ACA Implementation—Monitoring and Tracking

Cross-Cutting Issues:

State Progress in Implementing Health Insurance Exchanges: Results from 10 State Analyses

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With support from the Robert Wood Johnson Foundation (RWJF), the Urban Institute is undertaking a comprehensive monitoring and tracking project to examine the implementation and effects of the Patient Protection and Affordable Care Act (ACA) of 2010. The project began in May 2011 and will take place over several years. The Urban Institute will document changes to the implementation of national health reform in Alabama, Colorado, Maryland, Michigan, Minnesota, New Mexico, New York, Oregon, Rhode Island and Virginia to help states, researchers and policymakers learn from the process as it unfolds. This report is one of a series of papers focusing on particular implementation issues in these case study states. In addition, state-specific reports on case study states can be found at www.rwjf.org and www.healthpolicycenter.org. The quantitative component of the project is producing analyses of the effects of the ACA on coverage, health expenditures, affordability, access and premiums in the states and nationally. For more information about the Robert Wood Johnson Foundation's work on coverage, visit www.rwjf.org/coverage.

INTRODUCTION

Under the ACA, each state has the option to develop a health insurance exchange, an organized marketplace for the purchase of health insurance in the small-group and nongroup insurance markets. While there are a number of federal regulations with which a state-operated exchange must comply, the law also provides considerable state flexibility in exchange development and design. Variations in these choices will, in turn, lead to exchanges with differing goals, characteristics, and levels of political support within the state. If, however, a state chooses not to develop its own exchange or is unable to demonstrate its ability to effectively do so, the federal government will operate an exchange in that state.

This paper describes the status of health insurance exchange development and design choices in the 10 states participating in the Robert Wood Johnson Foundation health reform implementation monitoring and tracking project. Information is drawn from publicly available sources, state legislation, and site visit interviews in each of the 10 states. We delineate an array of state approaches in exchange development, and provide examples of each based upon the situations in these states. While the examples provided are from states further along in the implementation process, Table 1 below depicts the exchange implementation status of all 10 states studied.

As is the case nationwide, the 10 case study states vary tremendously at the current time in their legal authority to develop exchanges, the status of health insurance exchange development, the design decisions that have been made, and those choices still to be made. However, unlike some states, all 10 of the participating states had expressed at least some interest in developing a state-based exchange, hence their inclusion in the project.

Table 1

State	Has Exchange Yes/No	Legal Authority	Governance
Alabama	No	N/A	Department of Insurance created a formal executive workgroup for exchange planning
Colorado	Yes	Senate Bill 11-200 passed May 5, 2011 creating the Colorado Health Benefit Exchange	Nonprofit unincorporated public entity with a nine-person governing board
Maryland	Yes	Health Benefit Exchange Act of 2011 established the Maryland Health Benefit Exchange	Public benefit corporation (quasi-public) with a six-person governing board
Michigan	No	Senate Bill 693 passed in the Senate, but has been held up in the House	None yet, but Senate Bill 693 outlined plans for a non-profit exchange
Minnesota	No, but have continued with planning efforts	House File 2290/Senate File 1872 would have created the Minnesota exchange, but was not acted upon	Exchange taskforce with 15 appointees which created 10 workgroups
New Mexico	No	Senate Bill 38/House Bill 33 passed in 2011, but was vetoed by the governor	Would have established a quasi-public exchange
New York	Yes, but very recently established	Executive Order #42	Government agency with option to become quasi-public
Oregon	Yes	Senate Bill 99 established the Oregon Health Benefit Exchange	Public corporation with a nine-member governing board
Rhode Island	Yes	Executive Order 11-09	Government agency within the executive department with guidance provided by an interagency exchange workgroup and a 13-member board
Virginia	No	Legal authority is yet to be determined, as the state has a law that some think gives authority to establish an exchange	Virginia Health Reform Initiative provides planning insight. Ongoing debates take place over quasi-governmental versus State Corporation Commission exchange

LEGAL AUTHORITY

In order to establish and begin building a state-based exchange, states need legal authority through either a governor's executive order or enacted legislation. There are advantages and disadvantages to each of these approaches. An executive order can be developed and implemented faster than a full legislative process. Most states have legislative sessions that last for only part of the year, limiting the time available for hearings and debate. Compromise between political parties and stakeholder interests also requires greater commitment of time than unilateral decision-making by the executive branch. However, legislation that is wrought from compromise and stakeholder input tends to engender broader-based political support for the ongoing exchange development and implementation phases, which is likely to be valuable in the long run. In addition, depending upon state law, exchange development by executive order may limit the governance options available for the exchange. For example, executive orders may necessitate development of the exchange as a state agency, foreclosing options of quasi-public entities or non-profit organizations governing the exchange. (Governance options are discussed further below.)

Rhode Island and New York are both examples of states that, following extended but failed efforts to pass legislation, used executive orders to establish their exchanges.

Of the 10 states studied, three—Oregon, Maryland and Colorado—have established exchanges via legislation and two—Rhode Island and New York—have done so via executive order. The remaining five states—Alabama, Minnesota, Michigan, New Mexico and Virginia—have yet to establish their own exchanges, and both of these options for legal authority remain under consideration.

Oregon was one of the first states to pass legislation (Senate Bill 99, June 2011) establishing a health insurance exchange consistent with the standards in the ACA. The law passed with strong bipartisan support. This early and broad support was credited to the fact that the Oregon Health Policy Commission, established by Governor Kulongoski in 2006, had already recommended development of a state exchange for individuals and small businesses. While this recommendation had been considered during the legislature's 2007 session and had broad support, the state's budget situation was too constrained to finance its development. Exchanges were considered in later legislative sessions, but with no progress made due to lack of funds. As a result, the ACA was widely perceived in Oregon as providing the state the financial resources it needed to move forward with a program that state officials had been planning for years.

Rhode Island and New York are both examples of states that, following extended but failed efforts to pass legislation, used executive orders to establish their exchanges. Rhode Island's S.B. 87, exchange establishment legislation that had broad support, was derailed in 2011 by an amendment that would have been more stringent than federal law in restricting the purchase of exchange-based abortion coverage. As a result, the Executive Committee of the Rhode Island Healthcare Reform Commission recommended that the governor establish the exchange—largely consistent with that laid out in the failed legislation—through an executive order. As such, it is being developed as a state agency at the present time. Similarly, even in the presence of a three-way consensus worked out between the New York governor, senate and assembly, legislation was not passed, owing to previously unexpected opposition from some Republican state senators. As a result, Governor Cuomo issued an executive order in April 2012, establishing a statewide exchange consistent with the requirements of the ACA.

Of the states that have not yet established an exchange, Virginia provides an interesting example of legal establishment authority. House Bill 2434 was signed into law by the governor in April 2011. This law expressed the intent to establish a state-based exchange, charging the Secretary of Health and Human Resources, in cooperation with the State Corporation Commission's Bureau of Insurance, the General Assembly, relevant experts, and stakeholders to "provide recommendations for consideration by the 2012 General Assembly regarding the structure and governance of the Health Benefit Exchange."[1] However, the legislation did not specifically establish the exchange. While the Virginia Health Reform Initiative's Advisory Council did make the requested set of recommendations, no exchange establishment legislation was brought to a vote in the state's legislature in 2012. The governor was clear that he

would not sign additional legislation prior to a Supreme Court decision being issued that upholds the ACA. There were many in the state who believed that the existing legislation was actually sufficient to begin exchange development. However, many design decisions, including the recommendations of the Advisory Council, could not be made without further action. While a special session of the legislature could be called in such an event, it is also possible that the governor would use an executive order to establish the exchange and make initial design decisions now that a Supreme Court decision has been issued.

GOVERNANCE

Governance of a health insurance exchange identifies where the exchange is institutionally located and delineates its decision-making structure. Three basic alternatives are available to states developing their own exchanges: a quasi-public entity, a non-profit organization, or a government agency. While there is no uniform definition of a quasi-public entity across all states, they can generally be thought of as organizations established by state law, usually overseen by a governing board appointed by the governor and/or legislature, and which operate with some degree of independence from the state. These entities usually have close working relationships with state agencies and will often be established using government funds, at least in part. Non-profit organizations are completely independent of government agencies and are also usually governed by a board of directors. The government agency approach establishes the exchange within either an existing or newly established arm of the state's executive or legislative branch. Each approach has advantages and disadvantages, as described below.

Consumer advocates and others often feel strongly that an exchange board should exclude those that could benefit financially, depending on how the exchange is run, such as those working for insurance carriers, insurance producers (brokers and agents), hospitals, physicians, other health care providers, and third party administrators.

The quasi-public governance approach provides greater flexibility to the exchange in areas such as hiring of personnel, salary levels, and procurement of outside services.[2] These entities generally are exempted from state requirements in these areas, which allows them to hire more quickly and potentially pay private sector salaries, attracting candidates with greater experience. They also can enter into contracts with outside vendors more quickly, as they are not held to the often onerous state procurement rules. While there tends to be frequent communication between quasi-public entities and government agencies, the quasi-public approach tends to provide leaders of these programs with greater political independence than those run directly out of government agencies. However, the quasi-public entities generally are required to meet state expectations for transparency of operations, with public board and advisory group meetings, and public release of reports. Quasi-public organizations can also be given rule-making (regulatory) authority by the state, as is the case with Massachusetts' Commonwealth Health Insurance Connector Authority and the Maryland Exchange Board.

Creating a quasi-public entity requires political support for the passage of legislation, however, which is challenging in many state political environments today. In addition, quasi-public entities are usually overseen by a board of trustees, and concerns about trustee conflict of interest can create contentious debates surrounding this governance approach. Consumer advocates and others often feel strongly that an exchange board should exclude those that could benefit financially, depending on how the exchange is run, such as those working for insurance carriers, insurance producers (brokers and agents), hospitals, physicians, other health care providers and third-party administrators. Conversely, insurance carriers, producers, and health care providers often feel just as strongly that their expertise and experience is precisely what is needed on exchange boards to best inform the decisions being made. Of the 10 states studied, Maryland, Oregon, and Colorado have opted for the quasi-governmental approach and recommendations for doing so have been made in Minnesota and Virginia. New York and Rhode Island seemed poised to do so as well, but were unable to follow through once their

state legislation failed. Thus, these two states will, at least initially, run their exchanges through government agencies.

The second governance option, development of a non-profit organization, likely leads to an exchange that has greater political independence than the quasi-public option, and has the same flexibility in hiring, salaries, and procurement as the quasi-public. However, non-profits do not have authority to issue state regulations, and may face greater communication challenges with state government agencies that will also play key roles in the implementation of the reforms in the ACA, since the non-profits are completely independent of state government. Non-profits are generally not bound by the same transparency and reporting requirements as quasi-public and state agencies, so they may develop less open and accessible processes than the other options. In addition, non-profits are also overseen by boards of trustees, meaning that they also face the challenges inherent in developing conflict of interest rules. Of the 10 states studied, New Mexico and Michigan appear to be headed toward the non-profit exchange route if they choose to develop their own exchanges.

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Finally, states can develop health insurance exchanges within existing government agencies or in new agencies of state government. This approach can be implemented relatively quickly and can be done by executive order. In at least some states, it is likely to be the only legal option available where the exchange is established through a governor's executive order. However, New Mexico is contemplating using an executive order to place its exchange in a non-profit entity—the New Mexico Health Insurance Alliance—a non-profit created by the state that has board members that are appointed by the governor. Exchanges run through a state agency must comply with state transparency guidelines, suggesting an open and publicly accessible administration. However, state procurement and hiring processes can be complex and time-consuming, slowing the exchange development and decision-making process in some areas, and rigid salary guidelines in some states may hamper the agency's ability to hire more experienced candidates for high-level exchange positions. In addition, as an agency of state government, an exchange could be perceived as political in nature as opposed to the other more independent options. Such a perception may compromise the exchange's ability to engender broad-based political support for its programs and goals.

Rhode Island has opted for a government agency-based exchange by necessity, as the exchange has been established by executive order. While the New York executive order did not specify the governance of the exchange, it is likely to be placed as a government agency due to the limited authority inherent in executive orders. Both states could move their exchanges into quasi-public or non-profit organizations if legislation is passed in the future.

As alluded to above, a number of the states studied faced challenges in establishing consensus between stakeholders, providers, and state agency staff on conflict of interest provisions for the exchange's governing or advisory board. In Oregon, consumer advocates and other community groups that tend to support their progressive state legislature strongly protested the inclusion of health insurance industry representatives on the exchange governance board. They expressed feeling alienated by the ultimate decision to allow, albeit restrictively, industry representatives to sit as voting members on the board. In contrast, Rhode Island's executive order outlined strict conflict of interest provisions for the board, barring the inclusion of any stakeholders who had a financial interest in the exchange, including insurance companies, brokers and health care providers. This decision, albeit different from the one made in Oregon, was met with a similar frustration from the excluded industry community who felt that their experience was essential to the operation of an effective exchange.

DESIGN DECISIONS

While legislative action and governance decisions determine control over the running of the exchange, the design decisions ultimately determine the nature of the exchange and *how* it will be run, delineating the exchange's role and impact on the state's insurance markets. Thus, design decisions often prove to be the most controversial aspects of exchange development in the states. States have considerable flexibility in design, providing space for state-based exchanges to reflect each state's particular health insurance culture and political climate within federal boundaries.

Several key design options available to states include (but are not limited to):

- Merging the nongroup and small-group markets for purposes of sharing health care risk. Merging these markets will tend to increase premiums in the small group market modestly and significantly decrease premiums in the nongroup market;[3]
- Setting the threshold size of employers in the small-group market between 50 and 100 workers prior to 2016, when all must be set at 100 by federal requirement. At the time that the employers of 50 to 100 workers are included in the small-group market, fully-insured non-grandfathered products sold to them must comply with the ACA's modified community rating rules, essential health benefit requirements, actuarial value tiers (bronze, silver, gold and platinum), as well as other small-group reforms;
- Having the exchange take an active purchasing or a passive purchasing role. The active approach authorizes an exchange to act on behalf of enrollees to deliver the insurance coverage that meets their needs. This can include, for example, allowing the exchange to set tougher participation rules for plans in the exchange, selectively contracting with qualified plans, and/or actively negotiating with exchange-based plans over price.[4] A passive exchange takes all eligible plans and does not act as an intermediary on behalf of participating consumers and small businesses;
- Choosing among the essential health benefit benchmark options.[5] This is a decision that affects all individual and small group plans in the state, not just those participating in exchanges. The federal bulletin on essential health benefits[6] provides each state with 10 possible benchmark plans for this purpose: the three largest enrollment plans in the state's small-group market, the largest three health benefit plans available to the state's employees, the three largest enrollment plans in the Federal Employee's Health Benefit Plan, and the largest commercial non-Medicaid health maintenance organization operating in the state. States also have the ability to allow plans to vary benefits around the chosen benchmark to some extent or to limit that variation further;
- Using state funds to further subsidize exchange plans. Some have expressed concern that federal subsidies for private coverage purchased in the nongroup exchanges may be insufficient to make coverage affordable for those with modest incomes. States could use their own funds to lower the costs further for some or all of those provided federal subsidies under the law;
- Eliminating or further tightening premium age rating bands beyond the federal maximums of 3:1[7] (e.g., requiring pure community rating or age-rating bands of no more than 2:1). Again, this is a decision that affects all small-group and nongroup plans in a state's market, not just those participating in the exchange. While the age-rating bands in the ACA will have the effect in many states of lowering premiums for older adults while increasing them for younger adults, some states already have tighter limits in place today (e.g., 2:1 in Massachusetts and 1:1 in New York), and other states may want to consider tighter bands within the reform context. Analysis has shown that doing so would not increase government costs or change the overall coverage effects of reform, but could significantly increase affordability of coverage for older adults while premium subsidies would play a major role in protecting affordability for younger adults;[8]
- Eliminating or further tightening premium variation by tobacco use. The ACA requires that the premium for a tobacco user be no more than 1.5 times that of a non-tobacco user of the same age for identical coverage. This decision affects all small-group and nongroup plans in a state's market as well. While some find tobacco-related premium variation attractive, others note that higher premiums are likely to dissuade significant numbers of lower-income

individuals from obtaining coverage under reform, since smoking is significantly more common among lower-than higher-income groups.[9] If federal regulations exclude the additional premium costs associated with smoking from the caps associated with the premium tax credits, for example, that will tend to increase the number of people who will not have affordable coverage (under the definition of the law) available to them, and enrollment in the nongroup exchange may be lower than would be the case otherwise;

As many of these design decisions can be politically divisive, many states have taken a moderate approach, so as to prevent any political ramifications that could impede the progress of exchange implementation.

- Delineating the level of employee plan choice in the Small Business Health Options Program (SHOP) exchange, or requiring additional SHOP participation requirements (e.g., requiring employers to make uniform contributions regardless of plan chosen by a worker in order to encourage cost-conscious decision-making). Employees highly value plan choice within exchanges, yet employers value the flexibility to set contribution levels for their workers' coverage. States have flexibility to design SHOP exchanges that emphasize various high-value options for workers and/or employers and that emphasize additional incentives for market competition;
- Implementing additional strategies for minimizing adverse selection in the exchange. Some, but not all rules that the ACA lays out for small-group and nongroup market insurers participating in the new exchanges apply to insurers selling coverage in the non-exchange small-group and nongroup markets. Some analysts are concerned that such differences could lead to adverse selection into the exchanges, not all of which could be compensated for through risk adjustment.[10] States have the ability to require that all the rules (or, some of the rules beyond the federal requirements) that apply to plans offering coverage inside the exchange apply to those offering small-group and nongroup coverage outside the exchange;
- Developing a basic health program (BHP) to provide coverage to otherwise exchange-based tax-credit-eligible individuals with incomes up to 200 percent of the federal poverty level. If a BHP is adopted, a state will receive 95 percent of what the federal government would have spent on tax credits and subsidies for out-of-pocket costs. The state would then cover BHP eligible individuals by contracting with health plans or providers. The coverage provided must, at a minimum, meet the ACA's essential health benefit requirements, and enrollees cannot be charged more than they would be if enrolling in exchange-based coverage. Many analysts believe that the BHP option has the potential to provide such low-income consumers with coverage that costs them less out-of-pocket than would exchange-based plans;[11]
- Creating a consumer outreach and assistance campaign, to educate state residents about the components of the ACA and to facilitate enrollment in insurance coverage;
- Developing an approach for collecting and managing data from health insurance plans, particularly to monitor and review qualified health plans participating in exchanges; and
- Development of a dissemination approach for providing health insurance plan comparison materials to consumers. The ACA requires states operating their own exchanges to provide consumers with easily understandable information to facilitate their choice of qualified health plan. States have considerable flexibility, however, in deciding just how these requirements will be satisfied.

As many of these design decisions can be politically divisive, many states have taken a moderate approach, so as to prevent any political ramifications that could impede the progress of exchange implementation. Maryland, for instance, first passed legislation establishing the exchange and its governance structure, delaying major design decisions pending further study and analysis.

Maryland's exchange commissioned a number of studies, which were reviewed and developed into a set of recommendations by the exchange's four advisory groups. These recommendations were then submitted to the Exchange Board, which debated them and then submitted its own recommendations to the legislature and the governor. Based upon that work, the governor

developed a slightly modified version to the state legislature as an administration bill which was adopted into law through the Maryland Health Benefit Exchange Act of 2012. The bill demonstrates the state's desire to avoid contentious political debates and mitigate initial market disruption by delaying the merger of the small-group and nongroup market, allowing the legislature to wait until September 30, 2012 to decide on essential health benefits, keeping the small-group employer definition at 50 until 2016, and maintaining flexibility in deciding whether to pursue an active or passive purchasing role for the exchange. While the 2012 legislation has allowed for further exploration into selective contracting, Maryland, along with Rhode Island, are the only states out of the 10 studied pursuing the possibility of an active purchaser exchange.

Ultimately, the Oregon Health Insurance Exchange Corporation identified employee choice with employer-defined contribution as the option that most clearly aligned the goals of the small business community and the exchange.

Oregon, like Maryland, is cautiously approaching exchange implementation, attempting to reduce market disruption as much as possible. Thus, the state has decided to delay the merging of the small-group and nongroup markets and has kept the small group employer definition at 50 until 2016. While the state has yet to decide on a benchmark plan for essential health benefits, a meeting will convene in August 2012, at which point the two state workgroups evaluating benchmark plans will adopt a joint benchmark recommendation draft which will then be sent to the governor for his final decision.

In February 2012, the Oregon Health Insurance Exchange Corporation (ORHIX) published a business plan, containing a few key decisions necessary for the design and operation of the state-based exchange. One such decision relates to employer contributions in the SHOP exchange. After deliberation and input from the small business community, employer flexibility and employee choice of plans emerged as clear priorities. The ORHIX explored four options for employer contributions and level of employee plan choice, including: restricting employer choice to a single plan for all their employees from among the array of SHOP options; allowing the employer to choose an insurance company but leave plan selection up to the employee; allowing the employer to choose a plan tier (bronze, silver, gold) and the employee to choose a plan within the tier; or allowing the employee to select between all companies and plans using their employer's defined contribution.[12] Ultimately, the ORHIX identified employee choice with employer-defined contribution as the option that most clearly aligned the goals of the small business community and the exchange. This approach provides workers with the full range of plan options—the design option they value highly, while allowing the employers to control the level of contributions they make toward coverage for their workers—the highest priority for the small employers. In conjunction with the Oregon Insurance Department, ORHIX plans to design an appropriate defined contribution model for the SHOP exchange.

Adverse selection is a situation where certain plans, or the exchange as a whole, enroll a pool of individuals that are higher cost than enrollees in other plans, or the non-exchange market as a whole, leading to higher premiums in those plans/markets. Reducing adverse selection and compensating plans negatively affected by it is another key element in designing a successful, sustainable exchange. State officials working to develop their own exchange must create a market environment that encourages carrier participation in the exchange, while simultaneously minimizing adverse selection.[13] For example, under the ACA, catastrophic plans will be available for purchase by individuals under the age of 30, a relatively healthy and thus attractive population for insurance carriers. Recognizing the potential adverse selection risks in allowing insurance plans to solely offer catastrophic coverage outside of the exchange,[14] the Maryland legislature mandated that all carriers offering such plans outside the exchange also offer them inside the exchange, providing balance to both markets. Facing a similar concern, Oregon chose a different strategy than Maryland. In Oregon, catastrophic coverage will only be available for purchase inside the exchange, promoting a robust exchange by attracting young healthy lives into the market. States continue to assess additional policies and design decision options that can level the playing field between the exchange and outside markets, ensuring the long-term viability of both.

While states are making progress, many essential design decisions have yet to be made in most of the states studied. These include: definition of essential health benefits, the decision to implement a basic health program, outlining a consumer outreach/assistance campaign, strategies to collect and manage data

from health insurance plans, and delineating plans for dissemination of plan comparison information to consumers. Decisions on essential health benefits and the basic health program are two examples of decisions that states reported delaying due to late or still unavailable guidance from the federal government.[15] Maryland and Oregon have made the most progress on many of the basic design features outlined above.

CONCLUSIONS

In the 10 states we studied, we found state policymakers, their staffs, stakeholders, and consumer advocates to be highly engaged in the health insurance exchange policy discussions and development processes. By all accounts, each state was making concerted efforts to engage with a broad-swath of stakeholder and consumer interests and allowing all perspectives to be heard. There was also a strong sense across the political spectrum that a state-run exchange was preferable to a federally run one. Even among those opposing the ACA, there was considerable consensus that, if the law was to be implemented, the state's specific interests would be best served if the exchange could be tailored to the state's preferences as much as possible. However, many state policy environments remain politically contentious, and progress in exchange development has been slow for some of them as a result.

States not achieving significant milestones by now—for example, contracting with an IT vendor to develop exchange and Medicaid information systems, establishing an exchange entity and hiring staff, creating a time-limited process for making central design decisions—are unlikely to be able to establish a state-based exchange by late 2013, when open enrollment for January 1, 2014 will begin. States taking the slower path can work in partnership with the federal government to establish a federally facilitated exchange, perhaps moving to a state run exchange in the future. Even working with the federal government to jointly establish an exchange, states will have an array of policy options that will allow them to tailor their exchanges to their culture and preferences.

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ENDNOTES

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12. Oregon Health Insurance Exchange Corporation. 2012. "Oregon Health Insurance Exchange Corporation Approved Business Plan," http://www.orhix.org/pdfs/orhix_approved_business_plan.pdf.
13. Adverse selection in the exchange would mean that the average health care costs associated with those enrolling in exchange-based coverage were higher than those enrolling in coverage through non-exchange plans.
14. If catastrophic coverage was only offered outside the exchange, young healthy individuals would gravitate to the outside market, leaving a sicker more costly population inside the exchange market.
15. While the federal government has issued a nonbinding bulleting on essential health benefits, actual regulatory guidance is still unavailable.