ECONOMIC AFFAIRS IC
JUNE 12, 2012
EXHIBIT 7

Outline For HJR 33 Report

Overview — 2011 session actions, interim reviews, U.S. court case

Sections

I) Committee activities
II) Committee Policy Recommendations (none at this time)
III) Background information
- A) information gathered for a health insurance exchange and the Affordable Care Act -
  - i) health insurance coverage in Montana - indications from study by Bureau of Business and Economics Research for State Auditor;
  - ii) status of health insurers in Montana - by premium in small group and individual markets, by medical loss ratio, and regarding rate review (by federal officials and the State Auditor's Office with Leif Associates as actuarial contractors);
  - iii) status of Montana Comprehensive Health Association and the federal high risk pool (Montana Affordable Care Plan);
  - iv) subsidies paid to employers to help buy health insurance, under Insure Montana and under the Affordable Care Act;
  - v) status of the health co-operative that has received federal funding under the Affordable Care Act to provide a health plan alternative;
  - vi) other??
- B) information related to ways to address health care efficiencies and access
  - i) health care provider status in Montana and shortages plus options for expanding access
  - ii) use of the Board of Medical Examiners and the Board of Nursing licensing and renewal process to improve data gathering needed by DPHHS and as a way of decreasing the amount of time spent by physicians and others in responding to the same questions by various credentialing organizations.
  - iii) network adequacy for managed care insurers - having a hospital, primary care provider, and pharmacy within a 30-mile radius of enrollee
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Appendix A — Common terms and how they are used/referenced in the Affordable Care Act
Appendix B — Questions for legislative consideration

Considering a Health Insurance Exchange in Montana
Draft Report for House Joint Resolution # 33
By Pat Murdo, Legislative Research Analyst

Overview

Decisions by the 2011 Legislature not to pass legislation that would have implemented parts of the Affordable Care Act and a veto by the governor of a bill prohibiting creation of a health insurance exchange under the Patient Protection and Affordable Care Act[1] set the stage for a philosophical stalemate regarding how to proceed in the interim. However, passage of House Joint Resolution No. 33 to study creation of a health insurance exchange provided a starting point after that study bill was assigned to the Economic Affairs Committee (the Committee).

After narrowing the scope of the study based on votes to include or exclude options in the study plan, the Committee decided to further limit the study until after the U.S. Supreme Court ruled on challenges to the Affordable Care Act in June 2012. First, however, the Committee heard from federal officials in late August 2011 that even if Montana's 2013 Legislature chose to implement a state-based health insurance exchange the action would not be timely enough to have a state-run health insurance exchange running as of Jan. 1, 2014, the date required by the Affordable Care Act for nationwide implementation of health insurance exchanges. The federal officials noted that shared regulatory options might be available and that a state might be able to take over a federally run exchange after at least one year, although details were being worked out. The Committee decided to simply stay informed of activities being pursued in Montana related to a health insurance exchange but took no action as members awaited the U.S. Supreme Court's decision on constitutional challenges to the Affordable Care Act.

The following report contains policy recommendations from the Economic Affairs Committee related to health insurance coverage and affordability along with information presented to the Economic Affairs Committee over the 2011-2012 interim. The report also provides some basic information that may be of help to Montana legislators if the U.S. Supreme Court upholds the Affordable Care Act and legislation is proposed to implement some components of the Affordable Care Act.

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[1]The Patient Protection and Affordable Care Act will be termed the Affordable Care Act in this report.

In Appendix A, there is a list of terms related to the Affordable Care Act along with descriptions from proposed -- or -- adopted federal rules. Appendix B includes options regarding health care provisions that legislators might want to consider if the Affordable Care Act is overturned--sort of a "what next" preview.

I. Committee Activities

The first step by the Committee involved a survey (Appendix B in the work plan) to determine the scope of the HJR 33 study. The survey indicated the Committee's top priorities for the HJR 33 study were:

- the scope of service, plan components, and how to address state mandates whether an exchange is state, regional, or federal (high + medium scores = 6 of 8);
- the technological components of an exchange and what is needed for a state, regional, or federal interface. Because of some confusion about the "technological" aspects, this was included even though "high" and "low" each had 3 votes.
- the interaction of an exchange with Medicaid and the potential for premium assistance and Medicaid waivers. (Only 1 low-priority score, with 3 high, and 4 medium). There was a request to expand this section to address how the Indian Health Service and nonreservation Indians fit into the exchange concept.

The following were not addressed because of tie votes or a predominance of low priority votes: whether to review the role of insurance producers and agents in an exchange, the issue of insurance competition in Montana and possible impacts if insurance sales are allowed across state lines, the interaction of the state health plan and an exchange; and whether to address factors related to aggregation of premiums for employees with multiple employers. (The latter was intended to look at options for employees who work several jobs but may not receive health insurance benefits at any of them and what an exchange might do for them.)

A federal exchange

The Committee asked at its first meeting in June 2011 if federal officials could address the Committee on whether Montana would be able to qualify to have a state exchange if the federal deadline for certifying the possibility of a state exchange was Jan. 1, 2013, and Montana's legislature did not meet until after that date. The Affordable Care Act requires that health insurance exchanges, whether state-operated or federally operated, be running as of Jan. 1, 2014, with enrollment in insurance plans taking place in the previous quarter (starting Oct. 1, 2013) so that policies are effective as of Jan. 1, 2014. Evidence that a state would be able to get an exchange operating by Jan. 1, 2014, had to be clear to the Department of Health and Human Services by late 2012 for a go-ahead on a state rather than a federal exchange.

At the Committee's Aug. 23, 2011, meeting Marguerite Salazar from the Department of

Health and Human Services regional office in Denver met with the Committee in person and officials from the DHHS Center for Consumer Information and Insurance Oversight (CCIIO) phoned in to discuss expectations for an exchange in Montana. Their basic response was that, because the 2011 Legislature did not pass authorizing legislation for a state exchange, Montana would have a federally run health insurance exchange.[2]

But the federal officials opened the door on the prospect that Montana and other states still unsure about health insurance exchanges might be able eventually to take over an exchange in their state from the federal government or share the operational duties of an exchange. This concept generated a buzz the next day in Denver when CCIIO officials met with officials from several states in the region to discuss exchanges. Other states wanted to know what had been said in Montana about shared duties and transfer options.

In guidance released May 16, 2012, the Department of Health and Human Services reviewed these three types of health insurance exchanges and specified that for each type, there might be sharing of certain duties.

- A state-based exchange would operate all activities but may use federal services for premium tax credit and cost-sharing reduction determinations, or for the risk adjustment or reinsurance programs. Or the state may request exemptions from certain components.
- A state partnership would mean the state could choose to handle plan management or some consumer assistance activities (or both) on behalf of the federal exchange and may opt to determine Medicaid and CHIP eligibility. However, the federal government would handle any of the programs not covered by the state.
- The federally facilitated exchange also would offer an option for states to operate the reinsurance program and the assessment and determination of Medicaid or CHIP eligibility.

Monitoring activities

The combination of news that Montana would have a federally run exchange and the U.S. Supreme Court's decision to hear challenges to the Affordable Care Act put a damper on the Committee's study of an exchange, particularly because the Supreme Court was not expected to rule before late June 2012. At that late date the Committee would have only one meeting before completing its interim activities.

The Committee asked to be kept informed of what activities were happening with health insurance exchanges. The following e-mail notifications went out:

- Aug. 20, 2011, regarding responses to questions the Committee had about

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[2]All the references to an exchange are predicated on the Affordable Care Act being upheld because it is current law and for ease of reference. For the final report, the verbs will be adjusted..

exchanges, plus federal reviews of insurance rates, and a description of how a computer system would be expected to work to determine eligibility for either subsidies on a health insurance exchange or eligibility for Medicaid;

- Dec. 16, 2011, regarding federal guidance on essential health benefits that had to be covered in any plan offered on a health insurance exchange as well as on four types of health plans from which a state may choose a benchmark plan;
- Jan. 25, 2012, regarding preliminary findings of three small group health insurance products ranked as the highest by enrollment that the state might consider as the essential health benefit benchmark. However, the State Auditor's Office later noted that the largest products by enrollment in 2011 were not all offered in 2012, so the 2012 versions would include some different names. The final determination of enrollment is being done now by CCIIO, based on enrollment numbers from the first quarter of 2012.
- March 29, 2012, regarding federal rate review of health insurance premium rate increases. Because Montana's insurance commissioner does not have rate review authority for health insurance, the federal government assumed the task of determining whether insurers filing rates in Montana were requesting unreasonable rate increases on Sept. 1, 2011. The federal government does not review rate increases of less than 10%. The e-mail noted State Auditor Monica Lindeen in her review of her office's activities under the Affordable Care Act would be asked to address the posting of unreasonable rate increases. (She does this by posting a link to the CCIIO website regarding their findings on rate increases implemented in Montana.) The e-mail also noted that the U.S. Department of Health and Human Services had reviewed or would review 48 Montana policies with premium increases of 10% or more.

Impacts with Medicaid and Indian Health Service

Discussions about how an exchange would interact with Medicaid and with the Indian Health Service or tribal health services preceded Ms. Salazar's Aug. 23, 2011, presentation and responses by the CCIIO officials to questions posed by the Committee about health insurance exchanges.

Linda Snedigar with the Montana Department of Public Health and Human Services provided information about the 30-plus categories of people who currently are eligible for Medicaid in Montana.[3] She noted that the Affordable Care Act collapses most of those

[3]See the categories for Medicaid eligibility at: http://leg.mt.gov/content/Committees/Interim/2011-2012/Economic-Affairs/Meeting-Documents/August/MedicaidCoveragegroups4-11.pdf.

categories into four main groups[4] and removed asset tests for many but not all of the categories. She also pointed out that under the Affordable Care Act more Montanans would be eligible as of Jan. 1, 2014, for Medicaid under a provision that allows all adults with incomes up to 138% of the federal poverty level to get on Medicaid rolls, including single, able-bodied individuals. (The adult limit taking effect on Jan. 1, 2014, is 133% plus a 5% asset disregard so most people say eligibility is up to 138% of federal poverty levels). Current federal law requires Medicaid to cover children from lower-income families and pregnant women as well as low-income adults who are blind, disabled, or elderly. States vary in how they cover adults. Montana limits Medicaid for other adults to those with dependent children if the family's income is at or below 33% of federal poverty levels. This means few able-bodied adults between the ages of 18 and 65 are currently eligible for Medicaid in Montana.

The complexity of determining whether a person would be eligible for Medicaid or for subsidies under a health insurance exchange was apparent in a draft chart developed by Public Knowledge LLC under contract with the State Auditor's Office as part of the planning process for a health insurance exchange. Key to determining eligibility of one or the other form of assistance would be a federal "hub" that interacts with the Internal Revenue Service, the Social Security Administration, the Department of Health and Human Services, and the Department of Homeland Security (to determine citizenship).[5]

Ms. Snedigar noted that Montana's existing CHIMES eligibility system for Medicaid has the technological components necessary to meet the part of the process for consumers to determine if they are eligible for Medicaid. She explained that the public assistance officials would help with paper applications for those without access to the Internet and would be part of what is considered a "no wrong door" approach to helping people access Medicaid coverage as well as various public assistance benefits, including temporary assistance to needy families (TANF) or the supplemental nutrition assistance program (SNAP - formerly food stamps).

Although the Affordable Care Act does not mandate that Indians obtain insurance or pay a penalty as do others under the individual mandate, other provisions of the Affordable Care Act apply to Indians who have health insurance through employers. An Indian Health Service (IHS) representative was unable to provide his assessment of the impact of the Affordable Care Act on IHS or Indians getting health care on reservations, but a tribal

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[4]The simplification under the Affordable Care Act creates four main groups eligible for Medicaid: parents, infants and children, pregnant women, and adults without children. None of these would have an asset test.

[5]See the sample eligibility pathway at: http://leg.mt.gov/content/Committees/Interim/2011-2012/Economic-Affairs/Meeting-Documents/August/Exchange-Medicaid-pathway-sample.pdf.

health official with the Confederated Salish and Kootenai Tribes (CSKT) described how the CSKT expected to work with the Affordable Care Act. The CSKT operate their own health clinics under a self-governance compact with the federal government.

Kevin Howlett noted that the Affordable Care Act permanently reauthorized the Indian Health Care Improvement Act and further pointed out that the IHS is a payer of last resort, so that those who are eligible for Medicaid are expected to be enrolled in Medicaid before IHS pays. He noted that the state's eligibility determinations still would apply to Indians on Medicaid but that there is no state or tribal obligation to match Medicaid payments. This means 100% federal reimbursement for those on Medicaid at tribal clinics.

Mr. Howlett pointed out that the individual mandate did not distinguish between Indians living on reservations with access to the Indian Health Service and so-called urban Indians. He questioned how non-Indian agencies would provide services for Indians living in urban areas, although enrolled members still can access services on their own reservation. Mr. Howlett reviewed reasons for Indians to sign up on a health insurance exchange. Among these were that the IHS is funded at only about 50% of its expected expenditures. For those who want to ensure coverage year-round or access to care other than "life or limb" emergency care from IHS, insurance or Medicaid is necessary. Mr. Howlett also noted that access to catastrophic care coverage is available through IHS but that access through a health insurance exchange to catastrophic coverage might make more sense. He emphasized that if Indians rely solely on IHS for care, they may not get the care they need because funds are unlikely to be available throughout the fiscal year.

Indians are eligible and encouraged to purchase health insurance through the exchange. Unlike other citizens, they are eligible for affordability credits (no cost-sharing) up to 300% of the federal poverty level. Catastrophic coverage is available on the exchange only for individuals between 19 and 30 years old.

II. Committee Recommendations (if any)

III. Background Information

A. Information gathered for a health insurance exchange and the Affordable Care Act

Among purposes of health insurance exchanges are:

- to provide a way to help individuals to obtain premium subsidies and cost-sharing credits in the individual insurance market; and
- to provide a way of comparing insurance options on a level playing field.

Table 1 - Funding to Montana Government, Private Sector under the Affordable Care Act

Category	To Government	To Private Sector	Total Funding
Total Amount	*$18,559,360*	*$82,418,690*	*$100,978,050*
Employers/Business	$3,634,238	$3,131,625	$6,765,869
Health Care Facilities/Clinics	$500,000		$500,000
Health Centers	$185,498	$811,820	$997,318
Maternal - Pregnancy	$7,676,955	$212,000	$7,888,955
Medicare & Medicaid Special Projects	$201,824	$2,840,094	$5,471,920
Prevention & Public Health	$2,631,826	$2,840,094	$5,471,920
Private Insurance/Health Exchange	$2,769,016	$66,304,276	$69,073,292
Workforce and Training	$960,003	$6,244,625	$7,204,628

Source: The Henry J. Kaiser Foundation, ACA Federal Funds Tracker, accessed April 12, 2012: http://healthreform.kff.org/federal-funds-tracker.aspx

i) health insurance coverage in Montana - indications from study by Bureau of Business and Economics Research for State Auditor

The Bureau of Business and Economic Research study is not expected out until September. Information in the study[6] is to include:

- an evaluation of Montana's population by insurance status and stratified by income, age, employment, and health status. (Based on telephone and cell phone surveys.)
- responses of 500 surveyed businesses regarding health insurance expectations for their employees, including who is eligible, how much cost-sharing is done between employer and employees, what types of co-pays, deductibles, out-of-pocket provisions are offered, plus the acceptance rate by employees and whether dental, prescription ;
- responses from 2,500 household surveys as to reasons the uninsured do not have health insurance;
- estimates of how many Montanans will be eligible for expanded Medicaid, for the Healthy Montana Kids program, and for premium tax credits or premium assistance on the health insurance exchange;
- a review of insurance plans available in Montana and the size of various markets (large group, small group, individual);
- estimates of the number of people who might be eligible for a catastrophic plan in a federally facilitated exchange; and
- mitigation strategies to address people who will move back and forth between being eligible

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for Medicaid and eligible for subsidies on a health insurance exchange.

ii) status of health insurers in Montana - by premium in small group and individual market, by medical loss ratio, and regarding rate review (by federal officials and the State Auditor's Office through a contract with Leif Associates)

One of the purposes of health insurance exchanges was to promote an element of competition in the health insurance market and make selection of a health insurer easier for buyers who had become accustomed to comparing prices and features for airline travel or consumer goods. The attention to competition, however, found that very few areas of the United States have competition in health insurance. A study by the American Medical Association of metropolitan markets found that 83% of those markets were "highly concentrated", using a term of art related to a Department of Justice calculation to determine if a merger creates an antitrust or anticompetitive situation.[7]

Montana similarly has very little competition in the health insurance market, with the biggest insurer in this state's market in 2010, Blue Cross Blue Shield of Montana, having about 50% of earned market premium for the individual market, about 80% of the small group market, and nearly 70% of the large group market.[8] However, Montana did not rank as one of the least competitive markets in the AMA study.[9]

Another study undertaken by the State Auditor's Office uses actuarial firm Leif Associates to review Montana's market for health insurance plans and assess insurers' compliance with existing Montana rating laws. At a Feb. 24, 2012, meeting of the Exchange Stakeholder Involvement Council one of the stakeholders asked why Montana's small group market is so concentrated with so few players. Christina Goe with the State Auditor's Office noted that insurance markets nationwide are becoming more concentrated. However, the exchange is to add a health insurance co-op as a newly licensed insurer as well as two multi-state health plans operating under contract with the federal government. Response to a request from the State Auditor's Office for detailed information from insurers revealed that six of the individual carriers were no longer active in Montana in 2011 and three of the small group carriers had ceased doing active business in

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[7]Summary of an American Medical Association study reported in *Medical Benefits,* April 30, 2012, p. 12.

[8]Data provided by Leif Associates to the Exchange Stakeholder Involvement Council meeting in Helena, Feb. 24, 2012. Handouts 5 and 6.

[9]*Ibid.* The 10 bottom rankings in the AMA study reflecting the least competitive health insurance markets were: Alabama, Alaska, Delaware, Michigan, Hawaii, the District of Columbia, Nebraska, North Carolina, Indiana, and Maine.

Montana in 2011.[10] The State Auditor's Office later reported that the departed insurers had very small market shares and that two new insurers have been added to those companies actively marketing individual and small employer group coverage.

Leif Associates also took another perspective to determine in both earned premium and covered lives whether insurers not based in Montana had much business here. For the small group and large group markets, Montana-based firms predominated for both earned premiums and covered lives. In the individual market for both measures, Montana-based firms had about 50% of the market with the remainder held by what is called "foreign" firms, or those not based in Montana, such as Assurant, also known as John Alden and Time.

iii) status of Montana Comprehensive Health Association and the federal high risk pool - The Montana Affordable Care Plan

The Affordable Care Act offered states the choice of running their own program to cover people generally unable to obtain insurance because of preexisting conditions or having the federal government provide coverage to these citizens. The Montana Insurance Commissioner chose to run the federally subsidized plan alongside the existing Montana Comprehensive Health Association plans, which cover those Montanans who have been refused insurance by at least one insurer[11] (prior to 2011 the requirement was for rejected applications by two insurers) or proving the existence of a particular high-risk condition. Participants in the federal high risk pool must be uninsured for at least six months prior to enrollment.

The commissioner's office approved a single application for both programs in 2010 and began accepting applicants to the Montana Affordable Care Plan on July 1, 2010, with coverage available starting Aug. 1, 2010. In May this year, there were 321 enrollees.

iv) subsidies paid to employers to help buy health insurance, under Insure Montana and under the Affordable Care Act

Under Insure Montana, an employer of at least two but not more than nine employees may obtain either refundable tax credits for offering "qualified" insurance plans[12] to employees or a premium incentive payment to help for pay premium costs. Employees of the small employer also may

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[10]Leif Associates presentation to Exchange Stakeholder Involvement Council, op. cit., slide 11.

[11]The rejection is one of two main eligibility criteria described in 33-22-1501(7). The other may be met by having a restrictive rider or preexisting condition limitation requirement by at least one insurer (or equivalent). A waiver by the Montana Comprehensive Health Association may offset either criteria.

[12]The insurance must be either a group health plan or a qualified association health plan, with both terms defined in 33-22-2002, MCA.

receive a premium assistance payment. The program also sets an upper personal income limit of $75,000 per employee. The salaries of owners, partners, or shareholders in the business are not counted (33-22-2006).

Insure MT Participation, Costs

	February 2012	2/3/2011 Report to Joint Subcommittee
Purchasing Pool Group business participants	814	872
subscribers / covered employees	1,871	2,415
members / covered dependents	3,443	2,053
Total program annual cost		
Average annual cost per business		$3,496
Average annual cost per employee		$1,890
Number of businesses on waiting list		~125
Tax Credit Recipients		
Number of participating businesses		802
Average annual cost per business		$5,297
Total program annual cost		$4,248,194
Number of covered employees		2,687
Number of covered spouses		585
Number of covered dependents		2,053
Number of businesses pending enrollment or on waiting list		52
Administrative costs		5% of program budget
5 FTEs		

v) status of the health co-operative that has received federal funding under the Affordable Care Act to provide an insurance alternative

The Committee heard from Dr. Tom Roberts, the chairman of the board of the Montana Health CO-OP, which has received federal start-up financing for a nonprofit health insurance company intended to offer insurance on a health insurance exchange. Dr. Roberts said the financing is in the form of a $6.7 million loan, which will be distributed quarterly over the next two years if the Montana Health CO-OP meets certain requirements, plus initial funding for reserves of up to $51 million. The start-up loan is to be repaid over five years, with loans backing initial reserves to be paid back over

15 years.

Committee members asked Dr. Roberts what would happen if the U.S. Supreme Court overturned the Affordable Care Act. He noted that he had signed a contract with the federal government so he expected the Montana Health CO-OP to move forward. A report distributed to Committee members noted that the Montana Health CO-OP intends to start offering health insurance products in October 2013 with policies to be in force as of Jan. 1, 2014, but that the Montana Health CO-OP "cannot begin to offer fully insured health insurance products until certain state and/or federal market reform provisions of the Affordable Care Act are implemented in Montana".[13]

vi) other??

B. information related to ways to address health care efficiencies and access

i) health care provider status in Montana and shortages plus options for expanding access

ii) use of the Board of Medical Examiners and the Board of Nursing licensing and renewal process to improve data gathering needed by DPHHS and as a way of decreasing the amount of time spent by physicians and others in responding to the same questions by various credentialing organizations.

37.108.216, ARM. VERIFICATION OF PROVIDER CREDENTIALS (based on 33-36-203)

(1) Each health carrier shall establish and describe in its access plan the criteria utilized to review the credentials of the providers in its network. A health carrier must require a provider's credentials to be reviewed prior to the health carrier employing or entering into contractual relationship with a provider and a provider's credentials are to be reverified at least every 3 years thereafter.

As the number of health carriers (insurers) increases in Montana, which is expected to be a byproduct of a health insurance exchange, so will the time spent meeting the credentialing requirement unless insurers coordinate their requirements or use a central credentialing entity.

iii) network scope - status of primary care access in Montana

iv) other??

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[13]"Montana Health CO-OP", written submission from Dr. Tom Roberts to the Economic Affairs Interim Committee on April 20, 2012, p. 4.

Kaiser Study indicating percent of nonelderly population that could receive assistance in paying for health insurance (because incomes are within range for Medicaid, tax credits, or subsidies to buy insurance*)

Zip Code	Area	Percent
59101	400	19%
59201	300	25%
59301	300	25%
59401	200	24%
59501	200	24%
59601	600	15%
59701 59715	600 500	15% 25%
59801 59802 59840 59860	700 700 700a 100	28% 28% 28% 29%
59901	100	29%

*Income ranges for subsidies in 2012 were $44,680 for a single person and $92,200 for a family of four.
The percentages are shown by

Public Use Microdata Areas (PUMA), which are statistical geographic areas defined for the tabulation and dissemination of certain census data. PUMAs are built on counties and census tracks within states and each one contains about 100,000 people. Standard errors range from 1-4% within PUMAs.
http://healthreform.kff.org/Coverage-Expansion-Map.aspx

Appendix A Common terms and how they are used/referenced in the Affordable Care Act

- **Benchmark Coverage** - New enrollees in the expanded Medicaid (including childless adults at 133% of the federal poverty level or 139% if certain assets are disallowed) may be offered a more limited set of benefits, known as benchmark coverage, than those available to enrollees under traditional Medicaid.
- Essential Benefits -
- Health Insurance Exchange -
- Individual Responsibility Requirement (some say "mandate") -
- Medical Loss Ratio (MLR) -
- Pre-existing Condition -
- **Risk Corridors** -
- **Risk Reinsurance** - For a state to operate a risk reinsurance program, the state must complete and submit an Exchange Blueprint prior to Nov. 16, 2012, and submit a statement of intent to create its own reinsurance entity by Dec. 1, 2102. If the state does not, the federal government will operate the risk reinsurance program for that state.
- **QHP** - Qualified Health Plans are those that are approved for offering on a health insurance exchange.
- **SHOP - Small Business Health Options Program.** This component of a health insurance exchange will allow small businesses of up to 100 employees (initially - until 2016 - only up to 50 employees) to purchase insurance for their employees in the SHOP exchange.
- **Student Health Insurance** - Student health plans are allowed a phase-in period prior to being required as of Jan. 1, 2014, to have no annual limits on essential benefits. By July 1, 2012, limits may not be less than $100,000 for essential health benefits. For policy years between September 23, 2012, and January 1, 2014, the annual limits may not be less than $500,000.[14] Student health plans also have a different methodology for determining a medical loss ratio until January 1, 2014, at which time the standard rule for medical loss ratios apply.[15] Student coverage is to be aggregated nationally as a pool, not by state.
- **Summary of Benefits and Coverage** - Insurers, including self-insurers, must be in compliance by September 23, 2012. These are required consumer disclosures describing the health plan coverage in not-so-technical language.
- **Tax Considerations** - As related to determining eligibility for a subsidy on a health insurance exchange, rules provide that a person must authorize sharing of tax information to obtain the subsidy. An authorization is to last for 5 years, but may be rescinded and renewed.
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[14] http://www.healthcare.gov/news/factsheets/2012/03/student-health-plans03162012a.html. Accessed 3/19/12.

[15] *Ibid.*