Ohio Legislative Service Commission

Bill Analysis

Ashley Blackburn

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(As Introduced)

Reps. Sears, Kunze

BILL SUMMARY

- Provides for the certification of navigators for the purpose of assisting individuals in purchasing health insurance through a health insurance exchange established under the Patient Protection and Affordable Care Act of 2010 (ACA).
- Enables both an individual that *is* licensed as an insurance agent and an individual that is *not* licensed as an insurance agent to be certified as a navigator.
- Prohibits an individual or entity from acting or holding itself out to be a navigator, or from receiving navigator funding from the state or an exchange unless certified as a navigator.
- Specifies eligibility requirements for navigators.
- Specifies navigator duties.
- Prescribes duties for the Superintendent of Insurance in relation to the certification of navigators.
- Specifies the disciplinary actions that the Superintendent can take against a navigator that commits a violation of the Insurance Law.
- Requires a health insurance exchange to maintain a list of the contact information of licensed insurance agents that are also certified as navigators.
- Requires a health insurance exchange to provide information on contacting both licensed and nonlicensed individuals or entities who are certified as navigators and operating in an individual's area to any individual seeking such information.

- Permits an individual to be considered an in-person assister only if the individual is a licensed insurance agent certified to sell insurance through an exchange or a certified navigator.

- Requires health insuring corporations to impose annual maximums on copayments, cost sharing, and deductibles of covered health care services in certain health plans.

- Requires an actuary who is a member of the American Academy of Actuaries and qualified to provide such certifications to demonstrate the total annual cost of providing a health care service for a health insuring corporation.

- Adds catastrophic-only plans, as defined by the ACA as a type of plan that is not subject to the bill's copayment, cost sharing, and deductible annual maximums.

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Overview

The bill provides for the certification and oversight of health exchange navigators. These navigators are an element of the health care reforms included in the Patient Protection and Affordable Care Act of 2010 (ACA). Navigators are individuals or entities charged with helping individuals obtain information on purchasing health

insurance through health care exchanges established under the ACA.[1] Entities that have regular access to groups of working individuals who might not be provided with insurance through an employer group plan, such as trade associations, chambers of commerce, or community organizations, are likely candidates for becoming navigators. Finally, the bill revises the laws regarding health insuring corporation copayments, cost sharing, and deductibles.

General navigator provisions

Authorized activities

The bill prohibits an individual or entity from acting or holding itself out to be a navigator, or from receiving navigator funding from the state or an exchange unless certified as a navigator.[2] The bill expressly authorizes certified navigators to do all of the following:

- Conduct public education activities to raise awareness of the availability of qualified health plans;
- Distribute fair and impartial general information concerning enrollment in all qualified health plans offered within the exchange and on the availability of the premium tax credits and cost sharing reductions under the ACA;
- Facilitate enrollment in qualified health plans, without suggesting that an individual select a particular plan;
- Provide referrals to appropriate state agencies for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan coverage;
- Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange.[3]

Prohibited activities

The bill prohibits a navigator from doing any of the following:

- Sell, solicit, or negotiate health insurance;

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[1] Department of Health and Human Services, *Final rule on the Establishment of Exchanges and Qualified Health Plans,* published March 27, 2012, p. 140.

[2] R.C. 3905.471(A).

[3] R.C. 3905.471(B).

- Provide advice concerning the substantive benefits, terms, and conditions of a particular health benefit plan or offer advice about which health benefit plan is better or worse or suitable for a particular individual or entity;

- Recommend a particular health plan or advise consumers about which health benefit plan to choose;

- Provide any information or services related to health benefit plans or other products not offered in the exchange.[4]

Eligibility requirements

Individuals

The bill outlines basic eligibility requirements for individuals seeking to be certified as a navigator or individuals working for an entity that is certified as a navigator. An individual, or an individual performing navigator duties on behalf of an organization serving as a navigator, must meet all of the following requirements:

- Is at least 18 years of age;

- Has completed and submitted an application and a disclosure form declaring that the statements made in the form are true, correct, and complete to the best of the applicant's knowledge and belief;

- Has successfully completed a criminal records check;

- Has successfully completed the navigator certification and training requirements adopted by the Superintendent;

- Has paid all associated fees.[5]

Under the bill, any fees collected in association with navigator certification are to be deposited in the Department of Insurance Operating Fund.[6] Also, the bill subjects navigators to Ohio Insurance Law, and any rules adopted pursuant to that Law, in so far as that Law is applicable.[7]

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[4] R.C. 3905.471(C).

[5] R.C. 3905.471(D).

[6] R.C. 3905.471(L).

[7] R.C. 3905.471(I).

Business entities

The bill also outlines eligibility requirements for a business entity that acts as a navigator, supervises the activities of individual navigators, or receives funding to provide navigator services. A business entity is required to obtain a navigator business entity certification. Any entity applying for a business entity certification must apply in a form specified, and provide any information required by, the Superintendent. The bill requires a business entity certified as a navigator to make available a list of all individual navigators that the business entity employs, supervises, or with which the business entity is affiliated, in a manner prescribed by the Superintendent.[8]

Responsibilities of the Superintendent of Insurance

The bill prescribes certain duties for the Superintendent of Insurance in relation to the certification of navigators. The bill requires the Superintendent to adopt rules to establish a certification and training program for a prospective navigator and the navigator's employees that includes screening via a criminal records check, initial and continuing education requirements, and an examination. The certification and training program is required to include training on compliance with the Health Insurance Portability and Accountability Act of 1996 (popularly known as HIPAA), training on ethics, and training on provisions of the ACA related to navigators and exchanges. Additionally, the Superintendent is required to develop a disclosure form by which a navigator may disclose any potential conflicts of interest and any other information the Superintendent considers pertinent. These duties must be performed prior to any exchange becoming operational in Ohio.[9]

Revocation of certification

The bill authorizes the Superintendent to examine and investigate the business affairs and records of any navigator. The Superintendent may suspend, revoke, or refuse to issue or renew the navigator certification of any person, or levy a civil penalty against any person, that has violated the requirements of the bill, or that has committed any act that would be a ground for the denial, suspension, or revocation of an insurance agent license. The bill requires the Superintendent to not certify as a navigator, or to revoke any existing navigator certification of, any person or entity that is receiving financial compensation, including monetary and in-kind compensation, gifts, or grants,

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[8] R.C. 3905.471(E).

[9] R.C. 3905.471(F).

on or after October 1, 2013, from an insurer offering a qualified health benefit plan through an exchange operating in Ohio. [10]

If the Superintendent finds that an individual navigator has violated the requirements of the bill with the knowledge of the employing or supervising entity, or that the employing or supervising entity should reasonably have been aware of the individual navigator's violation, and the violation was not reported to the Superintendent and no corrective action was undertaken on a timely basis, then the Superintendent may suspend, revoke, or refuse to renew the navigator certification of the supervising or employing entity. The Superintendent may also levy a civil penalty against such an entity.[11]

A business entity that terminates the employment, engagement, affiliation, or other relationship with an individual navigator must notify the Superintendent within 30 days following the effective date of the termination, using a format prescribed by the Superintendent, if the reason for termination would be grounds for termination of a licensed insurance agent, or the entity has knowledge that the navigator was found by a court or government body to have engaged in any prohibited activity relating to licensed insurance agents.[12]

Finally, the Superintendent may deny, suspend, approve, renew, or revoke the certification of a navigator if the Superintendent determines that doing so would be in the interest of Ohio insureds or the general public. These latter actions are not subject to the Administrative Procedure Act.[13]

The bill authorizes the Superintendent to adopt rules to implement the bill's provisions.[14]

Insurance agents receiving navigator certification

The bill provides for insurance agents to be certified as navigators. The bill requires agents seeking such certification to complete initial training related to the ACA and exchanges. The bill requires the Superintendent to adopt appropriate education requirements and specifies what must be included in these courses. Any course the

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[10] R.C. 3905.471(G).

[11] R.C. 3905.471(G).

[12] R.C. 3905.14 and 3905.471(H).

[13] R.C. 3905.471(J).

[14] R.C. 3905.471(K).

Superintendent approves must consist of topics related to insurance offered within an exchange, including (1) the levels of coverage provided in an exchange, (2) the eligibility requirements for individuals to purchase insurance through an exchange, (3) the eligibility requirements for employers to make insurance available to their employees through a SHOP program, (4) individual eligibility requirements for Medicaid, (5) the use of enrollment forms used in an exchange, and (6) any other topics as required by the Superintendent. The bill authorizes agents that complete this required training to receive continuing education course credit that is required under continuing law.[15]

Current list of licensed and unlicensed navigators

The bill requires the exchange to maintain a current list of licensed and nonlicensed navigators and their contact information. An exchange is required to make available to an individual, upon the individual's request, a list of navigators operating near the individual's residence. Also, any web site, software application, or other electronic medium, or an exchange-sanctioned outreach event that provides information related to the purchase of health insurance through an exchange must also provide information on how an individual can contact an individual or entity that is certified as a navigator.[16]

In-person assisters

Under the bill, an "in-person assister" is any entity or person that receives funding from the Centers for Medicare and Medicaid Services for the purpose of developing and operating an in-person assistance program within an exchange. In order to be an in-person assister, the individual must either be a licensed insurance agent certified to sell insurance through an exchange or a certified navigator.[17]

Plans offered through an exchange

The bill requires an exchange to permit an insurer to offer any health benefit plan that the insurer seeks to offer through the exchange, so long as the health benefit plan in question is a qualified health plan under the ACA, as determined by the Superintendent. This provision does not impose any additional state certification requirements in order to be a qualified health plan.[18]

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[15] R.C. 3905.47(A) to (C).

[16] R.C. 3905.473.

[17] R.C. 3905.01(D) and 3905.474.

[18] R.C. 3905.472.

Health insuring corporations: copayments, cost sharing, and deductibles

Under current law, copayments must be reasonable and must not be a barrier to the necessary utilization of services by enrollees in a health plan. The bill adds cost sharing and deductibles to this requirement.[19] Current law also authorizes, but does not require, a health insuring corporation to take certain actions in order to ensure that copayments are reasonable and not a barrier to the necessary use of basic health care services by enrollees in a health plan. The bill, however, requires a health insuring corporation to take certain steps to ensure not only reasonable copayments, but also reasonable cost sharing and deductibles.

Annual maximums under *current law*

Under current law, in order to ensure that copayments are reasonable a health insuring corporation may do one of the following:

(1) Impose copayment charges on any single covered basic health care service that did not exceed 40% of the average cost to the health insuring corporation of providing the service;

(2) Impose copayment charges that annually do not exceed 20% of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, when aggregated as to all persons covered under the filed product in question.

In addition, current law requires that annual copayment charges as to each enrollee must not exceed 20% of the total annual cost to the health insuring corporation of providing all covered basic health care services, including physician office visits, urgent care services, and emergency health services, as to such enrollee. Finally, current law prohibits a health insuring corporation from imposing, in any contract year, on any subscriber or enrollee in a health plan, copayments that exceed 200% of the average annual premium rate to the subscribers or enrollees. The bill eliminates these provisions.[20]

Annual maximums *under the bill*

Under the bill, in order to ensure that copayments, cost sharing, and deductibles are reasonable, a health insuring corporation is required to impose a limit on copayment charges, cost sharing, and deductible charges to a maximum 40% of the total

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[19] R.C. 1751.12(D)(1).

[20] R.C. 1751.12(D)(2) and (3).

annual cost to the health insuring corporation of providing all covered health care services applied to a standard population expected to be covered under the filed product in question.

Under continuing law, the total annual cost of providing a health care service is the cost to the health insuring corporation of providing the health care service to its enrollees less any applicable provider discount. The bill requires that total annual cost of providing a health care service to enrollees be demonstrated by an actuary who is a member of the American Academy of Actuaries and qualified to provide such certifications as described in the United States Qualification Standards promulgated by the American Academy of Actuaries pursuant to the code of professional conduct. [21]

Exclusions from annual maximums

The bill's annual maximums for copayments, cost sharing, and deductible charges do not apply to the following:

(1) High deductible health plans that are linked to a health savings account (under current law, the exclusion is limited to copayments);

(2) Catastrophic-only plans, as defined by the ACA and any related regulations, provided that such plans meet all applicable minimum federal requirements.[22]

Continuing law prohibits a health insuring corporation from imposing lifetime maximums on basic health care services. However, a health insuring corporation may establish a benefit limit for inpatient hospital services that are provided pursuant to a policy, contract, certificate, or agreement for supplemental health care services.[23]

Authorized higher charges for certain health plans

The bill authorizes the Superintendent to adopt rules allowing different copayment, cost sharing, and deductible amounts for plans with a medical savings account, health reimbursement arraignment, flexible spending account, or similar account. Under current law this authorization only applies to annual deductible amounts for these plans.

The bill also eliminates the authority of a health insuring corporation to require that an enrollee pay an annual deductible that does not exceed $1,000 per enrollee or

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[21] R.C. 1751.12(D)(2).

[22] R.C. 1751.12(D)(3).

[23] R.C. 1751.12(E).

$2,000 per family, except that a health insuring corporation may impose higher deductibles for high deductible health plans that are linked to health savings accounts.[24]

Under the bill, a health insuring corporation is authorized to impose higher copayment (as under current law), cost sharing, and deductible charges under health plans if requested by the group contract, policy, certificate, or agreement holder, or an individual seeking coverage under an individual health plan. As under current law for copayments, this may not be construed as requiring the health insuring corporation to create customized health plans for group contract holders or individuals.[25]

Definitions

The bill adds the following definitions to Ohio Insurance Law:

- "Affordable Care Act" means the "Patient Protection and Affordable Care Act," 124 Stat. 119, 42 U.S.C. 18031 (2011).

- "Navigator" means a person selected to perform the activities and duties identified in division (i) of section 1311 of the Affordable Care Act that is certified by the Superintendent under the provisions of the bill. Under that division, an entity that serves as a navigator must (1) conduct public education activities to raise awareness of the availability of qualified health plans, (2) distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits and cost-sharing reductions under the Affordable Care Act, (3) facilitate enrollment in qualified health plans, (4) provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under the federal Public Health Service Act or any other appropriate state agency or agencies, for any enrollee with a grievance, complaint, or question regarding the enrollee's health plan, coverage, or a determination under such plan or coverage, and (5) provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the exchange or exchanges.[26]

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[24] R.C. 1751.12(F).

[25] R.C. 1751.12(G).

[26] 42 U.S.C. 18031(i)(3).

- "Exchange" means a health benefit exchange established by Ohio or an exchange established by the United States Department of Health and Human Services in accordance with the Affordable Care Act.[27]

HISTORY

ACTION	DATE
Introduced	01-30-13

H0003-I-130/ejs

[27] R.C. 3905.01(A), (N), and (W).