Ohio Legislative Service Commission

Bill Analysis

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H.B. 412

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(As Introduced)

Reps. Antonio and Carney, Pillich, Murray, Fedor, Foley, Boyd, Goyal, Garland, Winburn, R. Hagan, Stinziano, Yuko, Ramos, Williams, Celeste

BILL SUMMARY

Ohio Health Benefit Exchange Agency

- Creates the Ohio Health Benefit Exchange Agency (OHBEA) to facilitate the purchase of health benefit plans by individuals and small employers.
- Creates the Ohio Health Benefit Exchange Program within OHBEA, consisting of an exchange for individuals to purchase health coverage and a Small Business Health Options Program (SHOP) to enable small businesses to purchase health insurance for employees.
- Prescribes the duties of OHBEA and other requirements that OHBEA must follow when conducting business.
- Authorizes OHBEA to enter into contracts or information-sharing arrangements in order to carry out its duties.
- Authorizes OHBEA to offer supplemental health coverage, so long as the coverage meets certain requirements.
- Specifies those actions that OHBEA is expressly prohibited from undertaking.

Certification of health benefit plans

- Provides criteria for the qualification of health benefit plans to be offered through the Exchange.

- Provides criteria for those carriers seeking to offer health benefit plans through the Exchange and prescribes the form that carriers must follow in applying to have a benefit plan be certified for offer through the Exchange.

- Specifies that OHBEA is not required to offer all qualified health plans through the Exchange and requires OHBEA to offer only those plans that are in the best interest of the state.

- Prescribes the criteria by which OHBEA is to determine which plans are in the best interest of the state.

- Prohibits OHBEA from excluding a health benefit plan for offer through the Exchange for specified reasons.

- Specifies which types of health benefit plans are expressly prohibited from being offered through the Exchange.

- Enables a carrier to "bid" to have a health benefit plan offered through the Exchange and prescribes the criteria by which OHBEA is to score each plan that is bid.

- Specifies that OHBEA is not required to offer all health benefit plans that are bid through the Exchange.

- Prescribes the criteria that dental plans must meet in order to be certified to be offered through the Exchange.

Individuals qualified to participate in the Exchange

- Specifies the criteria that individuals must meet in order to purchase health insurance through the Exchange.

- Exempts specified individuals from the requirement of the Patient Protection and Affordable Care Act that all eligible individuals purchase some form of health insurance.

SHOP exchange

- Provides for a SHOP exchange through which a small employer can purchase health insurance for its employees.

- Specifies the qualifications that employers must meet in order to qualify to purchase insurance through the SHOP exchange.

Exchange fees and funding

- Provides for the funding of OHBEA and authorizes the Agency to charge assessments to carriers in Ohio to fund its activities.

- Creates the Ohio Health Benefit Exchange Operating Fund and requires that all amounts collected by OHBEA be deposited into the Fund.

OHBEA Board of Directors

- Creates an OHBEA Board of Directors to oversee the activities of the Agency and lays out the Board's duties.

- Specifies how OHBEA board members are to be compensated.

- Specifies the process by which OHBEA board members that are appointed by the Governor are to be appointed and makes other requirements with regard to a board member's term of office.

- Creates the Exchange Agency Nominating Council for the purpose of nominating individuals for the Governor to consider when making appointments to the OHBEA Board of Directors.

- Specifies the duties of the Nominating Council and the compensation of its members.

- Authorizes OHBEA to appoint an advisory committee and specifies which type of individuals may be on the committee.

Navigator program

- Requires OHBEA to establish a navigator program to advise individuals and employers on the use of the Exchange.

- Authorizes OHBEA to make monetary grants from the Ohio Health Benefit Exchange Operating Fund to chosen navigators to carry out the navigator program's purpose.

- Prescribes the responsibilities of navigators.

Rules

- Authorizes the OHBEA to adopt rules to carry out its duties.

Construction

- Clarifies that nothing contained in the bill and no action taken by OHBEA shall be construed as preempting the authority of the Superintendent of Insurance to regulate the business of insurance in Ohio.

Definition of "small employer" in the Small Employer Benefit Plan Law

- Conforms the definition of "small employer" in the Small Employer Benefit Plan Law to the definition of "small employer" in the bill for health benefit exchanges.

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CONTENT AND OPERATION

Ohio Health Benefit Exchange Agency

The bill establishes the Ohio Health Benefit Exchange Agency (OHBEA).[1] The Patient Protection and Affordable Care Act (PPACA) of 2010 requires states to establish health benefit exchanges through which individuals and small employers can purchase health care insurance. States that have not established an exchange by January 1, 2013, or which are not expected to have an operational exchange by January 1, 2014, will have an exchange established by the Secretary of Health and Human Services (HHS).

Ohio Health Benefit Exchange Program

The bill creates the Ohio Health Benefit Exchange Program (Exchange) within OHBEA, consisting of an exchange for the purchase of individual coverage and a Small Business Health Options Program (SHOP) exchange through which employers may purchase health benefit plans for employees. The bill establishes an OHBEA Board of Directors and requires the Board to appoint an Executive Director of OHBEA. The Executive Director of OHBEA is responsible for operating the Exchange and is required to hire staff as necessary to do so. All OHBEA staff are to be in the classified civil service.[2]

Responsibilities of the Executive Director

The Executive Director of OHBEA is required to do all of the following:

- Make qualified health plans available to qualified individuals and qualified employers, beginning on January 1, 2014;
- Establish procedures to certify, recertify, or decertify health benefit plans as "qualified" to be offered through the Exchange according to state and federal law;
- Operate a toll-free telephone hotline to respond to requests for assistance regarding the Exchange;

[1] R.C. 3965.03(A).

[2] R.C. 3965.05(A).

- Establish enrollment periods consistent with federal law;

- Maintain a web site through which individuals can compare qualified health benefit plans and then enroll;

- Rate and determine the level of coverage of each health plan offered through the Exchange according to criteria developed by the Secretary of HHS;

- Ensure that throughout the state a variety of health plans are offered at the various coverage levels described in the PPACA. The bill specifies that a plan may be offered in one part of the state and not another so long as there is a comparable selection of options available at each coverage level throughout the state;

- Use a standardized format for presenting health benefit options offered through the Exchange, including the use of the uniform outline of coverage established under the Public Health Service Act of 2010;

- Inform individuals of eligibility requirements for Medicaid, the Children's Health Insurance Program (CHIP), or any other applicable state or local public program and enroll all eligible individuals in those programs;

- Exempt those individuals that meet the applicable criteria from the individual responsibility requirement of the PPACA, which generally requires all individuals to carry some form of health insurance;

- Make available on the Internet a means to calculate the cost of health insurance coverage after factoring in any premium tax credit made available under the PPACA;

- Review the rate of premium growth within the Exchange and outside the Exchange and consider this information in making recommendations to the Agency Board of Directors on whether to continue limiting qualified employer status to small employers;

- Refer any enrollee with a grievance or question regarding the enrollee's health plan to any applicable office of health insurance consumer assistance, any health insurance ombudsman established under the Federal Public Health Service Act of 2010, or to the Department of Insurance, as applicable;

- Market and publicize the availability of health care coverage and federal subsidies through the Exchange, including efforts to reach hard-to-reach populations;

- Collaborate with state and local government entities in Ohio, including the Department of Job and Family Services and the Department of Insurance, to allow an individual to remain enrolled with the individual's carrier and provider network if the individual loses eligibility for premium tax credits and becomes eligible for Medicaid, or vice versa;

- Ensure that the privacy of applicants and enrollees that use the Exchange is protected by enforcing the privacy policies developed by the OHBEA Board of Directors.[3]

Reporting requirements

The Exchange is required to transfer certain operational information to the United States Secretary of the Treasury. Information provided by the Exchange on individuals must include the person's name and taxpayer identification number. The Exchange must provide a list of the individuals that qualify for an exemption from the requirement that all individuals carry some form of health insurance. Also, the Exchange must provide a list of each individual who was an employee of an employer, but who was determined to be eligible for the premium tax credit under the PPACA for either of the following reasons:

- The employer did not provide minimum essential coverage.

- The employer provided minimum essential coverage, but it was determined to either be unaffordable to the employee or to not provide the required minimum actuarial value.

The Exchange must notify the Secretary of the Treasury when individuals inform the Exchange that the individual has changed employers. It must also provide notice with regard to individuals who cease coverage under a qualified health plan offered by the Exchange during a plan year, providing the effective date of that cessation. In relation to these requirements, the Exchange must provide each employer with the name of each employee who ceases coverage under a qualified health plan during the plan year and the date of the cessation.[4]

[3] R.C. 3965.05(B)(1) to (11), (14), (16), (17), (19), and (20).

[4] R.C. 3965.05(B)(12) and (13).

Study of Exchange activities

The Exchange must, prior to January 1, 2019, conduct an ongoing study of Exchange activities and the enrollees in plans offered through the Exchange. The study must include all of the following:

- A survey of the cost and affordability of insurance provided through the Exchange for individual and SHOP coverage;
- The number of physicians by area and specialty who are not taking or accepting new patients who are enrolled in qualified health plans through the Exchange;
- The adequacy of provider networks of qualified health plans.[5]

All data collected by the Exchange pursuant to the proposed Health Benefit Exchange Law must contain demographic information, including racial and ethnic information as specified by any related rules adopted by the OHBEA.[6]

Financial integrity requirements

The Exchange must meet all of the following financial integrity requirements:

- Keep an accurate accounting of all activities, receipts, and expenditures, and annually submit to the Secretary of HHS an accounting report as required by the PPACA;
- Conduct an annual fiscal audit;
- Annually prepare a written report on the implementation and performance of the Exchange functions during the preceding fiscal year, including, at a minimum, how funds were expended and the Exchange's progress in meeting the requirements of the proposed Health Benefit Exchange Law.

The annual report must be submitted to the General Assembly and the Governor, and must also be made available on the OHBEA's public web site. The OHBEA is required to cooperate with any investigation conducted by the Secretary of HHS and allow the Secretary to do all of the following:

[5] R.C. 3965.05(B)(18).

[6] R.C. 3965.05(E).

- Investigate the affairs of the Exchange;
- Examine the properties and records of the Exchange;
- Require periodic reports in relation to the activities undertaken by the Exchange.

Finally, the bill prohibits the Exchange from using any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation, or for the promotion of federal or state legislative and regulatory modifications.[7]

Exchange authorizations

The bill makes certain authorizations to allow the Exchange to carry out its duties. The Exchange is allowed to contract with eligible entities to carry out any of the Exchange's responsibilities for functions required under the proposed Health Benefit Exchange Law. Insurance carriers or affiliates of carriers are not eligible for such contracts.

The Exchange may enter into information-sharing arrangements with federal or state agencies, as well as other state exchanges. However, such agreements must include safeguards adequate to protect the confidentiality of the shared information and to ensure compliance with all federal and state laws, rules, and regulations.

The Exchange may make available supplemental coverage for enrollees. However, the Exchange may not use funds in the Ohio Health Benefit Exchange Operating Fund to pay the cost of such supplemental coverage. Any supplemental coverage offered through the Exchange is to be subject to the charge imposed on qualified health plans.[8]

Prohibited actions

The Exchange, as well as any carrier offering a health benefit plan through the Exchange, is prohibited from making available any health benefit plan that is not a qualified health plan. The Exchange and participating carriers are also prohibited from charging an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has

[7] R.C. 3965.05(B)(15).

[8] R.C. 3965.05(C).

become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of the PPACA.[9]

Certification of health benefit plans

The bill provides criteria for the certification of health benefit plans as qualified health plans, or, in other words, those plans that are eligible to be offered through the Exchange. The Executive Director of OHBEA may, but is not required, to certify a health benefit plan that meets the following conditions. The plan must provide the essential health benefits prescribed in PPACA. The essential health benefits include coverage of at least the following areas:

- 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;
- Pediatric services, including oral and vision care.

Coverage levels for each category of service is to be set by choosing a "benchmark" plan that is already offered in the state, meaning that plans can offer coverage greater than the benchmark plan, but not lower.[10] However, if there is a qualified dental plan that is offered through the Exchange, then qualified health benefit plans are not required to offer duplicative dental coverage. Carriers that take advantage of this exception and that do not offer dental benefits through their qualified

[9] R.C. 3965.05(D).

[10] Http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html (accessed February 27, 2011).

health benefit plan must disclose this fact to enrollees and notify them that dental benefits not offered in the health benefit plan are offered through the Exchange.[11]

Plans must meet all of the following additional criteria to become qualified:

- The premium rates and contract language of the plan must be approved by the Superintendent of Insurance.
- The plan must provide at least a bronze level of coverage, as defined by PPACA, unless the plan is certified as a qualified catastrophic plan.
- The plan's cost-sharing requirements must not exceed the limits established under PPACA and, if the plan is offered through the SHOP exchange, the plan's deductible must not exceed the limits established under the Act, which is $2,000 in the case of a health plan covering a single individual, and $4,000 in the case of any other plan.[12]
- The plan must meet other criteria or guidelines established by either the Executive Director of the OHBEA or the Secretary of HHS.[13]

Carrier requirements

In addition to the requirements set for plans, carriers must also meet basic certification requirements in order to offer health benefit plans through the Exchange. Carriers must meet all of the following:

- The carrier must be licensed to offer insurance in Ohio.
- The carrier must offer at least one qualified catastrophic health plan, one bronze-level health plan, one silver-level health plan, one gold-level health plan, and one platinum-level health plan. If a carrier offers both individual health benefit plans and employer plans, then the carrier must offer all such levels in both the individual exchange and the SHOP exchange.

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[11] R.C. 3965.06(A)(1).

[12] *Patient Protection and Affordable Care Act of 2010, as amended by Health Care and Education Reconciliation Act of 2010,* P.L. 111-148, 124 Stat. 119, 42 U.S.C. 300gg-11 and 18022.

[13] R.C. 3965.06(A)(2), (3), (4), and (6).

- The carrier must charge the same rate for a plan both when it is offered through, or independent of, the Exchange and regardless of whether the plan is offered directly from the carrier or through an insurance agent.

- The carrier must not charge any fee or penalty for termination of coverage if an individual enrolls in another type of minimum essential coverage because that person has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable.

- The carrier complies with all other regulations developed by the Secretary of HHS and other requirements established by the Executive Director of the OHBEA.[14]

The Executive Director of the OHBEA is prohibited from exempting any carrier seeking certification of a qualified health plan from state licensure or solvency requirements, and is required to apply the certification criteria in a manner that assures a level playing field among carriers participating in the Exchange.[15]

Carrier application for certification

The bill prescribes the form that carriers must follow in applying to have a benefit plan be certified for offer through the Exchange. Carriers seeking to have a health benefit plan be certified for offer through the Exchange must do all of the following:

- Submit a letter of justification to the Executive Director for any premium increase before implementing that increase;

- Prominently post any information regarding a premium increase on its web site;

- Inform an individual, upon that individual's request, of the amount that the individual will have to pay for a specified service or treatment under the individual's plan, including deductibles, copayments, and coinsurance.

[14] R.C. 3965.06(A)(5).

[15] R.C. 3965.06(E).

Additionally, carriers must make all of the following information available to the public in language that can be easily understood, even by those with limited English proficiency:

- Policies and practices related to claim payment;
- Periodic financial disclosures;
- The number of individuals that enroll and disenroll with the carrier;
- The number of claims the carrier denies;
- Rating practices;
- Cost-sharing and payments made by the carrier with respect to any out-of-network coverage;
- Enrollee and participant rights under the PPACA;
- Other information as required by the Secretary of HHS.[16]

Plans in the best interest of the state

A health benefit plan may be considered a qualified plan, but might not be allowed to be offered through the Exchange. The Executive Director of the OHBEA must determine that making a plan available through the Exchange is in the interest of qualified individuals and qualified employers in Ohio. In making this determination, the Executive Director must consider all of the following with regard to a plan that a carrier is seeking to offer through the Exchange:

- Use of marketing practices that would discourage enrollment by people with significant health needs;
- Accreditation by a recognized accreditation organization, or achieve accreditation from a recognized accreditation organization within a time period defined by the OHBEA Board of Directors, based on a review of their clinical quality patient experience, access, utilization management, quality assurance, provider credentialing, complaints and appeals processes, network adequacy and access, and patient information programs;
- Implementation of a quality improvement strategy;

[16] R.C. 3965.06(C).

- Use of a uniform enrollment form for individuals and small employers;
- Use of a standard format for presenting plan options;
- Providing of information about the carrier's performance on standardized quality measures as determined by the OHBEA Board of Directors;
- Annual reporting to the federal government on the quality of their pediatric care;
- Provision of a sufficient choice of providers and, where available, inclusion of essential community providers that serve low-income, medically underserved individuals;
- Whether the plan is a prohibited health plan.[17]

Prohibited exclusions

The bill prohibits the Executive Director from excluding a health benefit plan for either of the following reasons (see **COMMENT**):

- The fact that the plan is a fee-for-service plan;
- The plan provides treatments necessary to prevent patients' deaths in circumstances that the Executive Director deems inappropriate or too costly.[18]

Prohibited health plans

The bill prohibits health benefit plans with certain characteristics from being certified to be offered through the Exchange. The Executive Director of the OHBEA is prohibited from considering for certification any health benefit plan if the health benefit plan includes any of the following:

- Certain benefits if they are not an integral part of the plan, including limited dental or vision benefits, long-term care benefits, and other similar limited benefits specified in federal regulations pursuant to the Health Insurance Portability and Accountability Act of 1996;
- Coverage only for a specified disease or illness or hospital indemnity or other fixed indemnity if the benefits are provided under a separate policy

[17] R.C. 3965.06(A)(7).

[18] R.C. 3965.06(B).

or contract, there is no coordination between the providing of the benefits and any exclusion of benefits under any health benefit plan maintained by the same carrier, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any health benefit plan maintained by the same carrier;

- Various forms of supplemental coverage, including a Medicare supplement, if offered as a separate policy certificate, or contract of insurance.[19]

Bidding of qualified plans to participate in the Exchange

The bill allows carriers to "bid" to have qualified certified health and dental plans be offered through the individual coverage and the SHOP exchange. Such plans will be given a score by the Executive Director of OHBEA based upon the following criteria:

- The cost of the plan to enrollees in terms of premium and out-of-pocket expenses;
- The carrier's overall offering and plan design;
- The use of a select, high performance network;
- The use of centers of excellence for complex conditions or procedures;
- Innovative pharmacy management;
- Active consumer engagement;
- Wellness incentives and management;
- Preventive and flex benefits for chronic conditions;
- The use of multilingual community outreach and other methods of reaching hard-to-reach communities for marketing purposes;
- The ability of the plan to confirm its compliance with various rules and reporting requirements;
- The design of the plan's enrollment process, including the level of burden to the enrollee and ease of enrollment with regard to populations that may

[19] R.C. 3965.06(A)(8) and (D).

experience barriers, such as the disabled and those with limited English proficiency;

- Whether or not including a plan in question in the Exchange will encourage a robust system of regional plans.[20]

After providing scores to each qualified health plan, the Executive Director of the Exchange is required to choose those plans that will be offered through the Exchange. There is no limit on the number of plans that can be offered.[21] In choosing plans to be offered through the Exchange and in contracting with carriers, the Executive Director of the Exchange is required to seek to provide health care coverage choices that offer the optimal combination of choice, value, quality, and service. The Executive Director is also required to maintain a robust system of regional plans.[22]

Certification of dental plans

The bill prescribes the criteria that dental plans must meet in order to be certified to be offered through the Exchange. The Executive Director of OHBEA may certify a dental plan to be offered through the Exchange if all of the following conditions are met:

- The plan provides limited scope dental benefits distinct from a qualified health plan.

- The plan does not substantially duplicate the benefits typically offered by health benefit plans without dental coverage.

- The plan includes, at a minimum, the essential pediatric dental benefits required by the Secretary of HHS pursuant to the PPACA and such other benefits as the Executive Director of the OHBEA or the Secretary requires.[23]

The bill stipulates that all of the bill's provisions that are applicable to qualified health benefit plans also apply to qualified dental plans to the extent that such provisions are relevant. However, the bill allows for certain exceptions to this requirement. First, a carrier that is licensed to offer dental coverage need not be

[20] R.C. 3965.08(A).

[21] R.C. 3965.08(B).

[22] R.C. 3965.08(C).

[23] R.C. 3965.07(A).

licensed to offer other health benefits. And second, carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a qualified dental plan and the other benefits are provided by a separate carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same prices.[24]

The bill allows the Executive Director to adopt additional rules concerning qualified dental plans.[25]

Individuals qualified to participate in the Exchange

Only certain individuals are allowed to purchase insurance through the Exchange. The bill prescribes the criteria that an individual must meet in order to purchase insurance through the Exchange. A qualified individual meets all of the following:

- The individual is seeking to enroll in a qualified health plan offered to individuals through the Exchange.
- The individual resides in Ohio.
- The individual is not incarcerated at the time of enrollment, other than incarceration pending the disposition of charges.
- The individual is, and is reasonably expected to be, for the entire period of enrollment, a citizen, a legal alien, or a national of the United States.[26]

If the Executive Director of the Exchange determines that an individual seeking to purchase insurance through the Exchange is eligible either for Medicaid or for CHIP, then the Executive Director must enroll that person in the applicable program.[27]

Exemption from insurance purchase mandate

The bill exempts certain individuals from the requirement of the PPACA that all individuals be covered by some form of health insurance. To be exempt from this requirement, an individual must meet either of the following criteria:

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[24] R.C. 3965.07(B).

[25] R.C. 3965.07(C).

[26] R.C. 3965.10(A).

[27] R.C. 3965.05(B)(9) and 3965.10(B).

- There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual.

- The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty.[28]

SHOP exchange

The bill provides for a SHOP exchange through which qualified employers can purchase coverage for their employees. The SHOP exchange is required to enable any qualified employer to specify a level of coverage so that any of its eligible employees may enroll in a qualified health plan offered through the SHOP exchange at the specified level of coverage.[29]

Employer qualifications

Employers must meet certain qualifications to participate in the SHOP exchange. First, an employer must be a small employer, which the bill defines as being an employer that employed an average of not more than 50 employees during the preceding calendar year and, on and after January 1, 2016, an employer that employed an average of not more than 100 employees during the preceding calendar year.[30] And second, an employer must principally be located in Ohio and must decide to either offer insurance coverage through the SHOP exchange to *all* of its eligible employees, regardless of where they are employed, or to only its employees that are employed in Ohio.[31]

Employers that allow their employees to enroll in a health insurance policy through the SHOP exchange that cease to be a small employer may continue to offer insurance through the SHOP exchange so long as such an employer continuously makes enrollment through the SHOP exchange available to its employees.[32]

Exchange fees and funding

The bill provides for the funding of the OHBEA. OHBEA may charge assessments or user fees to carriers or may otherwise generate funding as needed to

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[28] R.C. 3965.10(C).

[29] R.C. 3965.11(A).

[30] R.C. 3965.02(L)(1).

[31] R.C. 3965.11(B).

[32] R.C. 3965.11(C).

support its operations and the operations of the Exchange. The bill creates the Ohio Health Benefit Exchange Operating Fund and requires that all amounts collected by OHBEA be deposited into the Fund. The bill requires the OHBEA to publish the average costs of licensing, regulatory fees, and any other payments required by the OHBEA, as well as the administrative costs of the OHBEA on a web site. The web site is also required to include information on amounts lost to waste, fraud, and abuse.[33]

OHBEA Board of Directors

The bill creates the OHBEA Board of Directors to direct and oversee OHBEA. The Superintendent of Insurance, the Director of Medicaid, and the Director of Health are all permanent members of the Board. Each permanent member is authorized to have a designee act in the member's place with regard to the Board. The Board also consists of the following members appointed by the Governor:

- A representative of unions;
- A representative of consumers;
- A representative of small businesses;
- An actuary;
- An economist;
- An employee benefits specialist.[34]

Duties of OHBEA Board

The OHBEA Board of Directors is responsible for the effective operation of all OHBEA responsibilities and compliance with all relevant federal and state rules and regulations. Additionally, the Board must do all of the following:

- Exercise powers necessary to carry out the requirements of the proposed Health Benefit Exchange Law and with the PPACA.
- Hire an executive director who will be in the unclassified civil service and be responsible for the operation of the Exchange program.

[33] R.C. 3965.12.

[34] R.C. 3965.03(A).

- Set the salaries of the staff that are hired by OHBEA in amounts necessary to attract and maintain individuals of superior qualification. The Board is also required to publish these salaries in the Board's annual budget, and to post this budget on the web site of OHBEA. Such salaries are not subject to certain standard civil service requirements.[35]

- Develop standardized criteria to evaluate the performance of health benefit plans that are offered through the Exchange.

- Establish a navigator program designed to help individual and employer consumers with using the services of the Exchange.

- Develop privacy policies to protect sensitive applicant and enrollee information.

- Adopt bylaws for the regulation of its affairs and the conduct of its business.

The Board is also required to consult with stakeholders relevant to carrying out the Board's duties, including health care consumers, individuals and entities with experience in facilitating enrollment in health plans, representatives of small businesses and self-employed individuals, advocates for enrolling hard-to-reach populations.[36] The Board is required to meet as necessary to perform its duties, but is required to meet no less than 12 times a year. A majority of the members constitutes a quorum.[37]

The bill stipulates that the Board may sue and be sued in the name of the OHBEA.[38]

Board member compensation

A board member will receive compensation of $5,000 for each month that the member attends a meeting of the OHBEA Board of Directors, with the total amount of compensation not to exceed $60,000, regardless of the number of meetings held or attended by the member. A board member will not receive any payment during a month that the member does not attend a meeting. A board member will also be

[35] R.C. 124.14(B)(6).

[36] R.C. 3965.03(H).

[37] R.C. 3965.03(E).

[38] R.C. 3965.03(I).

compensated for all reasonable and necessary expenses incurred in conducting the member's duties.[39]

Appointing members

The bill makes several restrictions with regard to the members of the Board of Directors who are appointed by the Governor and prescribes how such members are to be chosen. No more than half of the members are to be of the same political party. None of the members are to be, or have been, employed as an insurance agent or health care provider during the three years previous to the member's appointment. All members are required to be Ohio residents. At least one of the members is required to have knowledge of best practices used to address disparities in quality, access, and affordability of health care. Health care providers and insurers, or their representatives, as well as health insurance brokers and agents are prohibited from board membership.[40] All members are required to take an oath of office before commencing duties.[41]

Duration and staggering of appointments

The bill requires the Governor, in making initial appointments, to appoint two members to a term ending on June 30, 2013, two members to a term ending on June 30, 2014, and two members to a term ending on June 30, 2015. The terms of members appointed after these initial terms are to be for three years, with each term ending on the same day of the same month as the previous term. Members of the Board are required to hold the office until the expiration of their term.[42]

The Governor is prohibited from appointing any person to more than two terms as a member of the Board. However, in a situation where an appointment is made to fill a vacancy caused by death, resignation, or removal, the Governor may appoint a person to fill such a vacancy and then appoint that person to two additional full terms, or the Governor may appoint a person who has already completed two terms to fill such a vacancy.[43] The bill places no limit on the number of times that an individual may be appointed to fill a vacancy. An individual appointed to fill a vacancy is to hold office until the expiration of the member's predecessor's term.[44]

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[39] R.C. 3965.03(D).

[40] R.C. 3965.03(A) and (B).

[41] R.C. 3965.03(F).

[42] R.C. 3965.03(C)(1).

[43] R.C. 3965.03(C)(2).

[44] R.C. 3965.03(C)(3).

A member of the Board is to hold office until either a successor takes office or until 60 days after the expiration of the member's term, whichever comes first.[45]

Exchange Agency Board of Directors Nominating Council

The bill creates the Exchange Agency Board of Directors Nominating Council for the purpose of nominating individuals for the Governor to appoint. The Nominating Council will consist of the following individuals or such individuals' designated representatives:

- The Chief Executive Officer of the American Association of Retired Persons (AARP);
- The Executive Director of the Ohio Developmental Disabilities Council;
- The Director, or equivalent representative, of the Ohio Small Business Council of the Ohio Chamber of Commerce;
- The Chairperson of the Board of Directors of the Council of Smaller Enterprises;
- The Executive Director of the Universal Health Care Action Network of Ohio;
- The President of the Ohio chapter of the American Federation of Labor and Congress of Industrial Organizations (AFL-CIO);
- The president, or equivalent representative, of the largest public employee organization in Ohio;
- The President of the Health Policy Institute of Ohio;
- The Executive Director of the Ohio Commission on Minority Health;
- The Chairperson of the Department of Economics at The Ohio State University;
- The President of the Ohio Association of Health Plans;
- The President of the Ohio State Medical Association;
- The Chief Executive Officer of the Ohio Hospital Association.

[45] R.C. 3965.03(C)(3).

The Nominating Council also includes an individual selected by the President of the Senate and one selected by the Speaker of the House of Representatives.[46]

At its first meeting each year, the Council is required to select from among its members a chairperson and secretary and may adopt bylaws governing its proceedings. The Council is required to keep a record of its proceedings. Special meetings may be called by the chairperson upon receipt of a written request for such a meeting signed by two or more members of the Council. Written notice of the time and place of all of the Council's meetings is required to be sent to each member of the Council. A quorum consists of eight of the 15 members of the Council.[47]

Duties of the Nominating Council

For those members of the OHBEA Board of Directors that are to be appointed, the Nominating Council is required to evaluate possible appointees for open positions on the Board. For every open position requiring an appointment, the Council is required to provide the Governor with a list of four individuals who are the most fully qualified to accede to the office of OHBEA board member. The Council may not nominate an individual whom, upon being appointed, would cause there to be more than three individuals affiliated with the same political party amongst the appointed members of the Board. The list of nominees is to be presented to the Governor not more than 85 or less than 65 days prior to the expiration of the term of an appointed OHBEA board member occurs. In the case of an unexpected vacancy in the Board, the Nominating Council is required to present a list of nominees to fill the vacancy not more than 30 days after the occurrence of the vacancy. In reviewing and evaluating possible appointees for the office of OHBEA board member, the Council may accept comments from and request information from any person. The bill authorizes the Council to make recommendations to the General Assembly concerning legislative changes that would assist the Council in carrying out its duties.[48]

Under the bill, the Governor is required to fill a vacancy on the OHBEA Board of Directors within 30 days of receiving the Council's recommendations. The Governor is required to fill such a vacancy from the list of four individuals provided by the Council. However, the Governor is allowed to reject the Council's nominees and require the Council to provide four additional nominees. After this, the Governor must fill a vacancy on the OHBEA Board of Directors from either the first or the second list of

[46] R.C. 3965.04(A).

[47] R.C. 3965.04(B) and (C).

[48] R.C. 3965.04(D) and (E).

nominees. Each appointment made by the Governor is subject to consent by the Senate.[49]

Within 90 days after the bill's effective date, the Council must produce two, three, or four nominees for the initial appointment of each appointed position. Following nomination, the Governor must appoint the members to the OHBEA Board of Directors in accordance with the bill's general appointment provisions. At the time of appointment, the Governor must determine which members of the Board will serve the various staggered terms. For each subsequent nomination period, the Council will produce four nominees for each position.[50]

Nominating Council compensation

The bill provides that members of the Council shall receive a per diem for each meeting they attend and will be reimbursed for all reasonable travel expenses. All of the expenses of the Nominating Council are to be paid from those amounts appropriated to OHBEA for that purpose.[51]

OHBEA board advisory committee

The bill authorizes the Board to appoint an advisory committee, consisting of between 10 and 12 members. The advisory committee is prohibited from voting on matters placed before the Board. Unlike the Board, there is no restriction on the type of individual that may be appointed to the advisory committee. The bill specifically authorizes all of the following types of individuals to be appointed to the advisory committee:

- Representatives of health insuring corporations;
- Insurance brokers;
- Health care providers;
- Consumers, including persons with disabilities;
- Small business owners;

[49] R.C. 3965.04(F).

[50] Section 3 of the bill.

[51] R.C. 3965.04(G).

- Representatives of organizations or community members that represent ethnic, racial, and rural communities.[52]

Navigator program

The bill requires the Board to establish a navigator program to advise individual consumers and employers on the use of the Exchange. The Board must award grants to individuals and entities approved by the Board to carry out this task. Funds in the Ohio Health Benefit Exchange Operating Fund are to be used to make these grants. To be eligible for such a grant, an individual or entity must meet all of the following criteria:

- The individual or entity has existing relationships or could readily establish relationships with consumers, employers and employees, or self-employed individuals, likely to be qualified to enroll in a plan offered through the Exchange.

- The individual or entity is not a health insurance issuer and does not receive any compensation from any health insurance issuer in connection with the enrollment of individuals in a health benefit plan offered through the Exchange.

- The individual or entity is capable of carrying out all required duties and responsibilities.[53]

Responsibilities of navigators

Chosen navigators are required to do all of the following:

- Conduct public education activities to raise awareness of the availability of qualified health benefit plans;

- Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under the PPACA, as well as cost-sharing reductions under it;

- Facilitate enrollment in qualified health plans;

- Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under the Public Health Service Act, or the Department of Insurance, for any enrollee with

[52] R.C. 3965.03(G).

[53] R.C. 3965.09(A), (B), and (D).

a grievance, complaint, or question regarding their health benefit plan or coverage or a determination under that plan or coverage;

- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange.[54]

Rules

The bill authorizes OHBEA and the Executive Director of OHBEA to adopt rules to implement the requirements of the proposed Health Benefit Exchange Law. Such rules are prohibited from conflicting with the application of regulations made by the Secretary of HHS under the PPACA.[55]

Authority of the OHBEA

The bill clarifies that nothing in the proposed Health Benefit Exchange Law and no action taken by the Executive Director of the OHBEA may be construed to preempt the authority of the Superintendent of Insurance to regulate the business of insurance within Ohio.[56]

Definitions

The bill makes the following definitions for use in the proposed Health Benefit Exchange Law:

- "Carrier" means any sickness and accident insurance company or health insuring corporation authorized to issue health benefit plans in Ohio.

- "Exchange" or "exchange program" means the Ohio Health Benefit Exchange Program established under the bill.

- "Exchange agency" means the Ohio Health Benefit Exchange Agency established under the bill.

- "Federal act" means the federal "Patient Protection and Affordable Care Act of 2010," 124 Stat. 119, as amended by the federal "Health Care and Education Reconciliation Act of 2010," 124 Stat. 1029, and any amendments to those acts, or regulations or guidance issued under those acts.

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[54] R.C. 3965.09.

[55] R.C. 3965.13.

[56] R.C. 3965.14.

- "Qualified dental plan" means a limited scope dental plan that has been certified under the bill.

- "Qualified employer" means a small employer that meets the criteria for a qualified employer established in the provisions described in "**SHOP exchange**," above.

- "Qualified health plan" means a health benefit plan that has been certified pursuant to the bill.

- "Qualified individual" means an individual who meets the criteria for a qualified individual established in the bill under "**Individuals qualified to participate in the Exchange**," above.

- "Secretary" means the Secretary of the United States Department of Health and Human Services.

- "SHOP exchange" means the Small Business Health Options Program established in the bill.

The bill makes several additional definitions. "Small employer" means, until January 1, 2016, an employer that employed an average of not more than 50 employees during the preceding calendar year and, on and after January 1, 2016, an employer that employed an average of not more than 100 employees during the preceding calendar year.

All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the "Internal Revenue Code of 1986," 100 Stat. 2085, 26 U.S.C. 1, as amended, are to be treated as a single employer. Any reference to an "employer" under the bill includes any predecessor of the employer. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small or large employer is to be based on the average number of eligible employees that the employer is reasonably expected to employ on business days in the current calendar year. All employees are to be counted, including part-time employees and employees who are not eligible for coverage through the employer.

The bill also provides a definition for "health benefit plan." Under the bill, "health benefit plan" means a policy, contract, certificate, or agreement offered or issued by a carrier to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services. "Health benefit plan" does not include any of the following:

- Policies covering only accident or disability income;

- Coverage issued as a supplement to liability insurance;
- Liability insurance, including general liability insurance and automobile liability insurance;
- Workers' compensation or similar insurance;
- Automobile medical payment insurance;
- Credit-only insurance;
- Coverage for on-site medical clinics;
- Other similar insurance coverage under which benefits for health care services are secondary or incidental to other insurance benefits;
- Any plan the Executive Director excludes from possible certification as a qualified health plan under the provisions described above under "**Ohio Health Benefit Exchange Program; Prohibited actions**."[57]

Bill objectives

The bill declares that its purpose is to provide for the establishment of an Ohio Health Benefit Exchange Agency and an Ohio Health Benefit Exchange Program to facilitate the purchase and sale of qualified health plans in the individual market in Ohio, and to provide for the establishment of SHOP exchange as a part of the Ohio Health Benefit Exchange Program to assist qualified small employers in Ohio in facilitating the enrollment of their employees in qualified health plans offered in the small group market.

The bill declares that the all of the following objectives are to be served though its enactment:

- Extend access to high quality, affordable health plans to all Ohioans;
- Reduce the number of uninsured Ohioans by creating a cost-effective, user-friendly, and transparent marketplace to help consumers and employers select high quality, affordable health plan and claim available federal tax credits and cost-sharing subsidies;
- Strengthen the health care delivery system;

[57] R.C. 3965.02.

- Guarantee the availability and renewability of health care coverage through the private health insurance market to qualified individuals and qualified small employers;

- Require that health care service plans and health insurers issuing coverage in the individual and small employer markets compete on the basis of price, quality, and service, not on risk selection;

- Meet the requirements of the federal act and applicable federal guidance and regulations.[58]

Context

The PPACA allows states a certain amount of flexibility in establishing health benefit exchanges. The following is a brief summary of some of the more notable options that are available to states when establishing exchanges. States may do any of the following:

- Establish an exchange as either a state agency or as a nonprofit organization;

- Join with other states in the operation of a single exchange;

- Establish regional exchanges underneath a central, governing body;

- Contract with third parties to carry out various functions of the Exchange, including the state Medicaid agency;

- Adopt more stringent conflict of interest or other membership requirements than those set forth in the PPACA with regard to an exchange's board of directors;

- Establish a separate administrative structure for a SHOP exchange;

- Adopt one of the following ways for enrollees to pay premiums to carriers: directly to the carrier, passing premiums through the exchange to the carrier, or collecting premiums and then making a lump sum payment to the carrier;

- Adopt privacy standards appropriate to the nature of the exchange while still meeting certain baseline standards;

[58] R.C. 3965.01.

- Allow employers choosing health benefit plans through a SHOP exchange various options, including allowing employers to enable employees to choose from a variety of health plan options or only a single option;

- Elect to limit participation in the SHOP exchange to employers with less than 50 employees until January 1, 2016;

- Exercise discretion in deciding which qualified health plans are to be offered through the exchange.[59]

Levels of coverage

The PPACA describes the following levels of coverage:

Bronze level. A plan in the bronze level provides a level of coverage that is designed to provide benefits that are actuarially equivalent to 60% of the full actuarial value of the benefits provided under the plan.

Silver level. A plan in the silver level provides a level of coverage that is designed to provide benefits that are actuarially equivalent to 70% of the full actuarial value of the benefits provided under the plan.

Gold level. A plan in the gold level provides a level of coverage that is designed to provide benefits that are actuarially equivalent to 80% of the full actuarial value of the benefits provided under the plan.

Platinum level. A plan in the platinum level provides a level of coverage that is designed to provide benefits that are actuarially equivalent to 90% of the full actuarial value of the benefits provided under the plan.[60]

Other changes

Small Employer Benefit Plan Law

The bill also conforms the definition of "small employer" in the Small Employer Benefit Plan Law to the definition of "small employer" in the bill for heath benefit exchanges. Under the bill, "small employer" means, until January 1, 2016, in connection with a group health benefit plan and with respect to a calendar year and a plan year, an employer who employed an average of at least two but no more than 50 eligible employees on business days during the preceding calendar year and who employs at

[59] Affordable Care Act.

[60] 42 U.S.C. 18022(d).

least two employees on the first day of the plan year (current law), but on and after January 1, 2016, an employer that employed an average of not more than 100 employees during the preceding calendar year.[61]

COMMENT

1. R.C. 3965.06(B) prohibits the Executive Director of the Exchange from excluding a health benefit plan from being offered through the Exchange for certain reasons. Listed among the reasons is "Through the imposition of premium price controls by the exchange." This is likely a drafting error, as it is not a characteristic of a health benefit plan for which it would be excluded, but rather a means by which a health benefit plan would be excluded. It is expected that the bill should have rather read, "The executive director shall not exclude plans from being offered through the exchange through the imposition of premium price controls."

2. There are several instances in the bill where the term "exchange" is used, but where it would be more appropriate to use the term "exchange agency" to avoid confusion. For example, the first sentence of division (A) of R.C. 3965.06 states "The executive director of the exchange may [. . .]." It would be more appropriate to state "The executive director of the exchange *agency* may [. . .]."

HISTORY

ACTION	DATE
Introduced	01-11-12

H0412-I-129.docx/emr

[61] R.C. 3924.01(N).