Inside
HEALTH INSURANCE EXCHANGES

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Timely News and Strategies for Doing Business on Federal, State and Private Exchanges

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Competition From Private Exchanges, Teeny Tax Credit Keep Businesses From SHOP-ing

Since the beginning of the year, HHS has offered regular enrollment updates for federally facilitated exchanges (FFEs). The agency, however, has been noticeably mum when it comes to participation in the federal Small Business Health Options Program (SHOP). The newness of the model has kept many employers on the fence when it comes to both private and public exchanges. But some industry observers contacted by *HEX* wonder if the SHOP program will ever attract substantial interest from small employers.

"The underlying market isn't so broken that employers are crying out for a solution. What they want is dramatically lower premiums, and that's not what SHOP offers," says Rosemarie Day, president of Day Health Strategies and former chief operating officer of the Massachusetts exchange. "I think SHOP is a tough sell." Moreover, she notes that HHS hasn't focused much attention on promoting SHOP to small businesses. Some state-based exchanges have worked hard to promote them, but haven't yet seen significant results.

There are four key barriers that could limit SHOP enrollment:

(1) The small-business tax credit: Although there is a financial incentive, the tax credit for small businesses is widely viewed as too rigid and too small to attract many employers. To qualify, businesses must have no more than the equivalent of 25 full-time workers, pay average annual wages below $50,000, and cover at least 50% of the cost of health care coverage for their workers. The maximum credit goes to employers with

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Self-Sustaining? SBEs Eye New Funding, Leaner Budgets and Leased IT Systems

With the federal funding spigot turned off, state-based insurance exchanges (SBEs) must get creative to keep themselves going. In order to be self-sustaining, as required by the Affordable Care Act (ACA), some SBEs have turned to the federal government to take on some IT functions. Others are looking to new assessments — or are increasing the size of existing ones — to cover administrative costs.

The definition of "sustainable" differs from group to group, notes Jon Hager, former executive director of Nevada's insurance exchange. To the feds, he explains, sustainable is an exchange that is not reliant on federal funds, which has prompted some states to institute broad-based taxes to fund their SBEs. But for states such as Nevada, "sustainable" means it's not reliant on government funding at all — federal or state. Those exchanges are modeled after fully sustainable private exchanges that rely on commissions paid by carriers, he explains.

Unlike private exchanges, however, public exchanges must also comply with stringent IRS security requirements, challenging questionnaires to determine tax-credit eligibility and funding for navigators. Add to that the participation of brokers, which is optional according to CMS, but often is a requirement of state politics. "SBEs are simply not allowed to operate in a lean business manner, despite the efforts of their administrators," he adds. Hager is now with Reno, Nev.-based health insurer Hometown Health.

continued

"The long-term sustainability of exchanges has always been a question…and certainly now states have to make tough decisions about how to move forward," says Elizabeth Carpenter, a director at Avalere Health LLC in Washington, D.C.

When drafting the health reform law, no one imagined the operating costs would be so high for state-based exchanges, adds Chris Condeluci, a principal at CC Law & Policy in Washington, D.C., who worked for the Senate Finance Committee during the crafting of the health reform law. "We didn't expect [state exchanges] to be bureaucracies. And we didn't expect [states] to recreate the [technology] wheel."

In her budget, Rhode Island Gov. Gina Raimondo (D) recently proposed a new fee — 3.8% for qualified health plans (QHPs) and 1% for Small Business Health Options Program (SHOP) plans — to help cover the exchange's administrative costs. The state legislature is expected to vote on the proposal by July 1 (see story, p. 3). Late last month, New York's legislature passed its state budget, but lawmakers excluded Gov. Andrew Cuomo's (D) proposed fee for health plans, which would have equated to about $25 per member. The fee would have generated nearly $69 million for New York State of Health, the state's public insurance exchange. A year ago, the DC Health Benefit Exchange Authority Executive Board approved a broad 1% assessment of all health-related insurance products sold inside and outside of the exchange. The American Council of Life Insurance (ACLI) called the assessment unconstitutional and filed a complaint in U.S. District Court. The suit was dismissed in November, but an ACLI spokesperson says the decision is being appealed.

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SBEs Must Get Creative

HealthCare.gov is beating the state-run exchanges in both retention and new enrollment, according to an Avalere analysis released April 7. Federally facilitated exchange states re-enrolled 78% of their 2014 enrollees in 2015, on average. But state-based exchanges collectively re-enrolled just 69% of their 2014 members. California, the state with the highest enrollment in 2014, retained just 65% of its enrollees. Kentucky, by contrast, saw 94.4% re-enrollment.

With limited funds and lackluster enrollment growth, SBE leaders must think creatively about how to spend. The exchanges are paying close attention to administrative costs tied to marketing and outreach efforts, and might try to determine a "cost-per-acquisition" price to see where the best value is in terms of marketing, says Enrique Martinez-Vidal, vice president at AcademyHealth in Washington, D.C. Exchanges might be able to use their existing data to guide brokers and navigators to target hard-to-reach uninsured. Some state exchange leaders also are eyeing vendor contracts tied to back-office functions such customer call centers and Web portals. Key contractual areas to review include whether the contract should be a fixed fee or a per-member per-month amount. They also need to look at the length of the contracts and determine if they should renegotiate at renewal, Martinez-Vidal tells *HEX*.

For plans sold through HealthCare.gov, CMS charges 3.5% of the premium. Hager notes the fee is lower than many brokerage commissions, despite the additional requirements. For states that charge more than that, there is political pressure to bring costs down to the federal fee level or let the feds run the exchange, he says. While large states typically can spread their fixed costs across a large number of enrollees, small states that don't have access to state funding may struggle to continue operations, Hager says.

Will CMS Power More SBEs?

Connecticut's exchange, which leased its IT system to Maryland's exchange, is discussing strategies with other states to share IT or call-center capabilities. Several SBEs, including Oregon and Nevada, have tapped HealthCare.gov for eligibility determination and enrollment. Vermont is expected to transition to the federal exchange if the state is unable to fix its ongoing IT

problems. New Mexico this month decided to scrap its exchange IT system and will instead lease it from CMS. The decision comes after a detailed analysis that found establishing its own technology would be more costly. The state's exchange is still expected to be considered a state-based exchange and not at risk in the Supreme Court's *King v. Burwell* decision *(HEX 7/31/14, p. 1).*

Of states that are outsourcing federal technology, "I'm not sure they are going back at this point," says Martinez-Vidal. "It doesn't seem like there is funding to support the build of a state-specific platform." Other states could follow that path if they struggle with costs tied to their IT systems. States with larger populations and broad assessments already in place appear to be in better financial shape than those that are relying strictly on transaction fees, he adds.

"We have been working with them at a strategic planning level so that they have a good handle on what are the expense drivers, how to think about staffing levels/types, ensure they have internal control and management of operational spending, that they have a robust budget planning and development process, and that they are building and maintaining reasonable reserves," he says.

Leasing IT Could Cut Costs

Linda Tiano, a member of the Health Care and Life Sciences practice at the law firm Epstein Becker & Green, P.C., agrees and says it would be helpful for CMS to lease some of its available infrastructure to states that want to operate their own exchanges. "The dollars being spent to create multiple systems with the same functionality are truly unnecessary, and it will continue to be costly for each state exchange to update, maintain and enhance the systems they have created," she says. While licensing federal systems, states could still add enhancements if they have some different requirements, and have local input into operations, she says. Carpenter agrees that as states grapple with the issue of sustainability, moving some functions to HealthCare.gov becomes more attractive.

But some issues still need to be resolved about the cost of contracting with the FFE for the use of its eligibility and enrollment systems, especially if the state continues to collect its own assessment. The outcome of such negotiations could depend on which activities/functions are done by the state exchange and which ones are done by HealthCare.gov, says Martinez-Vidal. Conversely, he suggests that some partnership states, such as Arkansas or Delaware, might examine the financial benefit of moving to the SBE model, which would allow them to levy their own assessment to cover customer assistance and, possibly, plan management costs. "I think this will all come down to calculating whether a state can run its own [exchange] more efficiently than the feds can, even with a fee to HealthCare.gov," he says.

The key to self-sustainability will be "significant volume," says Tiano. Most exchanges are financed by a per-enrollee fee, so the more enrollees you have, the more revenue you raise. Ironically, additional fees added to premiums could be collected and used to drive outreach, but higher premiums could negatively impact enrollment, Carpenter says. Exchange directors tell *HEX* they will need to scale back on expenses such as outreach and marketing. But that could have a negative impact on enrollment growth. While HealthCare.gov reported higher-than-expected enrollment, sign-ups among many state exchanges stagnated. And cutting outreach and marketing costs could make it more difficult to reach potential enrollees.

Hager says he wouldn't be surprised to see an increase in the number of SBEs operated by HealthCare.gov. But those are likely to be federally facilitated states that want to bypass legislation to receive state-based or state-supported status.

"If *King v. Burwell* goes in King's favor, I would anticipate a handful of states to pass legislation within a year to obtain state-supported status to allow their citizens to continue to receive the tax credit," says Hager. "You may even see several special or emergency legislative sessions since many legislative sessions will end prior to the Supreme Court's release of the decision."

See the Avalere report on SBE enrollment and retention trends at http://tinyurl.com/latz9ov.

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SBEs Look to Add or Maintain Assessments for Sustainability

In her budget, Rhode Island Gov. Gina Raimondo (D) recently proposed a new fee — 3.8% for qualified health plans (QHPs) and 1% for Small Business Health Options Program (SHOP) plans — to help cover the exchange's administrative costs. The proposed assessment is just one strategy state-based exchanges are considering to move forward without federal funding (see story, p. 1).

Rhode Island's state legislature is expected to vote on the proposal by July 1. The assessment is based on fees that would be used if Rhode Island were a federally facilitated exchange (FFE) state.

The state's exchange, which is spending down its remaining federal funding, also intends to significantly

scale back on expenses, says Anya Rader Wallack, who took over as executive director early this year. For fiscal years 2017 and beyond, the targeted budget for HealthSource RI is $11.2 million. For Rhode Island and other state-based exchanges, maintenance and operation of the IT infrastructure for eligibility and enrollment systems is the biggest expense. Maintaining customer service staff is another large expense. The Affordable Care Act also requires state-based exchanges to have funding to cover audits and legal appeals. Wallack says that leaves little funding for outreach and advertising. "We'll need to be more targeted and strategic" in those areas, she tells *HEX*.

Prior to the enactment of the ACA, Rhode Island had an uninsured population of about 126,000 (12% of the population). About 30,000 Rhode Islanders have signed up for individual coverage on the exchange, and an additional 3,477 have coverage through SHOP.

As of Jan. 1, the ACA requires each SBE to be self-sustaining. The law allows the exchanges to charge an assessment or user fee to participating issuers, but also permits an exchange to find other ways to generate funds to sustain its operations. Here's a look at what other SBEs are doing to cover administrative costs now that federal grant funding has ended:

◆ ***California:*** At a March meeting, Covered California's board recommended that the exchange maintain its monthly assessment fee of $13.95 for each member enrolled through an exchange-based QHP, and an $18.60 per-member per-month (PMPM) fee for people enrolled through the SHOP marketplace. It also will collect a PMPM fee of 83 cents for pediatric dental plans. The fees are built into the premiums and are paid by the QHPs. That is the exchange's only funding mechanism once federal dollars are exhausted, says spokesperson Roy Kennedy. "We believe we are in a good position moving forward and as we take a long, hard look at every dollar spent." About 1.3 million people signed up for coverage during the recently concluded open-enrollment period, which was on the low end of its projections. That translates to about $197 million in revenue. By 2018, the exchange anticipates nearly 2 million enrollees, which would mean $329 million in revenue. The board forecasts up to a $340 million budget for the current fiscal year, and projects that amount will decline to $300 million for the 2017-2018 plan year.

◆ ***Colorado:*** Since Jan. 1, 2015, carriers that sell health insurance in Colorado have been charged a fee of $1.25 per month for each policy sold in the state — both on and off the public exchange — to help cover the cost of operating the state-run marketplace once federal funding runs out. The fee, which the exchange's board approved last June, will allow it to maintain a six-month operating reserve of $13 million. The exchange also collects 1.4% of the premiums sold in the exchange.

◆ ***Idaho:*** Enabling legislation called for a 1.5% assessment fee from carriers on all plans sold on the exchange. Your Health Idaho's board is evaluating the assessment fee and operating costs to determine if any changes need to be made to that funding model, says spokesperson Jody Olson. State legislation restricts the exchange from using any state tax dollars or resources.

◆ ***New Mexico:*** In December 2014, the exchange's board passed a financial sustainability plan that assesses New

OIG Says Maryland Misallocated $28.4 Million Due to Outdated Data

During the development of its state-run insurance exchange, Maryland officials misallocated about $28.4 million, HHS's Office of Inspector General (OIG) explained in a federal audit sent to CMS's acting Administrator Andy Slavitt on March 26.

Between Sept. 30, 2010, and the end of 2014, Maryland's exchange was awarded $182 million in establishment grants. OIG recommends that the state agency in charge of the exchange refund money allocated to the exchange.

In a prepared statement issued March 27, Maryland Health Connector officials note that OIG found no fault with the use of federal funds by the exchange. However, the exchange contends that it followed federal guidance and disagrees with OIG's conclusion that it "erred in its allocation of costs between Medicaid and grant funds for qualified health plans." OIG recommends that Maryland refund $28 million that had been allocated to qualified health plans and seek reimbursement from the Medicaid side. The reallocation of funding, according to the state's response, would result in a refund of about $5 million. Before the first open-enrollment season began, many industry observers expected Maryland to have one of the most successful state-based exchanges. The state's insurance exchange board voted March 31 to swap the failed platform for one used by Connecticut.

As of Feb. 28, the Maryland exchange says 122,778 people had signed up for a qualified health plan and 166,353 had enrolled in Medicaid.

The report is available at http://oig.hhs.gov. See Maryland's response at http://tinyurl.com/pkujz5y.

Mexico issuers that offer major medical plans on and off the exchange. The assessment for each issuer is calculated by multiplying the exchange's annual budget by each carrier's market share for major medical and Medicaid managed care premiums written in the state. Because it got a late start as an SBE, BeWell New Mexico has access to federal grant funds until Jan. 1, 2016, before being required to be self-sustaining. The staff will present a 2015 revised budget to the board at a meeting slated for May 8. New Mexico will scrap its own exchange technology and instead lease the technology from CMS's HealthCare.gov (see story, p. 1). The decision comes after a detailed analysis that found establishing its own technology would be more costly. New Mexico launched its SHOP in October 2013 and became self-sustaining in January 2015. The board had approved an operating budget of $1.5 million for maintenance and operation of the SHOP exchange, and it plans to assess the carriers in the second quarter of this year.

◆ ***New York:*** Late last month, New York's legislature passed its state budget, but lawmakers excluded Gov. Andrew Cuomo's (D) proposed fee for health plans, which would have equated to about $25 per member. The fee would have generated nearly $69 million for New York State of Health, the state's public insurance exchange. Instead, the final budget agreement will tap existing taxes on health care, which currently total more than $5 billion annually. The New York Health Plan Association has argued for using a portion of the currently collected health taxes, "and we're pleased that's the route lawmakers chose," says spokesperson Leslie Moran. Adding a new "exchange tax would have been a bitter pill to swallow for New York families and small businesses."

◆ ***Utah:*** Avenue H is the state-run SHOP, and the feds run the individual marketplace. The state's small business exchange, which pre-dates the ACA, intends to keep its fees at $12 per enrolled employee per month for medical insurance and $2 per enrolled employee for dental for 2016. The fee covers technology and vendor costs and some personnel expenses, but not all, says executive director Patty Conner. "As participation grows, our revenue will grow. Our staff is small relative to other states and we plan to continue to leverage the technology so that we don't increase our ongoing administrative costs." The state receives general appropriations funds to help defray costs, but Conner says it will be less reliant on that as participation grows.

continued

Federal Reg Tracker: March 10 – April 6

Notices

◆ Cooperative Agreement to Support Navigators (March 30)

This notice advises of a new collection pertaining to formulary drug lists and provider directories that Qualified Health Plans (QHPs) are required to publish, and revises an old collection regarding progress reports from health insurance exchange navigator programs.

Visit http://tinyurl.com/mdnvvxm.

Instructions/Guidance

◆ Plan Year 2016 Vendor Application

This vendor application is to be completed by entities requesting approval to develop and host Federally-facilitated Exchange training, including information verification, for FFE agents and brokers for the 2016 plan year.

Visit http://tinyurl.com/qdq526x.

◆ Hardship Exemptions for Persons Meeting Certain Criteria (March 20)

This guidance provides information about hardship exemption criteria pertaining to enrollees in programs such as the Children's Health Insurance Program, Elite Athlete Health Insurance and Medicaid for use in the exchanges.

Visit http://tinyurl.com/l4gmh7n.

◆ Ending Special Enrollment Periods (March 31)

As of April 1, 2015, all Special Enrollment Period (SEP) requests to CMS seeking 2014 coverage, with the exception of SEPs issued as a result of an eligibility appeal, if eligible for retroactive coverage, will be given a coverage effective date of Jan. 1, 2015.

Visit http://tinyurl.com/om8on9x.

Regulations

◆ Establishment of Multi-State Plan Program; Correction (March 30)

The Office of Personnel Management (OPM) issued this correction to a final rule that appeared in the *Federal Register* on Feb. 24, 2015 (80 FR 9649), implementing modifications to the Multi-State Plan (MSP) Program based on the experience of the program to date.

Visit http://tinyurl.com/ongcwle.

Compiled by AIS, April 2015.

◆ ***Washington, D.C.:*** For fiscal year 2015, DC Health Link has an approved budget of $28.7 million. In early May 2014, the exchange board approved a broad 1% assessment on all health-related insurance products. The American Council of Life Insurance (ACLI) called the assessment unconstitutional and filed a complaint in U.S. District Court. The suit was dismissed last November, but ACLI intends to appeal, according to a spokesperson for the group.

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Private Insurance Exchange Vendors Tout a Workaround for FFE States

At least two private exchange vendors say they have a workaround for federally facilitated exchange (FFE) states if the Supreme Court determines federal subsidies can be distributed only through state-based exchanges (SBEs).

Private exchanges could be very helpful to states in providing the "back office" infrastructure and the IT platform needed to operate their own ACA exchanges, says Mark Hall, a professor of law and public health at Wake Forest University. "However, current law makes it difficult to do this on a simple turn-key basis, because the ACA requires state exchanges to be operated under government authority and supervision," he says.

In a recent white paper, eHealth, Inc., which bills itself as "the nation's first and largest private online health insurance exchange," proposed a legislative solution that would allow states to certify private exchanges both to enroll individuals in health plans and to assist individuals in applying for subsidies.

Under eHealth's proposal, private exchanges would be certified by the state in which they operate and maintain a website for enrolling individuals in health plans. They also would need to display plan-rating information and demonstrate the ability to receive tax credit information for individuals enrolling in health plans. HHS would be required to design a process to provide private exchanges with the minimum information necessary to enroll individuals in health plans, and to communicate to consumers eligibility for subsidies and cost-sharing reductions, according to the paper.

On March 23, Virginia-based hCentive said it would lease the technology already used by several states and HHS. The company says the lease option would allow states to maintain federal subsidies and health coverage for the 2016 plan year. hCentive's private exchange clients include Coventry (Aetna Inc.), Geisinger Health Plan, Health Alliance (of Illinois), Delta Dental and Alliant Health Plans.

Three state-based exchanges (SBEs) — Colorado, Kentucky and New York — have been running on an hCentive platform since 2013. The company recently added Massachusetts, which had been plagued with technical problems (from another vendor) since the first open-enrollment period, and hCentive is a finalist to operate the state's Small Business Health Options Program (SHOP). It recently was awarded a contract to operate Arkansas' SHOP exchange platform.

The company also successfully built the platform being used to operate the federally facilitated SHOP, which is up and running after a year-long delay by the federal government, says Peter McCann, hCentive's chief business development officer. The dismal 2013 launch of HealthCare.gov's individual portal prompted HHS to delay the SHOP program.

Once the individual market appeared to be on track, CMS turned its attention back to SHOP. Prabhakar Ram, senior vice president and head of products at hCentive, says his team was heavily scrutinized by CMS's chief technology officer, who had helped turn around HealthCare.gov. hCentive was awarded the SHOP contract last April and is now being used to operate the 33 FFE SHOPs.

McCann says hCentive's involvement in the federal SHOP doesn't get much attention, "but we're particularly proud of it." He touts his firm as "the largest and most successful" developer of government exchanges.

Ready by Fall Enrollment?

Now that state platforms are operational, the costs for states that want to move to an SBE model are more palatable, McCann says. hCentive's off-the-shelf, cloud-based platform requires little customization and can be put into place without systems integrators, which can add significantly to the overall price tag, he says. The system also is pre-integrated with the federal data services hub and pre-tested on a single platform. McCann says a leased system could be up and running within six months.

Last year, Maryland scrapped its non-functioning exchange platform and implemented software developed for Connecticut's exchange. But McCann says that might not be the best solution for states interested in transitioning to an SBE model. "While I think the exchange Maryland is using is a very good one, Connecticut is not a technology company. They don't have an army of programmers to enhance and maintain that system," he

asserts. Ram notes that Maryland had to pay high transfer costs to add the system.

See eHealth's proposal at http://tinyurl.com/nq7ocsm.

Contact Hall at mhall@wakehealth.edu and McCann at peter.mccann@hcentive.com. ✧

CO-OPs Enroll 1 Million for 2015, Up About 150% From One Year Ago

After a lackluster start a year ago, more than 1 million people in 23 states have purchased health coverage through a Consumer Operated and Oriented Plan (CO-OP) as of March 25, according to the National Alliance of State Health CO-OPs (NASHCO). That's up substantially from the 400,000 enrollees NASHCO reported at the end of last year's open-enrollment period.

Here's a snapshot of individual and small-group enrollment among six CO-OPs:

◆ As of the end of March, Utah-based ***Arches Health Plan*** had 48,680 members. The insurer added 18,494 new individual members and 589 employers (1,476 lives) through the state-run Small Business Health Options Program (SHOP), dubbed Avenue H. The CO-OP says its individual exchange-based enrollment is up almost 150% so far this year. It enrolled nearly 1,900 small groups outside of the state's SHOP. Arches also targets larger employers and recently signed an 8,000-employee business. "At this point we have several hundred quotes out to businesses that we are working directly and/or in conjunction with the broker community," says spokesperson Shaun Greene. "We also work closely with Avenue H as small employers who had grandfathered traditional plans come into play in the SHOP marketplace."

◆ In 2014, Maryland-based ***Evergreen Health Cooperative*** says it was underpriced by Blues plan operator CareFirst, Inc., and wound up with a sliver of the individual market as a result *(HEX 12/18/14, p. 1)*. Evergreen says it ended the 2015 open-enrollment period with 17,500 members — about 5,000 enrolled through the state-based exchange. The enrollment met internal expectations, says CEO Peter Beilenson, M.D. While Evergreen didn't enroll any small groups through SHOP, it has 12,500 small employer lives outside of the exchange.

◆ Ohio-based ***InHealth Mutual*** says it had slightly more than 22,000 members as of April 1. The CO-OP says 11,500 found coverage through the exchange. The most popular exchange-based option was its silver plan, according to spokesperson Amy Wells. The enrollment met internal expectations, she says.

◆ ***Land of Lincoln Health*** (LLH) says it has more than 50,000 members, which exceeded its 2015 goal by eight months, according to the Illinois-based CO-OP. About 32,000 enrollees came through the exchange during the recently concluded enrollment period. LLH enrolled 97 small employers through SHOP, and another 400 outside of SHOP. The CO-OP says it is promoting the SEP through a press release, on its website and via social media channels. In December, LLH told *HEX* that it had reduced premiums by as much as 30% for some products *(HEX 12/18/14, p. 1)*.

◆ ***Maine Community Health Options,*** which sells coverage in Maine and New Hampshire, says it enrolled 71,076 people between the two states — nearly 60,000 signed up through HealthCare.gov. The exchange says it enrolled 94 groups through SHOP and 522 employers outside of the exchange. Enrollment is in line with expectations, says spokesperson Michael Gendreau. During the special enrollment period (SEP) for people who were penalized for not having coverage in 2014, Gendreau says the CO-OP's outreach and education team distributed materials to community partners such as federally qualified health centers, certified application counselors, navigators and libraries. Maine Options also sent out a broker bulletin explaining the SEP, which ends April 30 (see story, p. 8).

People on the Move

California-based eHealth Inc., a private health insurance exchange, said last month that it would lay off more than 160 employees — about 15% of its workforce. The publicly traded company said its new "strategic cost reduction program" is needed to counter lower-than-anticipated individual and family enrollment. Among those leaving is **Sam Gibbs,** president of Government Systems. Gibbs says he intends to complete a Master's degree in public affairs. **Brian Mast,** the company's former vice president of communications, also left….Connect for Health Colorado's board of directors named long-time health care executive **Robert Malone** as the finalist to fill the CEO/executive director post previously held by **Patty Fontneau.** She now oversees private exchanges at Cigna Corp. Interim CEO **Gary Drews,** who did not seek the permanent position, will continue to serve the organization and help in the transition once a new CEO is hired….**Jason Madrak,** formerly chief marketing officer for Connecticut's insurance exchange, was named vice president for Connecticut for Harvard Pilgrim Health Care, Inc., a nonprofit insurance company. Prior to joining the exchange, he was vice president of consumer experience at WellPoint Inc., now Anthem Inc.

◆ ***Minuteman Health,*** which sells coverage in Massachusetts and New Hampshire, says its combined paid membership as of April 1 was 14,113. That includes individual plans sold on and off the exchange and off-exchange small-group plans. Enrollment through SHOP is not yet available. In New Hampshire, Minuteman enrolled 7,753 through HealthCare.gov and 556 outside of the exchange. In Massachusetts, the CO-OP enrolled 4,254 through the state-run exchange and 1,550 outside of it.

Recent *E-News Alerts*

These items were included in *E-News Alerts* that were transmitted since the last print issue of *HEX* was published on March 12:

March 18, 2015

- Starwood Hotels Moves Employees to Towers Watson's Private Exchange
- Minnesota House Panel Votes to End State-Run Exchange
- Study: Silver-Plan Premiums Grew 2.9%
- HHS: ACA Reduced Uninsured Population by 35%

March 25, 2015

- Illinois CO-OP Gets 25% of New Exchange Enrollees
- CDC: 11 Million More People Have Insurance After ACA
- Big Subsidies Are Most Likely to Prompt Insurance Purchase
- Private Exchange Vendor Says States Could Use Its Platform

April 1, 2015

- Maryland Exchange Misallocated Millions, OIG Audit Finds
- Paul Ryan Is Building an Obamacare 'Off Ramp'
- For Many Uninsured, Cost of Coverage Outweighs Tax Penalty
- Blues Plans See Higher Costs for Exchange Members

April 8, 2015

- Nevada Lawmakers Look to Scrap State Exchange
- Republican Senators Raise Concerns About CMS's Slavitt
- 1095-A Errors Prompt IRS to Waive Penalties for Exchange Enrollees
- Highmark Notes $83 Million Risk Corridor Deficit

To retrieve copies of these *E-News Alerts*, visit *HEX*'s subscriber-only Web page at AISHealth.com. If you need a password or other assistance, please contact AIS's customer service department at 800-521-4323 or custserv@aishealth.com.

◆ ***New Jersey Health Republic*** says 54,000 people enrolled in coverage for 2015, which it says was a significant improvement over last year's enrollment. About 80% of its enrollment came through the federally run exchange. The increase was due to more competitive pricing and more than twice as many plan options — 21 in 2015 vs. just nine last year. It did not have any SHOP enrollment but added close to 300 new groups outside of the exchange for 2015. The CO-OP surpassed its internal expectations, says spokesperson Cynthia Jay.

Under the Affordable Care Act (ACA), CO-OPs were envisioned as operating in every state. But a last-minute deal to avert the so-called "fiscal cliff" in early 2013 stripped $2 billion in future funding from the CO-OP program, which meant applications that had not yet been approved went no further *(HEX 1/13, p. 1)*. Early this year, Iowa's insurance commissioner filed a petition to liquidate CoOportunity Health, a CO-OP that sold coverage in Iowa and Nebraska *(HEX 1/15, p. 1)*.

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New SEP Adds Just 36,000, but Could Spike by Tax Deadline

A penalty for not having health coverage in 2014 — combined with the likelihood of a much larger penalty for remaining uninsured this year — hasn't yet swayed many people to buy insurance during the new special enrollment period (SEP). CMS on March 29 said that just 36,000 had taken advantage of the SEP, which began March 15 — a month after the official open-enrollment period concluded. State-based exchanges (SBEs) also report lackluster enrollment results so far. But that could change once the uninsured complete their 2014 taxes and learn about penalties and advance premium tax credits.

Covered California, which began its tax-penalty-inspired SEP on Feb. 23 — much earlier than HealthCare.gov or other states — has enrolled 18,000 people so far, *The Sacramento Business Journal* reported April 7. The exchange enrolled about 1.4 million during the regular enrollment period — below its target of 1.7 million.

HealthCare.gov and most state-based exchanges (SBEs) launched a SEP for individuals and families who were assessed a "shared responsibility" penalty for not having coverage *(HEX 3/15, p. 1)*. The SEP for federally facilitated exchanges, and for most SBEs, runs from March 15 until April 30.

Tax preparation firms are explaining the penalties and urging uninsured clients to buy coverage to avoid

future penalties, which will be twice as high next year. As many as 6 million households might owe a penalty for not having insurance.

"What we're seeing is that taxpayers don't know they can still sign up for health [insurance] or that there are premium tax credits available," says Mark Steber, chief tax officer at Jackson Hewitt Tax Service. Nearly half (48%) of recently surveyed people think the window to buy coverage has closed. Another 27% "don't know" if the enrollment period has expired, according to results of a survey commissioned by the tax preparation firm.

Many uninsured don't see the value of paying for coverage and out-of-pocket costs, and will continue to pay the penalty. About 12% of recently surveyed uninsured adults said they would buy coverage after being told about the penalty, according to a survey of 3,000 adults polled through Feb. 24 by McKinsey & Co.'s Center for U.S. Health System Reform. But that percentage might be lower when people are actually faced with the decision, notes Jenny Cordina, an expert partner within McKinsey's Healthcare Systems and Services group.

While some of those surveyed said they would buy coverage, they probably don't know much about the cost of health insurance or understand that they might qualify for subsidies to cover part of the premium. But, she admits, the price of the penalty still outweighs the cost of coverage in the minds of some uninsured people. More than 60% of newly insured respondents bought coverage because they learned about the penalty.

According to the survey results, 88% of people dubbed "persistently uninsured" didn't know subsidies were available, and 41% didn't know about the tax penalty. Given how many people were unaware of the penalty at all, Cordina says it's likely they don't understand the penalty will double for not having coverage in 2015. Based on self-reported information, McKinsey determined 75% of this group has a low health risk.

Health plans, brokers and other stakeholders need to come up with more effective strategies to inform the

Special Enrollment Periods Are an Opportunity for Health Insurers

As of March 29, the Obama administration said just 36,000 people have taken advantage of a special enrollment period (SEP) for individuals and families who were assessed a "shared responsibility" penalty for not having coverage in 2014.

HealthCare.gov and most state-based exchanges announced a SEP that would run from March 15 until April 30 *(HEX 3/15, p. 1)*. People who have a qualifying life event, such as the loss of employer-sponsored coverage, marriage or a baby, also are able to buy health insurance outside of the regular enrollment period. But many uninsured are unaware of their options.

Health insurers are missing an opportunity to grow enrollment if they opt not to promote exchange-based products outside of the official open-enrollment period. There is a "vast lack of information" among the uninsured, says Sally Poblete, CEO of Wellthie, a software and analytics company that connects health plans to consumers. Prior to launching the company in 2013, Poblete spent eight years with Anthem, Inc. where she led various aspects of product development for commercial insurance.

Now that the official enrollment period is over, health insurers have an opportunity to stand out, because most have stopped actively promoting their exchange products, Poblete says. During the summer months, she says, carriers should promote the fact that certain life events allow people to enroll in coverage outside of the open-enrollment period.

Health insurers private-label Wellthie's software, which serves as the insurer's "front door" for consumers and small employers that want to compare coverage options and enroll. Individuals can determine whether they qualify for an advance premium tax credit and see the impact the subsidy will have on premiums. Small groups can use it to compare the cost of group coverage versus urging employees to buy on the individual market.

"You see a lot of branding and positioning during open enrollment and it's hard to stand out from all the clutter in the market. But the SEP is a great time to demonstrate there are health insurers out there that understand people go through changes in their families and their jobs," she says.

Since the start of last fall's open-enrollment season, Poblete says about 20% of Wellthie's quote volume has taken place since Feb. 15 — the day the official enrollment period concluded. "I was struck by the volume. It tells me there are a significant number of shoppers still trying to determine their options," she tells *HEX*. She notes that it's difficult to determine how many of them are shopping because of the tax penalty, or shopping because there was a change in their employer-based coverage or Medicaid.

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uninsured about subsidies and penalties. Cordina tells *HEX* that during a recent trip to California, she spotted an informational pamphlet from Covered California. While it contained information about advanced premium tax credits, it didn't mention penalties for not having coverage.

"It's important for stakeholders to speak to both…as well as the benefits of having insurance," she says.

See the Jackson Hewitt's survey results at http://tinyurl.com/krn79q6.

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SHOP Faces Four Barriers

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10 or fewer full-time equivalent employees with average annual wages of $25,000 or less *(HEX 10/12, p. 1)*. And without meaningful financial incentives, private insurance exchanges appear to be a better option for small employers that want to increase choice and/or move to a defined-contribution model.

"Qualifying for the tax credits is a complex process and in many cases the amount of the credit is not very significant and thus many employers don't see the benefit of shifting all of their employees to a SHOP," says Dan Schuyler, a director at Leavitt Partners, LLC in Salt Lake City.

(2) Employee choice: Employee choice gives workers the ability to choose any health plan from any participating carrier. In 14 FFE states, SHOP offers employee choice to small businesses. The other 18, however, have no choice component, due largely to calls for a delay from state regulators who worried that a poorly functioning employee choice program would lead to delayed payments to carriers, misinformation, consumer confusion and adverse selection *(HEX 6/19/14, p. 1)*. In 2016, all SHOPs will have to offer employee choice. But states will be able to limit employee choice in a way that restricts employees, for example, to one metal tier. "When we were developing SHOP in 2008, we wanted employee choice for a multi-carrier small-group exchange. Carriers lobbied against it because they were worried about adverse selection," recalls Chris Condeluci, a principal at CC Law & Policy in Washington, D.C., who worked for the Senate Finance Committee during the crafting of the health reform law. "Congress didn't listen." He refers to SHOP as "clunky" and "glitch-riddled."

(3) Grandfathered plans: Small employers that have a grandfathered, non-ACA-compliant plan can't retain those plans if they move to SHOP. Once employers are no longer able to keep grandfathered plans, enrollment on SHOP is likely to increase slightly. But the majority of employers will use a broker to find ACA-compliant options, move to a private exchange or drop coverage entirely.

(4) Competition from private exchanges: For most small businesses searching for an exchange-based model, private exchanges are a better option due to decision-support systems, education tools and end-to-end transactional services, says Condeluci. Along with full employee choice for medical coverage, private exchanges often also offer ancillary products and services such as vision, den-

tal, life, financial and payroll. This gives many private exchanges an advantage over SHOPs. Private exchanges are not permitted to provide the employer tax credit, but such tax credits are limited.

Case in point: Six million people now have health coverage through a private insurance exchange — double the number a year ago, according to an April 7 report from Accenture Plc, a management consulting and technology firm. Much of the increase came from mid-sized employers, which the company defines as having between 100 and 2,500 employees.

Based on its research, Accenture predicts private-exchange enrollment will grow to 12 million in 2016 and 22 million in 2017. The company stands by an earlier prediction of 40 million private exchange enrollees by 2018. In the March issue of *HEX*, however, several industry observers suggested that the prediction is overly ambitious *(HEX 3/15, p. 1)*.

Condeluci worries that more tax dollars will be funneled into the SHOP program "until we come to the realization that we spent billions of dollars on SHOP, which was a failing exercise."

Utah Exchange Touts 612 Businesses

Among state-based exchanges, Utah's Avenue H has been among the most successful. As of March 1, Avenue H had 612 small businesses, 4,921 employees and 12,879 covered lives. The SHOP charges carriers $12 per employee per month for medical coverage and $2 per employee per month for stand-alone dental plans. The carriers include the fee in their "market index" when filing fees for the qualified health plan (QHP), says Executive Director Patty Conner (see story, p. 5). The fee for the SHOP marketplace gets spread across the commercial market. In Utah, the individual exchange is federally run while the state operates SHOP.

Avenue H offers both full employee choice and defined contribution. Employers provide their employees with a defined dollar amount each month, and the employees can use that to pay their premiums and bank the remainder in a health savings account. Defined contribution gives employees much greater control over their health spending, says Schuyler. His company, a small employer, offers coverage to its employees through Avenue H.

As of Feb. 1, Covered California's SHOP had 2,311 participating employers representing 15,671 members. About 85% of those employers moved to SHOP with the help of an agent. New Mexico's SHOP has 147 employer groups and 877 covered lives, and Idaho has 55 participating employers.

Beginning next January, employers with 51 to 99 employees will be able to buy coverage through federal and state-run SHOPs, which is now available only to businesses with 50 or fewer workers But the larger employers are unlikely to shop on SHOP for the same reasons their smaller counterparts haven't flocked there.

Moreover, the expanded definition of "small group" could translate to higher premiums and increased conversions to self-funding. The larger small groups will have to adhere to provisions such as essential health benefits and metal-tiering plan classifications that previously were reserved for the 1- to 50-employee segment, likely pushing plenty of the 51- to 100-worker firms to self-insure, according to an issue brief released last month by the American Academy of Actuaries (AAA).

While self-insured business poses less risk for carriers, it also is less profitable. ASO plans are fee-based, so there is a smaller portion of total revenue compared to risk-based plans, and that does impact the top line to an extent.

"The big thing for employers and employees that are in the 51-100 group is that they are going to see some changes to their plans as a result of them now being considered small groups," Cori Uccello, senior fellow at the AAA, recently told *HEX* sister publication *Health Plan Week*. "They will face more restrictive rating rules, as well as additional benefit and cost-sharing requirements. As a result, some of these newly defined small employers may face an increased incentive to self-insure. And if they do that it could increase the average cost of those remaining being fully insured. And that in turn, it could actually result in an increased cost for the 1-50 groups because they are now going to be pooled together [with the 51-100s] when determining small-group rates."

The issue brief, "Potential Implications of the Small Group Definition Expanding to Employers with 51-100 Employees," estimates that the change could affect over 150,000 establishments with more than 3 million workers.

Read the brief at www.actuary.org.

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CLARIFICATION: A table in the February issue of *HEX* listed single-carrier private exchange and their vendors. It included incomplete information about hCentive's private-exchange clients. They include Aetna, Inc., Delta Dental of California, WellCare Health Plans, Health Alliance (of Illinois), Geisinger Health Plan and Alliant Health Plans. The company tells *HEX* it also is in negotiations with two other plans.

Average Premium Rates, by Metal Tier, for States Using Federal Small Business Health Options Program (SHOP) Platform

State	Carriers	Bronze	Silver	Gold	Platinum
Alabama	Blue Cross and Blue Shield of Alabama	$210.56	$267.73	$324.91	$390.28
Alaska	Moda Health, Premera Blue Cross Blue Shield of Alaska	$441.27	$552.36	$680.78	$352.95
Arizona	Blue Cross Blue Shield of Arizona, Inc.; Health Net, Inc.; Meritus Health Partners; UnitedHealthcare	$223.90	$294.78	$331.45	NA
Arkansas	Arkansas Blue Cross and Blue Shield	$276.43	$310.83	$355.94	NA
Delaware	Aetna, Inc.; Highmark Blue Cross Blue Shield Delaware	$320.12	$378.66	$459.76	NA
Florida	Florida Blue; Florida Health Care Plans; Health First Health Plans, Inc.; UnitedHealth Group	$271.14	$331.51	$394.22	$464.43
Georgia	Alliant Health Plans, Blue Cross Blue Shield Healthcare Plan of Georgia, Kaiser Permanente	$313.71	$393.46	$472.98	NA
Illinois	Blue Cross and Blue Shield of Illinois*; Health Alliance Medical Plans, Inc.; Land of Lincoln Mutual Health Insurance Co.	$233.04	$304.49	$364.66	$338.10
Indiana	ADVANTAGE Health Solutions, Inc.; Anthem Blue Cross and Blue Shield; SIHO Insurance Services	$353.97	$424.11	$478.25	NA
Iowa	Avera Health Plans, Inc.; Gundersen Health Plan, Inc.; Sanford Health Plan	$280.43	$354.01	$401.61	$450.16
Kansas	Blue Cross and Blue Shield of Kansas City; Blue Cross and Blue Shield of Kansas, Inc.	$211.56	$275.14	$322.78	NA
Louisiana	Blue Cross Blue Shield of Louisiana; Louisiana Health Cooperative; Vantage Health Plan	$288.38	$359.12	$416.25	$480.10
Maine	Anthem Blue Cross and Blue Shield; Harvard Pilgrim Health Care Inc.; Maine Community Health Options	$276.40	$356.67	$467.27	$431.56
Michigan	Blue Cross Blue Shield of Michigan; Consumers Mutual Insurance of Michigan; McLaren Health Plan; Priority Health; Total Health Care USA, Inc.; UnitedHealth Group	$269.39	$320.00	$360.72	$401.51
Missouri	Anthem Blue Cross and Blue Shield; Blue Cross and Blue Shield of Kansas City	$279.28	$370.54	$414.77	NA
Montana	Blue Cross and Blue Shield of Montana*; Montana Health CO-OP; PacificSource Health Plans	$258.53	$321.77	$373.69	$407.21
Nebraska	Blue Cross and Blue Shield of Nebraska	NA	$445.36	$534.18	NA
Nevada	Nevada Health CO-OP	$244.42	$283.25	$329.48	$382.86
New Hampshire	Anthem Blue Cross and Blue Shield; Community Health Options; Harvard Pilgrim Health Care of NE; Minuteman Health, Inc.	$257.35	$325.96	$414.17	$405.53
New Jersey	AmeriHealth New Jersey; Horizon Blue Cross Blue Shield of New Jersey	$353.50	$381.00	$507.03	$645.74
North Carolina	Blue Cross and Blue Shield of North Carolina	$344.17	$408.36	$473.63	$550.67
North Dakota	Blue Cross Blue Shield of North Dakota; Medica; Sanford Health Plan	$300.03	$351.53	$394.88	$449.17
Ohio	Anthem Blue Cross and Blue Shield; AultCare Insurance Company; HealthSpan; InHealth Mutual; MedMutual; SummaCare Inc.	$289.13	$364.90	$421.78	$490.69
Oklahoma	Blue Cross and Blue Shield of Oklahoma*; CommunityCare of Oklahoma; GlobalHealth	$189.63	$260.33	$334.14	$421.54
Pennsylvania	Blue Cross of Northeastern Pennsylvania; Capital BlueCross; Highmark Health Insurance Company; Independence Blue Cross; UPMC Health Plan	$267.97	$332.89	$382.96	$434.89
South Carolina	BlueCross BlueShield of South Carolina; Consumers' Choice Health Plan	$317.64	$378.26	$451.28	NA
South Dakota	Avera Health Plans, Inc.; DAKOTACARE; Sanford Health Plan	$282.01	$331.80	$406.17	$474.63
Tennessee	BlueCross BlueShield of Tennessee	NA	$336.33	$464.88	$577.54
Texas	Blue Cross and Blue Shield of Texas; FirstCare Health Plans; UnitedHealth Group	$216.26	$289.70	$350.83	NA
Virginia	CareFirst BlueCross BlueShield; HealthKeepers, Inc. (Anthem); Kaiser Permanente; Piedmont Community HealthCare	$243.52	$309.22	$366.11	$437.31
West Virginia	Highmark Blue Cross Blue Shield West Virginia	$327.02	$417.75	$495.10	$605.28
Wisconsin	Arise Health Plan; Common Ground Healthcare Cooperative; Group Health Cooperative-SCW; Gundersen Health Plan, Inc.; Health Tradition Health Plan; Medica; MercyCare Health Plans; Security Health Plan; UnitedHealthcare	$309.18	$376.89	$451.35	$531.85
Wyoming	Blue Cross Blue Shield of Wyoming, WINhealth Partners	$384.29	$452.78	$519.70	$541.58

* Health plan is a unit of Health Care Service Corp.
NA=No insurer in the state offers products in the metal tier indicated.
SOURCE: Calculated by AIS from a March 2015 HHS report.

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