FLORIDA CENTER FOR FISCAL AND ECONOMIC POLICY

Issue Brief **June 2013**

Uncovering Coverage Opportunities: Florida's Health Insurance Marketplace

Beginning October 1, 2013, millions of Floridians who are uninsured - or who are insured but have inadequate or unaffordable coverage[1] - will be able to purchase a health plan through the new Health Insurance Marketplace established by the federal Patient Protection and Affordable Care Act (ACA). Although Congress passed the ACA in 2010, almost three and a half years will have elapsed by the time Floridians are able to access this Marketplace (sometimes referred to by its former designation, the Exchange). An extended initial "open enrollment" period will run through March 31, 2014, but coverage can take effect as early as January 1, along with numerous new consumer protections that will apply to that coverage.

Although a number of details remain unclear about Florida's Marketplace and the specific plan offerings to be made available to consumers there, the bottom line is that many more Floridians will be able to get and keep quality, affordable health insurance coverage than ever before. This is particularly the case for low- and middle-income Floridians, many of whom can qualify for federal subsidies that lower premiums and out-of-pocket costs, but also for those with pre-existing medical conditions or who have lost access to coverage through an employer. However, despite the scope of this coverage expansion, the Florida Legislature's decision not to implement another key ACA initiative - the expansion of Medicaid - leaves uninsured Floridians below the poverty line without access to coverage. This brief aims to shed some light on these new coverage opportunities and challenges, and to illustrate the impact on consumers.

Many more Floridians will be able to get and keep quality, affordable health insurance coverage than ever before. This is particularly the case for low- and middle-income Floridians, many of whom can qualify for federal subsidies that lower premiums and out-of-pocket costs, but also for those with pre-existing medical conditions or who have lost access to coverage through an employer. However, the Florida Legislature's decision not to implement another key ACA initiative - the expansion of Medicaid - leaves uninsured Floridians below the poverty line without access to coverage.

Florida's Health Insurance Marketplace

The Marketplace serving Florida in 2014 will be "federally facilitated", which means that all aspects of

Marketplace administration will be overseen by the federal Department of Health and Human Services, as contrasted with purely "state-based" or hybrid "partnership" Marketplace models. The ACA gave states first right of refusal to run their own Marketplaces. The Florida Legislature formally elected to default to a federally facilitated Marketplace during its 2013 regular session.[2] However, because Florida's elected leaders declined to take any steps to implement the law for almost three years, the decision was in effect made long before then.[3]

Marketplace administration will be overseen by the federal Department of Health and Human Services, as contrasted with purely "state-based" or hybrid "partnership" Marketplace models. The ACA gave states first right of refusal to run their own Marketplaces. The Florida Legislature formally elected to default to a federally facilitated Marketplace during its 2013 regular session.

The 2013 Legislature also took additional steps to evade conforming state law to the ACA as well as avoid any direct involvement with the Marketplace. Senate Bill 1842[4] prohibits Florida's Office of Insurance Regulation (OIR) from enforcing the health insurance regulation-related provisions of the ACA, despite OIR's long history of effectively regulating the business of health insurance in Florida and the ACA's clear intent to empower states to continue their primary role in such regulation. Senate Bill 1842 not only stripped OIR of its authority to reject proposed policy forms (documents used to define an insurance policy, particularly including covered benefits and associated exclusions and conditions) for non-grandfathered** plans, but also of its authority to review proposed rates for those plans, at least for plan years 2014 and 2015.

** - "Non-grandfathered" is ACA terminology referring to plans that are new or significantly modified subsequent to the passage of the ACA, making them subject to all of the relevant provisions of the new law. A "grandfathered" plan, by contrast, is exempt from many (but not all) of the new requirements.

The ACA's most significant changes are to non-grandfathered plans purchased in the individual (self-purchased coverage) and small group (employers with 50 or fewer employees[5]) markets. The Marketplace itself actually consists of both an individual market and a small group market component: the individual Marketplace and the Small-Business Health Options Program ("SHOP") Marketplace.

Qualified Health Plans (and Coverage Generally Under the ACA)

The focus of this brief is the individual Marketplace (referred to hereafter simply as the Marketplace). The Marketplace is distinct from the rest of Florida's individual health insurance market in a number of important ways. First, in Florida's case, as noted above, the Marketplace will be federally facilitated and regulated. Second, only "Qualified Health Plans" (QHPs) that are certified by the Marketplace as meeting specific standards can be offered to consumers. Finally, and perhaps most importantly, low- and middle-income consumers can only access the Advance Premium Tax Credits that will lower monthly premiums and Cost-Sharing Reductions that will lower out-of-pocket costs through the Marketplace.

To obtain coverage through the Marketplace, consumers will need to undertake the potentially complicated task of comparing a number of plan options (although Marketplace-supplied outreach personnel called navigators will be made available to assist consumers). The price (i.e., monthly premium payment) is often the most scrutinized aspect of a plan, but meaningful plan selection requires consideration not only of premiums but of at least two other factors as well: the benefit package and cost-sharing (out-of-pocket cost) requirements.

In order to be certified by the Marketplace as a QHP (in fact, for any non-grandfathered plan to be considered coverage in either the individual or small group markets starting in 2014), a plan must meet two interconnected minimum standards for benefits and cost-sharing.[6] First, a QHP must offer a comprehensive benefit package, and second, it must reasonably limit the amount of required out-of-pocket costs, including deductibles, coinsurance and co-pays, that plan enrollees must pay. More specifically:

Under the ACA starting in 2014, consumers purchasing non-grandfathered plan can be assured that their coverage is meaningful and comprehensive, and the likelihood that they will be devastated or bankrupted by health care costs is significantly reduced. Nevertheless, low- and middle-income Floridians are likely to find that their premium and cost-sharing requirements remain out of reach without the use of ACA-provided subsidies.

- The benefit package for QHPs in the Marketplace will be Florida's **Essential Health Benefits** (EHB) package[7] (or a limited variation thereof.) The Essential Health Benefits package includes ten different categories of benefits (such as prescription drugs, hospitalization and mental health/substance abuse treatment). The intent is that the EHB package will be comparable to typical employer-based coverage, yet stronger in a number of important ways.

- With respect to cost-sharing, QHPs must have an **"actuarial value"** of at least 60 percent. The actuarial value of a plan is simply the percentage of the *total* cost of covered services (in this case, the Essential Health Benefits package) expected to be used by an average enrollee for which the plan (and not the enrollee) will pay. Actuarial value is based on an average across all plan enrollees, and is not calculated on an individual basis. An actuarial value of 60% means that the insurer will pay 60% of the total cost of care for an average enrollee, and that the enrollee will pay 40%. Unfortunately, actuarial value cannot easily be described in terms of dollar amounts, as there are an almost unlimited number of possible configurations of deductibles, coinsurance and co-pay requirements that correspond to the same actuarial value. This will be illustrated further below.

All QHPs will provide Essential Health Benefits. However, QHPs will be divided into four different levels - referred to as "metal levels" or "tiers" - where each level has a different actuarial value[8]: Bronze (60%), Silver (70%), Gold (80%), and Platinum (90%). (Consumers under age 30 will have access to Catastrophic plans.) Plans with higher actuarial values will require higher premium payments to offset the lower out-of-pocket costs, as illustrated in the example provided in Table 2 below.

Furthermore, a plan's actuarial value is not the only aspect of a plan that affects how much a QHP enrollee will be required to pay out of pocket. Separate from but related to the actuarial value of a plan and its associated out-of-pocket requirements, the ACA also imposes a cap on *total* out-of pocket costs. The cap for 2014 will be $6,400 for individual coverage and $12,800 for family coverage. [9]

Under the ACA starting in 2014, consumers purchasing non-grandfathered plan can be assured that their coverage is meaningful and comprehensive, and the likelihood that they will be devastated or bankrupted by health care costs is significantly reduced. Nevertheless, low- and middle-income Floridians are likely to find that their premium and cost-sharing requirements remain out of reach without the use of ACA-provided subsidies.

Making QHP Coverage Affordable: Advance Premium Tax Credits and Cost-Sharing Reductions

The two ACA mechanisms specifically created to reduce the financial burden of getting and keeping quality coverage for moderate-income and some low-income consumers (Advance Premium Tax Credits and Cost-Sharing Reductions) can be accessed only through the Marketplace. More specifically, Advanced Premium Tax Credits will only be available to consumers purchasing coverage at the Silver plan level or higher[10], and Cost-Sharing Reductions are only available in conjunction with a Silver plan. Thus, although unsubsidized Bronze plan premiums will be lowest among all metal levels, low- and middle-income consumers will likely fare far better with Silver plan coverage.

Advance Premium Tax Credits will be provided using a piecewise[11] sliding scale[12] based on income. These refundable tax credits will be available to consumers with family incomes between 100 and 400 percent of the federal poverty level. At the lower end of this range (100-150% of poverty), an individual[13] will pay 2% of family income for premiums (for a Silver plan), regardless of the unsubsidized premium amount. At the upper end (300-400% of poverty), he or she would pay 9.5% of income. Table 1 below summarizes the sliding scale and the specific income ranges that correspond to its various pieces:

Table 1 – Sliding Scale for Advance Premium Tax Credits Available in the Marketplace

Income Range (as % of Projected 2014 Poverty Level)	Income Range (Annual, for an individual)		Income Range (Annual, for a family of 3)		Premium Payment[a] (as % of Income)	
	Low	High	Low	High	Low	High
Below 100%	Less than $11,750		Less than $20,000		N/A (Ineligible[b])	
100% to 133%	$11,750	$15,628	$20,000	$26,667	2%	
>133%[c] to 150%	$15,629	$17,625	$26,668	$30,000	3%	4%
150% to 200%	$17,625	$23,500	$30,000	$40,000	4%	6.3%
200% to 250%	$23,500	$29,375	$40,000	$50,000	6.3%	8.05%
250% to 300%	$29,375	$35,250	$50,000	$60,000	8.05%	9.5%
300% to 400%	$35,250	$47,000	$60,000	$80,000	9.5%	
Above 400%	More than $47,000		More than $80,000		N/A (Ineligible[d])	

Notes:

a) The amount of the tax credit will be based on the second-lowest cost Silver level plan available.
b) The only individuals with income below 100% of poverty who can qualify for Advance Premium Tax Credits are lawfully residing immigrants who have been in the U.S. less than five years.
c) The sliding scale for Advanced Premium Tax Credits is continuous (no breaks or jumps) across all incomes between 100% and 400% of poverty, EXCEPT at 133% of poverty, where the premium jumps from 2% to 3% of income.
d) Individuals with incomes above 400% of poverty may purchase coverage through the Marketplace. That coverage will be unsubsidized (i.e., enrollees will pay the full premium amount), however.

With regard to Cost-Sharing Reductions, Silver plan (actuarial value of 70%) enrollees with family incomes between 100 and 250 percent of the poverty level will have reduced out-of-pocket costs. Like Advance Premium Tax Credits, Cost-Sharing Reduction subsidies will be provided along a sliding scale, albeit a simpler one. The reduction in out-of-pocket costs is measured in terms of an increase in the plan's actuarial value, the. For consumers with family incomes between 200 and 250 percent of poverty, the impact is limited, with actuarial value increasing to just 73% (i.e., the average enrollee still pays 27% of the total cost of care). By contrast, for enrollees just above the poverty line (100 to 150 percent of poverty), the plan's actuarial value must be increased to 94%. A reduction in the cap on total out-of-pocket costs also applies.[14]

Impact of Advance Premium Tax Credits and Cost-Sharing Reductions on Consumers: An Example

Official details about the QHPs certified for sale in Florida's Marketplace will likely not be available until the open enrollment period begins October 1. However, despite the fact that Office of Insurance Regulation will not be regulating these plans, insurers will still be required to file their policy forms and rates with OIR.[15] A recent query of filings[16] revealed that 11 insurers[17] had submitted forms and/or rates indicating their potential interest in offering QHPs in Florida's Marketplace.[18] Unfortunately, most declined to publish their rates and in some cases even their policy forms by asserting that those materials are "trade secrets."

Despite those limitations, this brief examines, for the sake of illustration only, the premiums and out-of-pocket costs as proposed by one of the few insurers for which relatively complete information was made available through the OIR insurer filing system. However, **the example provided below is not appropriate for use by consumers for plan comparison or selection purposes of any kind**, and the name of the insurer's identity has been withheld for that reason.

A. Unsubsidized QHP Premiums and Out-of-Pocket Costs

Table 2 below summarizes the 2014 QHP options[19] proposed by the example insurer for the Marketplace as filed with OIR in May 2013. Figures shown below pertain to a non-tobacco user residing in Miami-Dade or Broward County.[20] These are base rates that do not reflect the availability of any subsidy whatsoever to the enrollee. As such, the premiums and out-of-pocket costs for the Silver-level plan, which can be subsidized by Advanced Premium Tax Credits and Cost-Sharing Reductions, are higher than what many individuals would pay.

Table 2 – Example of Proposed Base (Unsubsidized) Premiums & Out-of-Pocket Costs in Florida's Marketplace												
Plan "Metal" Level	Premium (with no Advance Premium Tax Credits)				Maximum Out-of-Pocket Costs[a]	Out-of-Pocket Costs[21] (with no Cost-Sharing Reductions)						
						Deductible[b]		Co-Insurance	Co-Pays			
	Age 30	Age 40	Age 50	Age 60		Medical Care	Rx Drugs		Primary Care Visit	ER Visit	Rx Drugs[c]	
Gold	$322	$363	$507	$770	$6,400	$250	$0	20%	$20	$250	$20/50	
Silver	$295	$332	$464	$705	$6,400	$1,700	$200	30%	$40	$250	$20/55	
Bronze	$234	$264	$368	$560	$6,400	$4,000	$300	30%	$45	$300	$20/75	

Notes:

a) In 2014 only, some plans will be permitted to impose a separate out-of-pocket cap on pharmacy benefits. The example plan does not appear to impose such a separate out-of-pocket cap.

b) Equal deductible amounts are not necessarily equal in the financial burden they impose. Case in point, in the example, the medical deductible applies only to inpatient and outpatient facility services under the Silver and Gold plans, but it applies to all medical services (excluding the first three office visits) under the Bronze plan.

c) The first amount shown is the co-pay for plan-approved generic drugs; the second amount is the co-pay for plan-approved, preferred brand-name drugs.

B. Total Cost of Coverage (Premiums and Out-of-Pocket Costs) for "Average" Enrollee: By Income

Table 3 below illustrates the dramatic effect that the availability of Advance Premium Tax Credits and Cost-Sharing Reductions can have on the total cost of coverage. For the example Silver plan, two different scenarios related to out-of-pocket costs are presented. The first scenario depicts the expected cost incurred by an "average" plan enrollee. (Note: Because the sickest enrollees use disproportionate amounts of care, the majority of plan enrollees will have out-of-pocket costs that are lower than the overall average.) The second scenario depicts the maximum possible out-of-pocket cost that any enrollee could incur.

Table 3 – Example Monthly Premium & Out-of-Pocket Costs for Silver Plan Enrollee: "Average" and Maximum Scenarios (using Advance Premium Tax Credits and Cost-Sharing Reductions) – Based on a Family of 3									
% of Projected 2014 Poverty Level	Annual (Family) Income	Monthly Income (A)	Monthly Premium (B)	"Average" Enrollee			Maximum Possible		
				Monthly[a] Out-of-Pocket Costs (C)	Monthly Premium +Out-of-Pocket Costs (B)+(C)	Total % of Income (B)+(C)÷(A)	Monthly[a] Out-of-Pocket Costs (D)	Monthly Premium + Out-of-Pocket Costs (B)+(D)	Total % of Income (B)+(D)÷(A)
125%	$25,000	$2,080	$42	$41	$83	4%	$188	$230	11%
175%	$35,000	$2,920	$150	$87	$237	8%	$188	$338	12%
225%	$45,000	$3,750	$269	$184	$453	12%	$433	$722	19%
275%[b]	$55,000	$4,580	$390	$221	$611	13%	$533	$923	20%
325%	$65,000	$5,420	$390	$221	$611	11%	$533	$923	17%
> 400%[c]	>$80,000	$ 6,670	$390	$221	$611	9%	$533	$923	14%

Notes:

a) "Monthly" out-of-pocket costs are calculated as the expected annual total divided by 12. However, out-of-pocket costs almost certainly will not be distributed uniformly over the course of the year. For example,

deductibles must be fully met before certain costs are covered by the plan, and so out-of-pocket costs are often higher during the first part of the year.

b) An enrollee with family income greater than 250% of poverty does not qualify for Cost-Sharing Reductions and so must pay full out-of-pocket costs.

c) An enrollee with family income greater than 400% of poverty does not qualify for Advanced Premium Tax Credits and so pay full premiums.

Most importantly, as the above example illustrates, if an enrollee receives Advance Premium Tax Credits or Cost-Sharing Reductions, premium payments and maximum out-of-pocket costs, respectively, are determined by the individual's income, *not* the cost of the plan itself.

C. Premium Payments: By Age and Income

Table 4 below shows the projected monthly premiums to be paid by Silver plan enrollees across various income and age levels in 2014, using Advance Premium Tax Credits as applicable, except that the premiums shown in the shaded cells would not be subsidized and so correspond only to the example Silver plan. For example, the monthly premium for an enrollee age 40[22] without access to Advance Premium Tax Credits would be $332. For an enrollee in a family of 3, that would also be the subsidized premium using Advance Premium Tax Credits for an enrollee at 249% of the poverty level. Thus, if a 40-year old enrollee's income is at least 249% of poverty, he or she would pay the full (unsubsidized) premium amount.

Table 4 – Projected Monthly Premiums in 2014 for Silver Plan Enrollees Based on Age and Income (using Advance Premium Tax Credits) - Based on a Family of 3

% of Projected 2014 Poverty Level	Annual (Family) Income	Monthly Income	Monthly Premium			
			Age 30	Age 40	**Age 50**	Age 60
125%	$25,000	$2,080	$42	$42	$42	$42
175%	$35,000	$2,920	$150	$150	$150	$150
225%	$45,000	$3,750	$269	$269	$269	$269
275%	$55,000	$4,580	$295	$332	$402	$402
325%	$65,000	$5,420	$295	$332	$464	$515
Above 400% (no subsidy)	>$80,000	$ 6,670	$295	$332	$464	$705

D. Out-of-Pocket Costs: By Age and Income

Finally, Table 5 below shows the specific components of the out-of-pocket burden for enrollees in the example Silver plan, and how that burden is lifted by the availability of Cost-Sharing Reductions at various income levels. Out-of-pocket caps are also lowered as a separate but related ACA requirement, but the Cost-Sharing Reductions increase the plan's actuarial value, and this serves to directly reduce deductibles, co-insurance, and co-pays.

Table 5 – Specific Components of Out-of-Pocket Costs for Selected Example Silver Plan Enrollees, Based on Income (using Cost-Sharing Reductions) – Based on a Family of 3

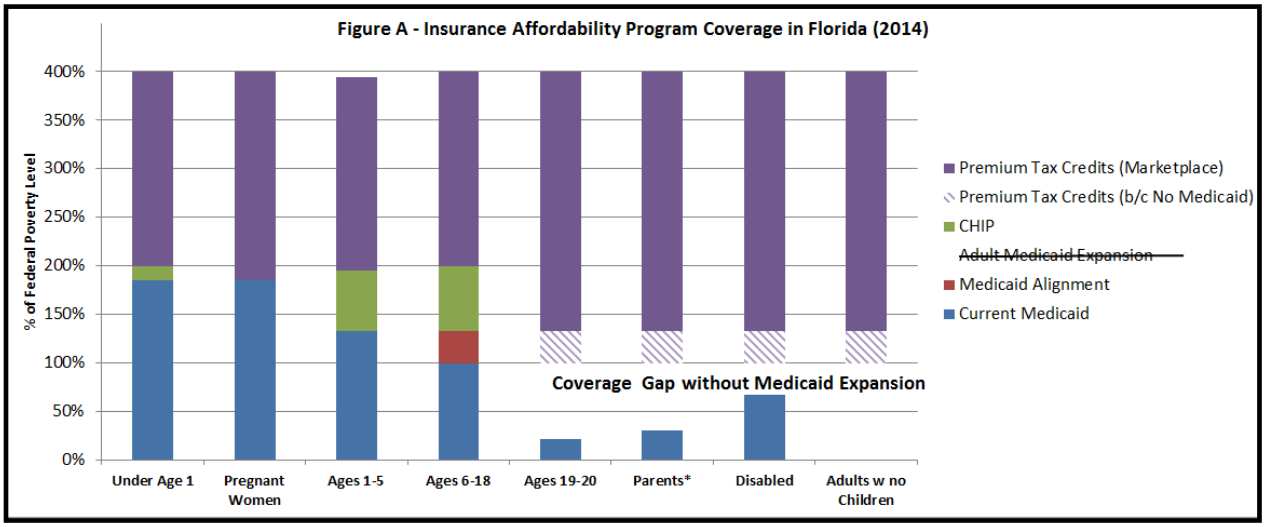
% of Projected 2014 Poverty Level	Annual (Family) Income	Monthly Income	Maximum Out-of-Pocket Costs	Deductible		Co-Insurance (Medical)	Co-Pays		
				Medical Care	Rx Drugs		Primary Care Visit	ER Visit	Rx Drugs
125%	$25,000	$2,080	$2,250	$0	$0	10%	$0	$100	$3/$8
175%	$35,000	$2,920	$2,250	$0	$0	25%	$15	$150	$8/$20
225%	$45,000	$3,750	$5,200	$1,500	$0	30%	$30	$250	$15/$40
275% (no subsidy)	$55,000	$4,580	$6,400	$1,700	$200	30%	$40	$250	$20/$55

Florida's Punitive Coverage Gap

Finally, despite the promise of the new resources available through the ACA in 2014 to make quality affordable coverage available to most Floridians, one significant and glaring gap will remain. Specifically, almost no uninsured adult with income below the poverty level (who is not elderly, disabled, or already Medicaid-eligible) will have access to meaningful, affordable coverage in 2014.

Despite the promise of the new resources available through the ACA in 2014 to make quality affordable coverage available to most Floridians, one significant and glaring gap will remain. Specifically, almost no uninsured adult with income below the poverty level (who is not elderly, disabled, or already Medicaid-eligible) will have access to meaningful, affordable coverage in 2014.

By design, an important complement to the creation of the Marketplace was the expansion of the coverage safety net to allow most Americans with incomes up to 133 percent of poverty to qualify for Medicaid. As a result of the June 2012 ruling of the U.S. Supreme Court in *National Federation of Independent Business v. Sebelius*, however, states cannot be penalized for refusing to increase their income limits for the Medicaid program for adults. The Florida Legislature did precisely that during its 2013 regular session, leaving the current income limits in place. Yet very few Floridians with income below the poverty line can qualify for either Advance Premium Tax Credits or Cost-Sharing Reductions in the Marketplace, precisely because Congress expected that these individuals would qualify for Medicaid instead.



The approximately 700,000 Florida adults who will fall into this gap will therefore have no access to Medicaid or to subsidized coverage through the Marketplace – see Figure A above. The coverage gap resulting from the decision not to expand Medicaid will create an extreme "reverse cliff" effect as illustrated by Table 6 below.

Table 6 – Illustration of Differences in Coverage Affordability Among Floridians with Incomes Near the Poverty Line - Based on an "Average" Enrollee in a Family of 3

	Enrollee #1	Enrollee #2
Monthly Family Income	$1,600	$1,700
Projected % of 2014 Poverty Level	96% (below poverty line)	102% (above poverty line)
Access to Affordable Coverage	Not eligible for any form of subsidized coverage (Medicaid or the Marketplace)	Eligible for subsidized coverage through the Marketplace
Monthly Premiums (Silver Plan)	$332	$34
% of Income Dedicated to Premiums	21%	2%

Adults with incomes between 100 and 133 percent of poverty *will* be eligible for subsidies through the Marketplace, but will therefore be required to pay premiums to retain coverage as well as potentially burdensome out-of-pocket costs to access care, which would not have been the case had they been able to enroll in Medicaid.

However, it should be noted that no adult with income under 133 percent of the poverty level will incur the penalty associated with not obtaining coverage under the ACA's so-called "individual mandate."[22,23] Consequently, if sustaining coverage through the Marketplace proves impossible for an individual just above the poverty line, although he or she will not have assured access to care, at least.

This report was researched and written by Greg Mellowe. Karen Woodall is Executive Director of FCFEP and Alan Stonecipher is Communications Director.

Endnotes

1 For those with coverage or an offer of coverage through an employer, what constitutes inadequate or unaffordable coverage is defined in federal rule.

2 See, e.g., http://www.flsenate.gov/usercontent/topics/ppaca/02-18-13ExchangeLetter.pdf

3 The Legislature could seek to change from reliance on a federally facilitated Marketplace to a model in which the state is more actively involved at a later date.

[4] Signed into law as Chapter 2013-101, Laws of Florida

[5] By 2017, the small group market must include employers with up to 100 employees.

[6] QHPs must meet a number of additional criteria in order to be sold in the Marketplace, although discussion of those is beyond the scope of this brief.)

[7] Florida's Essential Health Benefits "benchmark" for 2014 and 2015 can be found at http://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/florida-ehb-benchmark-plan.pdf

[8] Actuarial values for plans in the various metal tiers may actually fall anywhere within a range of 2 percentage points above or below the target percentage. For example, a Silver plan can have actuarial value between 68% and 72%.

[9] For more detailed information about Essential Health Benefits and actuarial value requirements, see 78 FR 12834.

[10] The amount of Advanced Premium Tax Credits available to a given individual is the amount necessary to reduce the premium for the second-lowest cost Silver plan available to him or her to the appropriate percentage of income. If that individual purchases a Gold plan or even a higher-priced Silver plan, he or she will pay the subsidized premium amount under the second-lowest Silver plan as well as the difference between their total unsubsidized premiums.

[11] A different sliding scale applies to different income ranges within the larger range of 100% to 400% of poverty. For example, at X% of poverty, where y is between 200% and 250% FPL, premiums are [6.3 + (1.75(X-200)/50)%] of income.

[12] The full sliding scale is depicted at Congressional Research Services, Health Insurance Premium Credits in the Patient Protection and Affordable Care Act, April 2010, p.6.

[13] Premium and cost-sharing amounts shown in this brief are for individual coverage only. There are a multiplicity of scenarios for family coverage, and discussion of those necessarily exceeds the scope of this brief.

[14] See Sections 1401 and 1402 of the ACA.

[15] See Section 627.410(9), Florida Statutes (effective June 3, 2013).

[16] The Office of Insurance Regulation maintains the I-File Forms and Rates Filing Rates (I-File)System, accessed at http://www.floir.com/Office/Filingsearch.aspx.

[17] A query of the I-File system on May 26, 2013, revealed QHP-related filings by 11 insurers. A subsequent query executed on June 5, 2013, revealed that one of these insurers had withdrawn its QHP-related filing.

[18] Each insurer will likely make multiple QHPs available for purchase. This includes not only plans at different metal levels, but also plans at the same metal level, but with different configurations of out-of-pocket costs.

[19] The insurer in the example did not propose making a Platinum or Catastrophic plan offering available in Florida for 2014.

[20] The insurer in the example only intends to offer coverage to residents in three Florida counties. The availability of QHP coverage throughout the state is unclear. This is the case in part because the Florida Office of Insurance Regulation sought to allow insurers to set rates for each county separately.

[21] Terms related to out-of-pocket costs are defined at http://www.healthcare.gov/glossary/

[22] Effective January 1, 2014, non-grandfathered plans may not vary rates by gender.

[23] See 45 CFR § 155.605(g)(4).