-employed can take advantage of federal tax credits to offset employee premium contributions.[14]

A state also has the option to establish and operate regional or multi-state exchanges, or to operate more than one exchange within state borders, as long as each exchange serves a distinct geographic area.[15]

What is a qualified health plan?

A qualified health plan (QHP) is a health plan that has been certified by an exchange. To be certified as a QHP, health plans must meet minimum standards of quality, value, and benefit design, and be offered by a health insurance issuer that meets specific accreditation requirements.[26]

Essential benefits

Health plans sold in the individual and small group markets — both inside and outside of the exchange — are required to offer a set of "essential benefits" that include: ambulatory and emergency services, hospitalization, maternity and newborn care, laboratory services, preventive and wellness services, prescription drugs, mental health, pediatric care, and rehabilitative services.[27]

Levels of coverage

Health plans are also required to offer four levels of coverage: bronze, silver, gold and platinum.[28] Platinum-level coverage provides the most generous value of benefits with the least cost-sharing, while bronze-level coverage is less generous with higher cost-sharing.[29] A QHP issuer must offer at least one silver and one gold level QHP through the exchange.[30]

Exchanges are responsible for determining that a QHP meets federal standards and that offering the QHP through the exchange is in the interest of qualified consumers and employers.[31] Exchanges are required to establish a process to monitor the continued certification of QHPs and decertify QHPs that fail to meet certification requirements.[32]

Who will be eligible to participate in exchanges?

Initially, exchanges will be open to all U.S. citizens, lawful residents and qualified small employers.[16] Exchanges are required to establish a simple, streamlined process for individuals to be determined eligible for Medicaid and CHIP programs, as well as premium tax credits and cost-sharing reductions.[17] Notably, in 2014, the ACA expands Medicaid coverage to adults under the age of 65 earning up to 138% of the FPL (133%, plus a 5% income disregard).[18]

Federal Poverty Level (FPL)[22]

2011 guidelines for a family of four (for larger families, add $3,820 for each additional person)

Percent of FPL	Income level
100% FPL	$22,350
138% FPL	$30,843
400% FPL	$89,400

Starting in 2014, primary tax payers with a household income between 100% and 400% of FPL will be eligible to receive premium tax credits for coverage purchased through the exchange for themselves or family members not eligible for other health insurance coverage.[19] Ohio is considered a *high subsidy impact* state, given that the largest proportion of nonelderly adults in the state live between 138% and 400% of the FPL.[20] Consequently, a substantial population of the state will likely be impacted by exchange subsidies. The Congressional Budget Office (CBO) estimates that each individual receiving premium tax credits will be subsidized over $5000 per year.[21]

On Aug. 17, 2011, three more proposed rules were published providing guidance on eligibility standards for uninsured individuals and small business employees,[23] eligibility determinations for low-income individuals applying for newly expanded Medicaid benefits,[24] and eligibility standards for the health insurance premium tax credits provided to subsidize the purchase of exchange-based insurance.[25] Public comment on these rules is due by **Oct. 31, 2011**. Additional guidance on exchanges will be provided through forthcoming rules.

What is required for approval of a state-run exchange?

Under the proposed rules, by Jan. 1, 2013 the Secretary of HHS will determine whether a state has demonstrated it is prepared for a fully operational state exchange by Jan. 1, 2014.[33] The Secretary may grant a state either **full** or **conditional approval** of an exchange. Conditional approval suggests that the state has made some progress in developing an operational exchange but has not yet reached "readiness level."[34] States granted conditional approval may continue to work with HHS to obtain full approval.[35]

To obtain **full approval**, a state must submit to HHS an exchange plan demonstrating that:

- The state's exchange is in accordance with and will carry out the functions required by the ACA.
- The exchange will implement processes for receipt and distribution of information regarding tax credits and federal subsidies.
- The state will establish any required reinsurance, risk adjustment, and risk corridor programs.
- The exchange will provide coverage for the entire state.[36]

States must notify HHS in writing of any substantial changes made to their exchange plans.[37] HHS is considering the use of a State Plan Amendment (SPA) to facilitate this process.[38]

States may also elect to operate an exchange after 2014.[39] This requires that states obtain exchange plan approval 12 months prior to the state's proposed exchange operation date (i.e. Jan. 1 of the prior year).[40] If a state creates an exchange and later decides to cede control of that state-operated exchange(s) to the federal government, it must provide 12 months advance notice.[41]

What are the operational and structural requirements for exchanges?

Exchanges must be operated by either a governmental agency or a non-profit entity.[42] States can choose to contract with eligible entities to provide various functions of the exchange.[43] The proposed rules provide minimum functional requirements for operation of exchanges. These requirements include:

- Providing streamlined processes for plan enrollment; eligibility determinations for health programs (Medicaid, CHIP), tax credits, or federal subsidies; certification of exemption from the individual coverage mandate; payment; and eligibility determination appeals.[44]
- Establishment of a navigator program.[45]
- Establishment of a website that provides comparative health plan information and allows easy access to individuals, including those with limited English proficiency and disabilities.[46]
- Establishment of processes to ensure the privacy and security of consumer information.[47]

What is a navigator program?

Exchanges must establish navigator programs that provide consumers with guidance to steer them through the exchange system.[50] Navigators are required to assist consumers with eligibility processes, access to federal subsidies and enrollment in QHPs.[51] Navigator programs are also required to implement educational activities that raise consumer awareness of QHP availability.[52]

Exchanges must award public and private grants to qualified Navigator entities[53] from at least two of the following categories:

- community and consumer-focused nonprofits,
- trade, industry, and professional associations,
- commercial fishing industry, ranching and farming organizations,
- chambers of commerce,
- unions,
- resource partners of the Small Business Administration,
- licensed agents and brokers and
- other public or private entities including Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies.[54]

Federal funds received by Ohio to establish an exchange cannot be used to fund Navigator grants.[55] However, Ohio may draw upon federal Medicaid and CHIP matching funds if Navigator activities provide administrative functions targeted towards Medicaid and CHIP populations.[56]

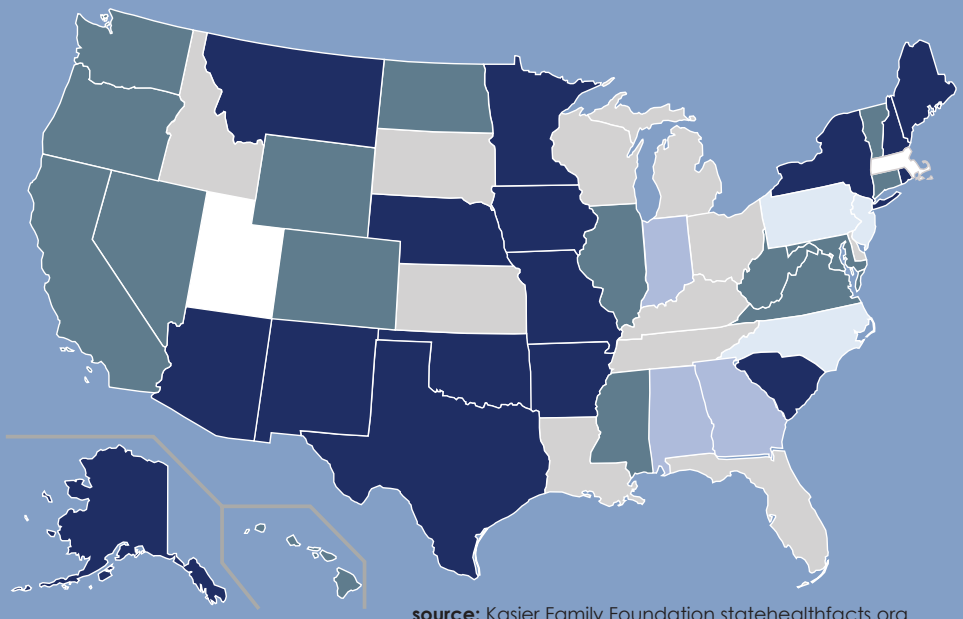
The proposed rules provide states with the option of structuring the exchange as a partnership with the federal government.[48] States may choose to implement a hybrid exchange model that combines both state and federal design and business-operated functions of the exchange.[49]

What does the enrollment process for individual exchanges look like?

Initial open enrollment for exchanges serving individuals and families will take place starting Oct. 1, 2013 through Feb. 28, 2014, for coverage starting Jan. 1, 2014.[57] For subsequent years, the open enrollment period may be from either Oct. 15 through Dec. 7 or Nov. 1 through Dec.15 of each year.[58] Individuals experiencing a "triggering event" may be eligible for special enrollment periods that last 60 days from the triggering event.[59] Triggering events include, but are not limited to, the following: loss of minimum essential coverage, changes in dependent status, changes in legal status, changes in eligibility determination, and permanent relocation outside the service area of a QHP.[60]

What are other states doing?

States are on all ends of the spectrum in the exchange establishment process. As of August 2011, Massachusetts and Utah had existing exchanges, 15 states had enacted legislation around exchange establishment, three states and DC had legislation pending, and 16 states proposed exchange related legislation that failed.[92] Ohio is one of 11 states that have not proposed any legislation around exchange establishment. Exchanges in operation prior to Jan. 1, 2010 are given a presumption of compliance with federal rules if their coverage level is no less than "the percentage of the population projected to be covered nationally after implementation of the ACA."[93] To date, Massachusetts is the only state that could possibly meet this requirement.



source: Kasier Family Foundation statehealthfacts.org

No proposed legislation (11 states)

Delaware
Florida
Idaho
Kansas
Kentucky
Michigan
Ohio
South Dakota
Tennessee
Wisconsin
Louisiana

Note: Gov. Bobby Jindal has announced that Louisiana will not have an exchange

Legislation failed (16 states)

Alaska
Arizona
Arkansas
Iowa
Maine
Minnesota
Missouri
Montana
Nebraska
New Hampshire
New Mexico (vetoed by governor)
New York
Oklahoma
Rhode Island
South Carolina
Texas

Executive order (3 states)

Alabama — Study feasibility of exchange
Georgia — Study feasibility of exchange
Indiana — Intent to establish exchange

Enacted legislation (15 states)

Establishment legislation
California
Colorado
Connecticut
Hawaii
Maryland
Nevada
Oregon
Vermont
Washington
West Virginia

Intent to establish legislation
Illinois
North Dakota
Virginia

Legislation to study feasibility
Mississippi
Wyoming

Pending legislation (3 states + D.C.)

District of Columbia
New Jersey
North Carolina
Pennsylvania

Existing exchange

Massachusetts
Utah

What does the payment process for individual exchanges look like?

The proposed rules provide the following payment options regarding the collection of individual premiums:

1. Exchanges can choose to take no part in the collection of premiums. This means that individuals must pay premiums directly to a QHP issuer.
2. Exchanges can create an electronic "pass-through" of premiums without retaining any portion of the payments.
3. Exchanges can collect premiums from enrollees and pay an aggregated sum to the QHP issuer. However, exchanges must preserve the right of enrollees to pay premiums directly to a QHP issuer.[61]

What are the specific requirements for SHOPs?

SHOPs must carry out all the required functions of an individual exchange, although they are not required to make individual eligibility determinations for government health programs, tax credits, or cost-sharing reductions.[62] SHOPs are required to determine employer eligibility to purchase coverage in a SHOP, determine employee eligibility for enrollment in a QHP and maintain enrollment and participation records.[63] Notably, under the proposed rules, SHOPs must also provide employers with a monthly statement of the total amount due to insurers and collect premium payments from employers to pay insurers.

The ACA requires that SHOPS allow employers to select a coverage level that provides qualified employees with the choice of any available QHP.[64] Under the proposed rules, SHOPs can also allow employers to restrict employee choice to one or more QHPs.[65]

The initial open enrollment period for SHOPs also begins Oct. 1, 2013.[66] However, the proposed rules require SHOPs to implement rolling enrollment that allows employers to enter a SHOP at any point throughout the year. An employer's plan year in a SHOP will be the 12-month period beginning with the coverage effective date. Annual open enrollment periods for employees will be standardized to the plan year — though newly hired qualified employees will be provided with the option to enroll upon employment.[67]

What are the standards for data collection?

Under the proposed rules for the risk adjustment program, Ohio — or HHS on behalf of Ohio — is required to collect data for risk adjustment calculations. However, the rules are unclear on whether states that choose to perform other risk adjustment functions can also opt for HHS to collect the data. Consequently, depending upon Ohio's role in the risk adjustment program, the state may be tasked with data collection. If so, the state would need to comply with minimum data collection standards.[87]

These data collection standards include a standardization of the electronic transmission of health care claims, enrollment and benefit data. The state will also have to ensure the privacy and security of the data and take measures to safeguard against the disclosure of individually identifiable information. Compliance with these standards is likely to require a significant undertaking of time, money and resources. **Notably, states that have established an All-Payer Claims Database (APCD) by Jan. 1, 2013, are exempt from the minimum data collection standards.**[88]

APCDs contain data derived from medical claims, pharmacy claims, eligibility files, provider files, and dental claims from both private and public payers. They have been recognized as providing a number of benefits including:

- Allowing for data-driven policymaking and legislative efforts
- Encouraging consumer engagement and informed decision-making
- Driving quality improvement efforts across systems and payers
- Supporting data-driven management of health care cost and utilization
- Improving population health by illuminating disease and vaccination patterns
- Informing private and public sector contracting decisions
- Assisting with state regulation of insurers

To date, more than 10 states have established APCDs and a number of states are exploring the development of APCDs.

How are exchanges governed?

Exchanges must be governed by a set of guiding principles that address ethics, conflict of interest, accountability, transparency standards, and member disclosure of financial interest. Every exchange must also have a formal, publicly adopted charter, by-laws and a governance board that holds regular public meetings.[68] The majority of representatives on the exchange board must have relevant health care administration, finance, purchasing, policy or public health experience and must not have conflicts of interest. "Conflicted" interests include insurance issuers, agents or brokers.[69]

The proposed rules provide Ohio with the option of creating separate but coordinated governance structures for the individual and SHOP exchanges, with preference expressed for a single structure.[70] Ohio may implement a more stringent governance structure than the minimum requirements articulated in the proposed rules.[71]

What are the standards for insurance issuers participating in the exchange?

Insurers participating in an exchange may only offer QHPs.[72] Insurance issuers must be licensed, in good standing with the state and comply with a number of quality improvement standards including reporting on quality and outcome measures and enrollee satisfaction surveys.[73] Issuers must also ensure compliance with state marketing laws and regulations and abstain from employing any practice that discourages the enrollment of individuals with significant health needs.[74]

QHPs must comply with "network adequacy standards."[75] As part of network adequacy standards, issuers must ensure that the QHPs they offer provide a sufficient number of essential community providers (ECPs) that serve predominantly low-income and underserved populations.[76] Issuers must also create a provider directory for consumers that identifies providers unable to accept new patients.[77]

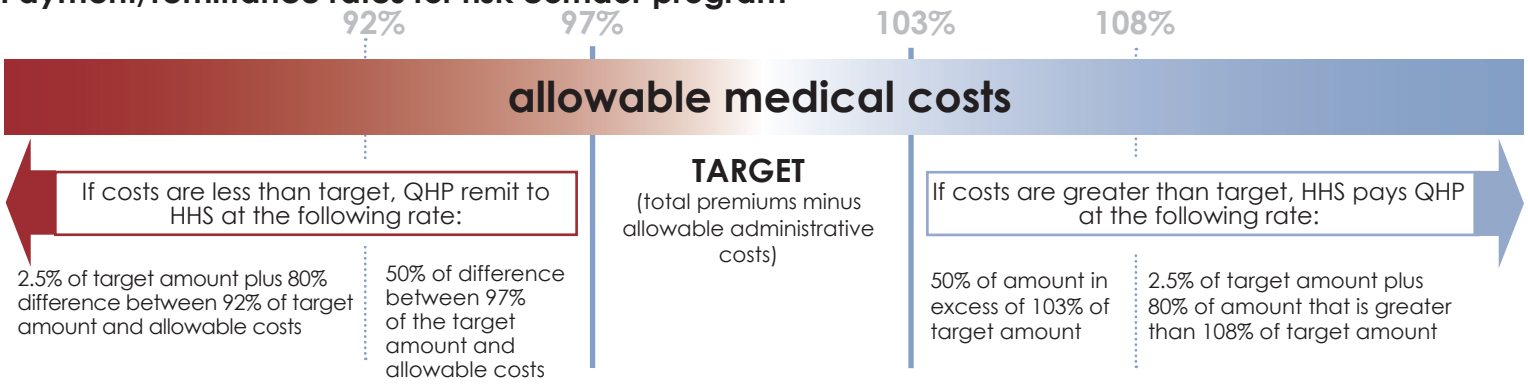
How will premium rates be determined for exchange coverage?

Premium rates charged by issuers may not be unreasonable and cannot vary except as permitted by federal law. Issuers may not vary rates except in relation to the following four factors: (1) individual versus family coverage, (2) geographic rating area, (3) age and (4) tobacco use.[78] The proposed rules also provide that QHP issuers must offer coverage to all individual and family types, but may vary premiums only based on the following family groupings: (1) individuals, (2) two-adult families, (3) one-adult families with a child or children and (4) all other families.[79] Issuers are also required to charge the same premium rate for a plan, regardless of whether

Program	administration		Purpose	Funding mechanism	Entities eligible for payment	Timeframe
	state run	federal				
Reinsurance	state	state or HHS	Stabilizes premiums in the individual market; protects plans that attract high-cost individuals	Issuers and TPAs contribute funding (based on national uniform contribution rate) to a non-profit reinsurance entity that then makes payments to eligible entities	Non-grandfathered individual market plans that are both inside and outside the exchange	2014-2016
Risk corridor	HHS	HHS	Limits issuer loss and gains	Payments to be made by HHS to QHPs with plan allowable medical costs greater than 103%	QHPs	2014-2016
Risk adjustment	state or HHS	HHS	Transfers funds from plans with lowest risk enrollees to plans with highest risk enrollees	Plans owing risk adjustment payments must remit owed amounts to the state	Non-granfathered individual and small-group plans that are both inside and outside the exchange	Permanent

NOTE: Under a federally operated exchange, the state can opt to run the exchange reinsurance program. Under a state-operated exchange, the state can opt to run the risk adjustment program or cede the option to run the risk adjustment program to HHS.

Payment/remittance rates for risk corridor program



it is offered inside or outside of the exchange.[80] Furthermore, issuers must provide justification for rate increases of QHPs prior to the implementation of the rate increases.[81]

How do the rules address the potential for adverse selection?

A big concern with exchanges is the potential for adverse selection. Adverse selection occurs when less healthy people disproportionately enroll in a health insurance plan. Generally, this occurs because individuals with higher-than-average risk of needing health care are more likely to purchase health insurance than healthier individuals. Consequently, for the purpose of stabilizing premiums and minimizing the potential for adverse selection, federal law requires the establishment of reinsurance, risk corridor and risk adjustment programs.[82]

Reinsurance

If opting to establish a state-run exchange, Ohio will have to establish a temporary reinsurance program. The program requires insurers and third-party administrators (TPAs) to contribute funds to a non-profit entity that will make payments to insurers who have higher-cost enrollees.[83] This temporary reinsurance program helps offset the negative impacts of adverse selection by requiring carriers with lower-cost enrollees to offset the high-claims experience of carriers with high-cost enrollees. This not only helps to spread the risk of unhealthy individuals throughout the market, but it brings a level of equality among carriers insuring different levels of risk.

Risk corridor

HHS is also required to administer a transitional risk corridor program that provides payments to QHPs in which allowable medical costs exceed a set target amount (total premiums minus allowable administrative costs) by 3%.[84] This program, like the temporary reinsurance program, helps mitigate the uneven burden on carriers with high-risk insureds, reimbursing them if their claims experience exceeds certain levels.

Risk adjustment

And finally, for a state-run exchange, Ohio has the option to administer a risk adjustment program or cede administration to HHS. However, HHS is required to administer the program for a federally run exchange.[85] The risk adjustment program is aimed at shifting funds from plans with lower risk enrollees to plans with disproportionately higher risk enrollees. Notably, Ohio can seek to have its own risk adjustment methodology federally certified by HHS or defer to using HHS' methodology.[86] The risk adjustment program works in concert with the reinsurance and transitional risk corridor programs to spread the risk of high risk insureds equally among all carriers.

Do the proposed rules provide states with flexibility?

Both proponents and critics of the exchanges have emphasized the necessity of providing state flexibility in structuring the exchanges. So, the question is, do the proposed rules on exchanges provide states with adequate flexibility?

If volume is any indicator, then yes. HHS took great care to infuse the word "flexibility" into the regulations, with the word appearing more than 50 times throughout the proposed rules. However, in reality, the issue is much more complex. The proposed rules provide a mixed bag of regulations that may appear broad in scope to some, but restrictive in implementation to others.

For example, some are wary of states' option to create a state-federal partnership, suggesting that the "partnership" provides a way for the federal government to restrict or restrain the operations of a state-run exchange.[89] Others view the partnership as a way to leverage resources, mitigate costs, and coordinate services. The option may also allow states to ease into the operation of an exchange without being held accountable for a comprehensive exchange.[90]

Similarly, there is concern around the proposed rules discussion of QHP benefit design and selection criteria. There is fear that allowing states to restrict the types of QHPs offered inside the exchanges will push insurers out of the exchanges. Conversely, others argue that tighter regulations around QHPs will intensify insurer competition, resulting in increased plan quality and value and decreased cost.[91]

However, the true test of flexibility will be time. Only after all of the Final Rules are promulgated and states have had time to process the various nuances of the rules, will the question of flexibility be resolved.

Key questions, concerns and considerations about exchanges

Issue	Exchange proposed rules
Funding and financing	• User fees and assessments may be levied on participating issuers in advance of the plan year. • State exchanges must be self-sustaining by Jan. 1, 2015, when federal funding for a state operated exchange will cease.
Coverage	• Coverage effective dates are placed at the first of the month. • Exceptions are made for special enrollments such as involuntary loss of coverage, births and adoptions, in which case the coverage effective date is the date of the event giving rise to the special enrollment.
Access to care	• The entire geographic area of a state must be covered by one or more exchanges. • Exchanges must ensure that enrollees of QHPs have a sufficient choice of providers. • QHPs must meet network adequacy standards that require the inclusion of essential community providers that provide care to predominantly low-income and medically-underserved populations.
Adverse selection	• Exchanges are required to have transitional reinsurance, risk corridor and permanent risk adjustment programs to stabilize premiums and minimize the risk for adverse selection.
Issuer and QHP regulation	• Exchanges are provided with discretion on determining which QHPs can be offered in the exchange. The rules suggest three strategies: 1. Allow all QHPs to participate 2. Utilize a competitive bidding process 3. Negotiate with health issuers on a case-by-case basis • States can implement selection criteria for QHPs that move beyond the minimum certification standards proposed.
Timeline	• Exchanges must be "fully operational" by Jan. 1, 2014. This means that exchanges are able to operate by Oct. 1, 2013 to support an initial open enrollment period. • By Jan. 1, 2013, a state must receive either full or conditional approval of their exchange by the secretary of HHS. Approval requires that the secretary determine whether a state has demonstrated it will have a fully operational state-run exchange by Jan. 1, 2014. • State exchanges must be self-sustaining by Jan. 1, 2015, when federal funding for a state operated exchange will cease. • Establishment grant applications will be accepted quarterly until June 29, 2012.
Exchange structure and governance	• Exchanges can be operated by a governmental agency or a non-profit entity established by the state. • States can elect to establish separate governance and administrative structures for their individual exchange and SHOP. • States may opt to operate a state-federal partnership exchange model
State flexibility	• Allows for a state partnership model combining state-designed and operated business functions with federally designed and operated business functions. • Exchanges are provided with discretion on determining which QHPs can be offered in the exchange.
Crowd-out of employer coverage	• Individual mandate • Medicaid expansion • Subsidies to purchase coverage through exchanges • Small business tax credits • Penalties on certain employers who do not offer coverage or offer unaffordable coverage

Considerations

- Plans offered outside of the exchange may not be subject to user fees. Consequently, issuers offering plans outside of the exchange may have reduced costs and sustain a competitive advantage over issuers participating in the exchange.
- States will have to establish funding streams to support exchange operations after 2015. States may need to explore other approaches to funding including the use of more broad-based funding mechanisms, such as implementing provider taxes or using state general revenue funds.

- The limitation on coverage effective dates brings into light issues of continuity in coverage.
- Under the proposed rules, individuals may experience gaps in coverage of more than 30 days from the time of enrollment.

- According to 2010 Ohio Family Health Survey data, there are more than 1,364,064 uninsured working-age Ohioans. Under the ACA, Ohioans will experience increased access to health insurance, through Medicaid expansions, health insurance subsidies, the creation of a health insurance exchange, and the federal mandate requiring individuals to purchase minimum health care coverage. However, Ohio is currently facing a health care workforce shortage. Without an adequate supply of health care workers, Ohio will likely face challenges meeting an increased demand for care.
- Issuers will face especially difficult challenges in connecting plan enrollees to providers in medically underserved regions and health professional shortage areas (HPSAs). HPSAs can be found in all four quadrants of Ohio, especially in rural and urban areas of the state.

- Although efforts have been taken to minimize adverse selection, any variation in the regulation of issuers or employers in the exchange versus those outside of the exchange could lead to risk selection issues.
- Issuers' minimum participation rules may need to be considered to help protect issuers against adverse selection. Health insurers often require minimum employee participation for group-level coverage to increase their plan pool, improve the risk mix, and increase the stability and predictability of plan costs.

- Restrictions on QHPs may limit insurers from offering all of their products in the exchange.
- Insurers may have to deal with different standards and regulations in each state, increasing their administrative costs and decreasing their willingness or ability to participate in an exchange.
- The level of insurer participation in the exchange significantly impacts the robustness of the exchange market and the efficacy of exchange policy objectives.

- Preparation for the exchanges is a time-intensive process and requires substantial resources and infrastructure that may not be readily available to states.
- States are likely to face challenges in defining exchange roles and responsibilities and operationalizing the exchange in the timeframe delineated by the rules.
- Final exchange rules may not be released in enough time to allow states, insurers, and other critical stakeholders to adequately process the regulations and prepare for exchange implementation.
- Federal funding of state-operated exchanges will end on Jan. 1, 2015. Furthermore, application deadlines have been set for states applying for federal funding for exchange establishment grants. States who do not apply for funding by the set deadlines will be disadvantaged in establishing and maintaining a state operated exchange.

- Existing state agencies may have limited experience in dealing with all the functions of an exchange. They may also be reluctant to establish new and innovative ways of conducting business that would be better suited to the functions of an Exchange.
- Non-profit entities may be politically isolated and have difficulty in coordinating and integrating with other state agencies to provide the services required in an exchange. They may also have difficulty in performing exchange functions that are typically performed by government agencies.
- Establishment of separate governance and administrative structures for the individual exchange and SHOP may increase operational costs, decrease operational efficiencies, and decrease operational and policy coordination.
- There is little guidance provided on state-federal partnership exchange models and what the structure and approval process for this model will look like.

- A partnership model may decrease state flexibility by allowing for the federal government to restrict or restrain the operations of a state-run exchange.
- Alternatively, a partnership model may help states leverage resources, mitigate costs, and coordinate services within an exchange.
- Restricting QHPs offered inside the exchanges can push insurers out of the exchanges.
- Regulations around QHPs may intensify insurer competition resulting in increased plan quality and value and decreased cost.

- Ohio has seen a drop in employer sponsored insurance coverage for firms of all sizes. Consequently, there is concern that ACA provisions, like Medicaid expansion and the provision of subsidies to eligible individuals who purchase coverage through exchanges, will further incentivize employers to stop providing coverage to their employees.

SOURCES listed on page 10

Notes

1. The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §1311(b) (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 11-152 (2010), is referred to herein as the "Affordable Care Act."
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