



Report to the Community on the Implementation of the Patient Protection and Affordable Care Act in Ohio

Ohio Consumers for Health Coverage
March 23, 2011



Acknowledgements

This report was prepared by Kathleen Gmeiner, Project Director, Ohio Consumers for Health Coverage.



Ohio Consumers for Health Coverage is a nonpartisan coalition uniting the diverse consumer voice with the goal of achieving affordable, high quality care for all. Its leadership team includes AFSCME Council 8 AFL-CIO, American Cancer Society East Central Division, Faith Community Alliance of Greater Cincinnati, Legal Aid Society of Southwest Ohio, National Alliance for Mental Illness of Ohio, National Multiple Sclerosis Society Ohio Chapters, Ohio Alliance for Retired Americans, Ohio Asian American Coalition, Ohio Council of Churches, Progress Ohio, Service Employees International Union, Toledo Area Jobs with Justice Coalition, United Food and Commercial Workers Local 1059, UHCAN Ohio, and We Are The Uninsured.

Co-Chairs: Cathy Levine, Executive Director, UHCAN Ohio

Col Owens, Senior Attorney, Legal Aid of Southwest Ohio

Special thanks to the UHCAN Ohio Executive Director Cathy Levine, Deputy Director of Operations Nita Carter and Field Staff Gary Benjamin, Julia Bingman, and Donald Washington, all of whom wrote parts of this report and identified the special people who have shared their stories within the report. Special thanks to Pamela Whyte for photographic support and to Marie Curry, Beverly Johnson, and Col Owens for writing, feedback and editorial assistance.

Special thanks to UHCAN Ohio Communications Consultants Dawn Hanson (The Fairmount Group and Susan Jagers (Initiative Consulting) for assistance in report preparation and distribution.

Special thanks to our national partners, particularly Community Catalyst and Families USA who provide much of the factual analysis of the Affordable Care Act that informs this report.

We are grateful to Families USA, the George Fund Foundation, the Nathan Cummings Foundation, the Robert Wood Johnson Foundation, Mt. Sinai Health Care Foundation, and St. Luke's Foundation which fund UHCAN Ohio to carry out the important work of educating the community about the Affordable Care Act.



UHCAN Ohio staffs the Ohio Consumers for Health Coverage
Cathy Levine, Executive Director

www.ohioconsumersforhealth.org

c/o UHCAN Ohio 370 S. Fifth Street Columbus, OH 43215 614.456.0060

Table of Contents

	Page
Executive Summary.....	2
Introduction	3
1. The Affordable Care Act is Helping Ohio Families and Children	3
2. The Affordable Care Act Is Helping Ohioans with Disabilities and Those with Chronic Health Conditions.....	5
3. How the Affordable Care Act Is Helping Older Adults	7
4. How the ACA Helps Communities of Color in Ohio	8
5. How the Affordable Care Act Has Helped All of Us	9
6. How the Affordable Care Act Has Helped Small Business	10
7. How the Affordable Care Act is Helping Ohio Improve Quality and Lower Costs	10
8. Affordable Care Act Insurance Reforms	11
Creation of a Health Care Exchange (Marketplace).....	11
Keeping Premiums Under Control Through Medical Loss Ratio Requirements	12
Strengthening State Review of Insurance Company Rate Increase Requests	12
9. Providing Consumer Assistance	13
10. Efforts in Ohio to Repeal or Restrict ACA Implementation	13
Coming in the Future.....	14
Conclusion.....	15

Executive Summary

After one year many Ohioans are benefitting in significant ways from the Affordable Care Act (ACA).

- Young adult Ohioans are allowed to keep or obtain insurance coverage on their family plans. 35,000 Ohio young adults stand to benefit from the ACA.
- Insurance companies are prohibited from denying coverage to children with pre-existing conditions., but many Ohio companies and insurers across the nation dropped their “child-only” plans in the individual market after September 23, 2010 when the provision became effective.
- 1,100 persons are now enrolled in Ohio’s High Risk Pool (HRP), funded by the ACA. On April 1, 2011, HRP premiums will be lowered for new enrollees over age 55, and current age 55+ enrollees will see the change on September 1, 2011.
- Starting September 23, 2010, insurance companies may no longer impose lifetime dollar caps on enrollees.
- In 2010, nearly 110,000 Ohio Medicare beneficiaries received a \$250 rebate upon entering the Medicare Prescription Drug benefit coverage gap (the so-called “doughnut hole”). These same Ohioans stand to gain in 2011 by paying only 50 percent of the price of brand name drugs while in the coverage gap.
- Beginning January 2011, Medicare beneficiaries can receive wellness checks and other preventive care without a co-pay or deductible. As of February 23rd, 150,000 Ohio Medicare beneficiaries had received a wellness exam.
- Ohioans are preparing for community transformation grants created by the ACA which will become available through the Centers for Disease and Prevention later this year.
- An estimated 127,800 small businesses in Ohio are eligible for the ACA’s tax credit and of those, 38,900 are estimated to be eligible for the full credit. It is too early to tell how many Ohio small businesses are benefiting from this credit.
- Grants, matching funds and other resources now available will help the Kasich Administration enact its plan to transform Medicaid by shifting away from institutional care toward home and community-based care and moving toward higher quality care at lower costs.

INTRODUCTION

On March 23, 2010 President Barack Obama signed into law the Patient Protection and Affordable Care Act (ACA). This historic legislation builds on existing employer-based health coverage and brings greater limitations and accountability to insurance industry practices that have resulted in nearly 50 million Americans having no health coverage. It has added important new benefits and responsibilities for individuals, businesses, providers, and government.

A number of benefits became available to Ohioans during the ACA's first year.

- The Pre-existing Condition Insurance Plan (also known as the "Ohio High Risk Pool") came on line September 1, 2010.
- On September 23, 2010 a set of benefits became available, including coverage for young adults up to age 26 on their parents' insurance plans and the end to lifetime dollar caps on health insurance policies.
- On January 1, 2011 Medicare beneficiaries received more help from the ACA, as the Medicare Part D coverage gap began to close.

The biggest coverage expansions in the ACA will go into effect on January 1, 2014. These include the ban on insurance companies denying coverage to adults based on pre-existing conditions and the availability of subsidies to make insurance more affordable. At the same time, the requirement that individuals secure health coverage for themselves and their families, if they can afford it, will go into effect. A Medicaid expansion will bring health care to those with the lowest incomes. The expected impact will be coverage for up to 32 million Americans, including close to 1 million Ohioans.

This report examines the impact of the ACA on Ohio after one year. It features stories of Ohioans who are better off now than they were before the ACA was passed.

We want to thank those persons who have allowed us to share their stories and photos here. They are the real heroes of the ACA—those who have made their personal stories public so that others can learn about the benefits of this new law.

1. The Affordable Care Act is Helping Ohio Families and Children

Children

Under the Affordable Care Act, health insurance plans that cover children can no longer deny coverage to those under age 19 solely based on a pre-existing health condition. Diseases like asthma, juvenile diabetes, or cancer will no longer keep a child off his or her family's health policy. This law applies to employer health plans when they renew on or after September 23,

2010, as well as health insurance policies purchased in the individual market on or after September 23, 2010.

In response, many insurance companies dropped their “child only” policies, sold in the individual market. Children can get on a *family* policy purchased in the individual market. In 2014 when insurance companies can no longer exclude anyone—adults or children—for a pre-existing condition, this problem will go away.

Taylor’s Story



Taylor White is a pretty typical 13-year-old, but she has what is known as a pre-existing medical condition. When she was 6, Taylor’s parents, Terry and Kimberly White, took her to see a pediatric urologist after multiple urinary tract infections. She had corrective surgery.

Terry White owns his own construction company. At the time of the surgery, he had a family insurance plan through the individual market. The policy contained substantial cost-sharing, so the Whites paid over half of the surgical and related costs for Taylor’s surgery out of pocket.

Then Terry’s insurance premiums climbed, forcing him to drop that policy. However, he could not find family coverage in the individual market that would accept Taylor and, reluctantly, he purchased coverage for his wife, his son and himself that did not cover Taylor, then age 7. During the time Taylor lacked coverage, she went without recommended routine follow-up treatment that the Whites could not afford.

Eventually, Terry was able to purchase a group plan for his very small business so that Taylor could get covered. In July of 2010, Taylor had a kidney removed. In December of 2010 Terry began to look for a more affordable family policy in the individual market. Thanks to the Affordable Care Act, after September 23, 2010 insurance companies could not exclude children due to a pre-existing condition. Terry was successful in covering his whole family, including Taylor, at an affordable premium.

Young Adults

The Affordable Care Act is helping young adult Ohioans keep or obtain insurance coverage by requiring their parents’ plans to cover them up to age 26, if the plan offers dependent coverage. This applies regardless of the young adult’s marital status, where the young adult lives, whether or not he or she is a student or financially dependent on his/her parents. The federal law applies both to state regulated insurance plans *and* self-insured plans. This provision of the ACA took effect on September 23, 2010 for new plans and for other plans it takes effect at the next open enrollment period on or after September 23rd. This provision will

bring relief to roughly 35,500 young adults in Ohio.¹

As of July 1, 2010 Ohio law requires insurers to allow an employer to continue dependent coverage for young adults up to the age of 28, but with more restrictions than the ACA.

Terrance' Story

Cincinnati resident Terrance Smith, age 21, has juvenile diabetes which is controlled with medication. Terrance lives with his mother, Marian Black, and had coverage through her employer-sponsored insurance until he turned 18. Without continuing his schooling, Terrance lost access to his mother's coverage. Fortunately Terrance was able to get help for his diabetes treatment through the Bureau of Children with Medical Handicaps until he turned 21, in the middle of 2010. Since that time it has been a rocky road for Terrance and Marian. Terrance' medications cost about \$800/month. Marian has worked a lot of overtime trying to afford the medications that Terrance desperately needs.



Now that the Affordable Care Act has been passed, Marian will be able to add Terrance to her policy at the next open enrollment period. He will be able to stay on that policy until the age of 26. In 2014 Terrance will have options for affordable coverage, when the ACA's Exchange, subsidies, and Medicaid expansion go into effect.

2. The Affordable Care Act Is Helping Ohioans with Disabilities and Those with Chronic Health Conditions

Ohio's High Risk Pool

On September 1, 2010, Ohio's High Risk Pool (HRP) began covering Ohioans who have a pre-existing medical condition that excludes them or limits their opportunities to purchase health coverage. As of March 10, 2011 Ohio's HRP has 1,100 active enrollees. The HRP is operated by Medical Mutual of Ohio (MMO). The program is temporary and will end in 2014 when the Affordable Care Act's Health Care "Exchange" (marketplace) becomes available and insurance companies can no longer exclude those with pre-existing conditions.

To be eligible for the HRP a person must

- be a citizen of the U.S.,
- a resident of Ohio,
- have been without creditable insurance for six months, and
- have a pre-existing condition – either one on the HRP list, or have been turned down (or

¹ U.S. Census Bureau, Current Population Survey. Annual Social and Economic Supplements, March 2009; and 45 CFR Parts 144, 146, and 147. http://www.hhs.gov/ociio/regulations/pract_omnibus_final.pdf

offered limited coverage excluding the condition) by two insurance companies in the previous six months due to a pre-existing condition.

As of April 1, 2011 premiums range from a low of \$92/month for a four year old in the counties with lowest medical costs to \$458/month for a non-smoking 64 year old in the highest cost counties. This reflects a premium reduction of over \$100 per month from the previous rate of \$575 for an older adult in the highest cost counties. This reduced premium becomes effective for current enrollees over age 55 on September 1, 2011

Seventy-eight percent of those who apply for the HRP are accepted; the most frequent reason people are turned down is that they have not been without creditable coverage for six months. Sixty percent of enrollees are age 50 or older, although it is available to people of all ages.

Linda's Story



In October 2008, after working as an administrative assistant for 26 years for a major corporation, Linda Ellis of Lyndhurst, Ohio was laid off from her position at the age of 60. Under COBRA, Linda was able to continue her group health insurance coverage for up to 18 months.

Linda's husband is several years older than she and benefits from Medicare and Social Security. Linda needed insurance only for herself.

Linda has not been able to find full-time employment with benefits. Therefore, after her COBRA expired, Linda applied for health coverage through three private insurance carriers. Linda has acid reflux and diverticulosis. She also takes thyroid medication. All three companies denied her due to these pre-existing conditions.

After being denied private insurance coverage, Linda looked into Ohio's Open Enrollment carriers, only to discover that premiums ranged from \$800 to \$2,100 per month to cover one individual. Unable to afford the high premiums, Linda found herself – after 26 years with employer-sponsored coverage – uninsured.

About the time that Linda's COBRA coverage expired, she learned that Ohio would be creating a high risk pool under the Affordable Care Act. Six months after losing COBRA, Linda applied and was approved for the Ohio High Risk Pool. She will remain enrolled until her 65th birthday on January 5, 2013, when she will become eligible for Medicare.

While the monthly premiums are still high for her at \$575, Linda is able to pay for her insurance and medication to treat her pre-existing conditions. Without the ACA Linda would endure two more years without insurance to treat her current, and possibly, future health conditions.

3. How the Affordable Care Act Is Helping Older Adults

Adults over 65 generally receive their health care from Medicare, often supplemented by an additional insurance policy or Medicaid. There are 1.8 million Medicare beneficiaries in Ohio.

Many Medicare beneficiaries join Medicare Advantage Plans to avoid the necessity of purchasing a supplemental policy and many purchase prescription drugs through Medicare Part D. Part D requires a monthly premium and has an annual deductible. Once the deductible is satisfied, Part D pays about 75 percent of the cost of the beneficiary's medication – until the beneficiary has purchased medications that total \$2,840 during the calendar year. At that point the beneficiary hits the so-called “donut hole.” Until this year, beneficiaries in the donut hole have been required to pay the full price of their drugs. In 2010, the Affordable Care Act provided a \$250 subsidy to beneficiaries who reached the “donut hole” and 109,102 Ohioans were sent a \$250 check.² In 2011, those who reach the coverage gap will see a 50 percent reduction in the price of brand-name drugs and a 7 percent price reduction for generic drugs. By 2020 the coverage gap will close.

Starting January 1, 2011 Medicare began to pay for preventive services for beneficiaries without having to pay a co-pay or deductible. This includes such services as an annual wellness visit, mammograms, and colonoscopies.

Sue's Story

Sue Willis is the owner and operator of AXIS Center for Public Awareness in Columbus, Ohio. Armed with a master's degree and partnering with a commercial photographer, she provides public relations, marketing, and graphics services, going back to 1976.

Sue was born with brittle bone disease and used crutches until about six years ago, when she began using a wheelchair. Sue turned 65 in January 2010 and began receiving Medicare, with Part D paying for the modest prescriptions she needed.

Unfortunately, in the fall of 2010, Sue developed an antibiotic-resistant bacterial infection. After three rounds of unsuccessful treatment with a lower cost drug, Sue's doctor prescribed a medication that cost Sue over \$1,000. She found herself in the “donut hole,” the point at which Medicare Part D shifts the whole cost of the drug to the beneficiary.

When the infection returned on Christmas Eve, Sue's doctor renewed the prescription and increased the dosage. Imagine her surprise when, arriving at the pharmacy at 6 PM, she learned she must pay \$1853 for the medication! She needed the medication and did what others in her situation would do—put it on her credit card, and now is paying off that bill with interest.

² See www.healthcare.gov

If the Affordable Care Act provision that went into effect in January 2011 had been there earlier, Sue would be paying off about half that debt. As a homeowner with a disability, Sue has many extra expenses for services in her home and for adaptive devices that make it possible for her to work. To remain independent and live in her own home, Sue must be able to manage her prescription drug costs. Without the ACA Sue cannot afford to get sick.

4. How the ACA Helps Communities of Color in Ohio

Since African-American, Latino and other communities of color in Ohio suffer disproportionately from chronic health conditions, many of the changes highlighted in this report will help them. But no matter how much the ACA transforms the delivery of health care, communities of color will still face health disparities that result, in part, from living in “unhealthy” neighborhoods – lacking access to fresh foods, places to exercise, clean air to breathe, and other problems.

The Affordable Care Act (ACA) contains an innovative program to help local communities address racial and ethnic health disparities and reduce chronic diseases by promoting healthy living and tackling the social and economic causes of poor health. If implemented, the Community Transformation Grants (CTGs) provision will make available funding for community-based initiatives for the prevention of chronic disease. These grants will not only be available to health departments and other governmental entities, but to community-based organizations and coalitions. To obtain a CTG, community coalitions must define and develop a strategic plan to address community needs. Doing so requires communities of color to organize internally and partner with other entities, such as local health departments and hospitals, which can bring expertise and resources to the table.



UHCAN Ohio is hosting meetings around the state to bring together community organizations and leaders with local health departments and other interested entities to engage in planning and increase collaboration to address health disparities in preparation for the Community Transformation Grants.

Another provision of the ACA requires hospitals to conduct community needs assessments every three years, as part of their federal obligations to address unmet community health needs. In many metropolitan areas, hospitals are joining together to conduct one assessment. Representatives of underserved communities, including communities of color, should be invited to participate in planning, conducting and evaluating the community needs assessment.

Once communities and hospitals collaborate on a community needs assessment, they should then work together on strategies to address priority unmet community needs in a more

methodical way than exists today. Collaborations between hospitals, under-served communities, local health departments, the business community, and other public and private partners can go a long way toward reducing or eliminating the health disparities that plague communities of color.

5. How the Affordable Care Act Has Helped All of Us

Preventive Services

Starting September 23, 2010, “new” health care plans are required to offer preventive services without being subject to a deductible or co-pay. Plans that were first purchased after March 23, 2010 are “new” plans. Plans in place on March 23rd are “grandfathered” plans, until the plan makes changes that cause it to lose “grandfathered” status. The grandfathered plans are not required to offer preventive services free of co-pays and deductibles.

Lifetime Limits and Annual Restrictions

Lifetime dollar limits were also eliminated starting September 23, 2010. There are 6.7 million Ohioans with health coverage who do not have to worry that a future catastrophic illness will leave them uninsured and bankrupt.

Many insurance policies have an annual dollar limit on claims. After September 23rd these are tightly restricted for employer plans and new plans in the individual market. Annual dollar limits will be eliminated in 2014.

Rescissions Outlawed

While insurance policy rescissions are less common in Ohio than in other states, the Affordable Care Act makes it clear that insurance companies may only rescind a policy because of actual fraud. Insurance companies faced with large claims can no longer search through a patient’s medical records to find something an ordinary person would not have remembered or considered relevant, and use that as an excuse to terminate a policy.



Sharry’s Story

Sharry Carey is a retired internet technology support specialist living in Columbus, Ohio who has not yet reached Medicare age. She’s healthy and wants to stay that way, so preventive care is important to her.

Sharry was covered under COBRA for 18 months after her job was outsourced and she involuntarily retired. After COBRA expired she needed to find coverage in the individual market. To have an affordable premium Sharry bought a policy with a \$5,000 deductible. Sharry was very pleasantly surprised when she learned that her preventive visits would not be subject to the deductible or have a co-pay. Being on a limited income Sharry would have a very hard time affording her \$237 monthly premium and the cost of her annual mammogram and other preventive measures if she had to pay out of pocket.

6. How the Affordable Care Act Has Helped Small Business

The Affordable Care Act has provided targeted tax credits to small business, starting in 2010, to encourage them to purchase or retain employer-sponsored health insurance. A full (35 percent) or partial tax credit is available for employers with fewer than 25 full time equivalent employees and average wages less than \$50,000. Non-profits can claim up to a 25 percent credit.

On July 21, 2010 Families USA, a national health care reform advocacy group, released a report estimating 127,800 small businesses in Ohio would be eligible for the tax credit, and of those 38,900 would be eligible for the full credit. <http://www.familiesusa.org/assets/pdfs/health-reform/Helping-Small-Businesses.pdf> It is difficult to know how many Ohio businesses have claimed the credit because the 2010 tax year has just closed. There is still a need to educate small businesses and their tax preparers about the credit.

Anecdotal information suggests that the tax credit is encouraging small businesses to purchase health insurance for their employees. According to an LA Times article December 27, 2010, several major insurance companies saw a growth in sales of insurance to businesses with 2-50 employees. UnitedHealth Group Inc., the country's largest insurer, added 75,000 new customers who work for companies with fewer than 50 employees. <http://www.latimes.com/health/healthcare/la-fi-health-coverage-20101227,0,5024491.story>

For small businesses, a critical aspect of how well the ACA works for them will be whether the Health Care Benefits Exchange that will go into effect on January 1, 2014 is built in a way that makes it attractive to many small businesses. The Exchange (a virtual "marketplace" for buying insurance) offers an opportunity for small businesses to be part of a much larger pool, and should result in reducing the steep increases that small businesses experience when an employee becomes ill and files significant claims. (Read more about the Exchange in Section 8, below).

7. How the Affordable Care Act is Helping Ohio Improve Quality and Lower Costs

The Affordable Care Act contains many tools to improve the quality of health care and reduce health care costs. A major problem with health care today is fragmentation. Different providers often don't communicate or coordinate patient care and the system rewards volume of care instead of good patient outcomes. For older adults and people with chronic conditions, huge amounts of money are being spent while patients experience preventable hospitalizations, repeated tests, or avoidable nursing home stays. The ACA offers many tools to improve care coordination and promote better outcomes.

ACA cost and quality tools are extremely important to Ohio because health care spending is stressing our state's economy. Governor Kasich's Medicaid budget proposal for the next two

years, developed by the Office of Health Transformation (OHT), takes advantage of ACA tools to improve quality and reduce costs in Medicaid, Ohio's largest payer of health care. In its analysis of Medicaid spending, OHT found that just 4 percent of Medicaid recipients account for HALF of all Medicaid spending. Many of these are people with severe disabilities or multiple health conditions that are receiving appropriate medical care and assistance. But others – especially people who are on both Medicaid and Medicare (“dually eligible”) – receive fragmented care that hurts the person and wastes money. Here are a few examples of where the administration will use the ACA to improve care and lower costs:

- OHT submitted a proposal to the federal Center For Medicaid and Medicare Innovation for an ACA-related planning grant to improve care coordination, with a person-centered approach for Ohioans who are dually eligible or just on Medicaid and have serious long term care needs (often as a result of serious mental illness).
- Ohio's budget proposes to draw down federal ACA matching funds to expand “health homes” for Ohioans on Medicaid with serious chronic conditions. For every \$10 of state funds, the federal government will pay \$90 for coordination and other services.
- For 37,544 disabled children on Medicaid, OHT plans to improve care coordination by encouraging the development of pediatric Accountable Care Organizations, a new model of care in the ACA in which groups of providers work together to improve the quality of care they deliver to beneficiaries.

The ACA tools promise to help Ohioans improve the patient experience and health outcomes, while lowering costs. But these changes also carry a risk of unintended consequences to consumers, such as reduced choice of provider or setting, or going without needed services resulting in poor outcomes. Therefore, the participation of organized consumers in the design of new models of care is critical. And, in designing new models, we must build on what is already working well for Ohio's Medicaid consumers.

8. Affordable Care Act Insurance Reforms

Creation of a Health Care Exchange (Marketplace)

The Affordable Care Act created the Health Benefits Exchange as a marketplace where individuals and small businesses can purchase qualified health plans as part of a larger pool of people/businesses. This will allow them to secure a more affordable premium than in today's individual and small group market. This marketplace will become available in 2014, but preparations for the exchange/marketplace began in Ohio shortly after the ACA was passed.

The Center for Consumer Information and Insurance Oversight (CCIIO), has been charged with assisting states to set up an Exchange. In September 2010 the Ohio Department of Insurance

was awarded \$1 million by CCIIO to begin the planning of the Exchange. With these funds Ohio committed to

- Coordinate public and stakeholders through a specially constituted task force.
- Inform Ohioans of Exchange planning activities through public notices and Ohio's health reform website.
- Conduct market analysis, modeling Ohio's public programs and private insurance markets to provide projections and analysis necessary for planning and implementing an Exchange.³

In October 2010 the Health Benefits Exchange Task Force was created within the prior Administration's Health Care Coverage and Quality Council to provide stakeholder input into the planning. This group reached consensus that Ohio should operate its own Exchange and established a vision, mission and four guiding principles. The guiding principles spoke to the need for an adequate network of providers, sustainability, ease of direct enrollment into the Exchange and continuity of coverage, particularly between Medicaid and the Exchange.

The Kasich Administration is moving forward on planning for the Exchange. ODI plans to apply for a grant to further its planning activities. The Department is working to gather necessary data to predict the health insurance market in 2014 when the Exchange will be operational. Legislation will be required to enact the Exchange. It is expected that the Kasich Administration will submit legislation to the Ohio Generally Assembly in 2011.

Keeping Premiums Under Control Through Medical Loss Ratio Requirements

The Affordable Care Act requires that insurance companies spend 80 percent of the premium dollar of small groups or individual policies on medical claims, and 85 percent of large group premiums on medical claims. The remainder may be spent on administrative expenses including profit. The Secretary of Health and Human Services has already issued regulations that define costs to be included as medical, and those that must count be counted as administrative. Beginning in 2012, insurance companies that do not meet the MLR requirements must pay rebates to their policy holders or employers that paid for the policies.

The ACA also demands greater transparency for consumers by requiring insurance companies to disclose how they spend premium dollars. Consumers will be able to see how much insurance companies are spending on medical claims, as well as on executive compensation, underwriting, marking, surplus, and other expenses.

Strengthening State Review of Insurance Company Rate Increase Requests

In December 2010 the Office of Consumer Information and Insurance Oversight (now the Centers for CIIO) proposed regulations to implement the Affordable Care Act's requirement that the Secretary of Health and Human Services establish a process for the annual review of

³ See www.healthcare.gov

“unreasonable” increases in health insurance premiums. If these regulations are finalized health insurance companies will be required to submit a justification to the U.S. Department of Health and Human Services for rate increase requests that meet or exceed a specified threshold. Ten percent is the recommended threshold in the proposed regulations. The justification and that final disposition will be placed on the HHS web site.

On August 16, 2010 HHS awarded Ohio a \$1 million grant to expand its rate review capacity. Ohio committed in its application that the grant funding will be used to hire additional staff for rate review and to upgrade Ohio’s processes, systems and data analysis capabilities. Ohio also committed to develop a consumer-friendly web application on its web site.

Consumers seek transparency in rate review increases, want consumers to get notice of filed rate increase requests, and want an opportunity to be heard on the proposed rate increase.

9. Providing Consumer Assistance

The Affordable Care Act provided \$29 million in grants to support states in their efforts to help consumers benefit from the Affordable Care Act. In October 2010 Ohio’s Department of Insurance was awarded a grant of \$1.1 million, to expand services to help Ohioans enroll in new programs made available by the Affordable Care Act, to pursue complaints and appeals of insurance decisions and to help uninsured consumers. See http://www.healthcare.gov/news/factsheets/capgrants_states.html#oh

At the point of application it was ODI’s intent to engage consumer advocacy groups in the provision of services and a contract to effectuate that intent was signed in December 2010.⁴ After the transition of state government following the election, the decision was made by the Department of Insurance that it could not carry out the deliverables required by the contract in the time allowed. ODI canceled its contract with its primary consumer partner in March 2011, and is returning the \$1.1 million to HHS. However, ODI has affirmed its commitment to assist consumers and intends to avail itself of upcoming opportunities to apply for consumer assistance program dollars.

10. Efforts in Ohio to Repeal or Restrict ACA Implementation

Legislative Action

Two bills and a joint resolution have been introduced in the Ohio House that would repeal or restrict aspects of the Affordable Care Act.

- HJR2 proposes to enact Section 21 of Article I of the Constitution of the State of Ohio to preserve the freedom of Ohioans to choose their health care and health care coverage.
- HB 11 would require the Kasich administration to justify to the Legislature each step of the ACA implementation.

⁴ UHCAN Ohio was a subcontractor in this program.

- HB 85 would prohibit requiring an individual to obtain or maintain health insurance.

The House bills have been assigned to the House Health and Aging Committee. A hearing for all testimony and a vote on HJR2 is scheduled for March 23, 2011.

The Senate's SJR1 also proposes to enact a constitutional amendment to Article 1.

Ballot Initiative

A petition campaign is underway to secure a constitutional amendment called the *Preservation of the Freedom to Choose Health Care and Health Care Coverage Amendment*. It is led by the Ohio Liberty Council. 385,425 valid signatures of registered voter are required to place this petition on the statewide ballot.

Litigation

On January 10, 2011 Attorney General Mike DeWine authorized the Attorney General of Florida to add Ohio to the lawsuit by 26 Attorneys General to declare the Affordable Care Act unconstitutional. On January 31, 2011 Florida District Judge Roger Vinson found the Affordable Care Act unconstitutional, and stayed his action while an expedited appeal is taken to the 11th Circuit Court of Appeals.

In other federal litigation where the merits of the Affordable Care Act's constitutionality have been reached, three have found the ACA to be constitutional (Eastern District of Michigan; District Court of the District of Columbia and the Western District of Virginia). One other court besides Florida found the individual responsibility provision to be unconstitutional. (Eastern District of Virginia). There has been one federal court challenge to the ACA in Ohio; federal litigation in the Northern District of Ohio was dismissed by Judge David Dowd, and is being appealed. It is anticipated that in the end the Supreme Court will render a decision on the constitutionality of the ACA.

Coming in the Future

The ACA Can Help Ohio to Balance Long Term Care

The Affordable Care Act provided states with incentives to shift the distribution of long term care toward home and community based services and away from institutional care. In Governor Kasich's proposed Fiscal Year 2012-13 budget, the Ohio Office of Health Transformation states the goal of transforming Medicaid by making a shift towards great utilization of home and community-based services. The ACA provides important tools to make progress toward this end. The *Balancing Incentive Payment Program* pays a higher Medicaid match rate to states that commit to expanding home and community-based services. The *Money Follows the Person* (MFP) is a five year demonstration program that began in 2008 to transition a projected 2,200 Ohioans from institutions to home and community-based settings. The Affordable Care Act extends the MFP project funding another 5 years. It has also changed the institutional residency

requirement from 6 months to 3 months. Ohio's MFP project is called Home Choice.

The ACA Will Extend the Availability of Coverage to Over a Million Ohioans

In 2014 the Affordable Care Act will prohibit insurance companies from excluding people with pre-existing conditions from coverage. Medicaid will be expanded to cover all adults with incomes up to 138 percent of the Federal Poverty Level, even if they no longer care for children. Subsidies will be available for people with incomes up to 400 percent of the Federal Poverty Level to help them afford health insurance in the Exchange.

According to the most recent Ohio Family Health Survey there are 1.5 million uninsured Ohioans. For these Ohioans 2014 cannot come soon enough.

Conclusion

The Affordable Care Act is already helping many Ohioans to obtain more affordable health coverage. It is important that all of us protect the Affordable Care Act and that Ohio take full advantage of all its opportunities so that all Ohioans have secure health coverage.
