What to Expect from Exchanges:
How One-Stop Shopping Will Shape the Future of Health Care

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Mr. Ario has 30 years of experience helping to shape and implement public policy, including two decades devoted to leading health insurance reform efforts at the state and federal government levels. He provides strategic consulting and policy analysis to assist state governments, health plans, hospitals, foundations, and other stakeholders in preparing for the broad implications of healthcare reform, with a particular emphasis on planning for and implementing the new exchange-based marketplaces.

Prior to his federal service, Mr. Ario was Pennsylvania Insurance Commissioner from 2007 to 2010 and Oregon Insurance Commissioner from 2000 to 2007. He served on the Executive Committee of the National Association of Insurance Commissioners (NAIC) for a decade and was an NAIC officer from 2003 to 2005.
Ms. Dutton has extensive experience working with public health insurance programs and the healthcare safety net in connection with the assistance she has provided a broad array of healthcare clients in navigating the legal, regulatory and political challenges of Medicaid, CHIP and other public programs. Ms. Dutton advises foundations, state governments and provider groups on the implications of health reform. She has led state health reform implementation engagements in North Carolina, New Hampshire and California and previously led statewide, multi-stakeholder engagements relating to health benefit exchange planning and health information exchange.

Ms. Dutton serves as an advisor to the Robert Wood Johnson State Health Reform Assistance Network, in which capacity she provides technical assistance to eleven states on issues related to Medicaid and Exchange implementation. She is also the project director for the Center for Medicare and Medicaid Services' Medicaid and CHIP Learning Collaborative and co-leads its Coverage Learning Collaborative, a convening of healthcare officials from eight states and CMS officials with the aim of promoting knowledge of new federal rules and advancing effective eligibility, enrollment and benefits policies.

**Education**
Overview

The Emerging Exchange Marketplace

Regulatory Framework

Trends Entering 2014

Broader Implications of Reform
Emerging Exchange Marketplace
Architecture of the Affordable Care Act (ACA)

Cost Control
- Payment reform (ACOs*)
- Innovation funding (CMMI*)
- Patient safety
- Wellness incentives
- Hospital readmissions
- Marketplaces
- Tax credits
- Medicaid expansion (at state option) and modernization

Coverage Expansion
- Targeted expansions (donut hole coverage, dependent coverage to 26)
- Public health
- Preventive services
- Small Business Health Options Program (SHOP) – employee choice
- Employer mandate

Insurer accountability (Medical Loss Ratio [MLR], rate review)
Quality and transparency
Healthcare workforce

* ACO = accountable care organizations
CMMI = Center for Medicare and Medicaid Innovation
ACA Coverage Plan

Keep current coverage in place for those already insured
  • Preserve employer provided coverage with employer mandate (delayed until 2015)

Implement insurance reforms combined with coverage “mandate”
  • Broad-based participation is critical

Provide sliding scale of tax credits to make coverage affordable

Create new insurance Marketplaces for individuals and small businesses

Expand Medicaid
  • Will be gaps in non-expansion states
ACA Impact on Coverage

**2013**
- 55 million Medicaid/CHIP
- 36 million Employer
- 26 million Nongroup/Other
- 158 million Total

**2020**
- 47 million Medicaid/CHIP
- 31 million Employer
- 22 million Nongroup/Other
- 20 million Unsubsidized Private Coverage through Marketplace
- 160 million Total

Total = 272 million people < 65

Source: Congressional Budget Office estimates of current law, May 2013
# Five Core Functions of Marketplaces

| **Consumer Assistance** | Educate and outreach to consumers  
Manage consumer assistance entities  
Operate a call center  
Correspond with consumers to support eligibility and enrollment |
|-------------------------|----------------------------------------------------------------------------------------------------------------------------------|
| **Plan Management**     | Select plans to be offered  
Collect and analyze benefit packages and plan rates  
Manage relations with issuers |
| **Eligibility**         | Accept applications and determine eligibility for Insurance Affordability Programs (IAPs) and Qualified Health Plans (QHPs)  
Connect Medicaid and Children’s Health Insurance Program (CHIP)-eligible applicants to Medicaid and CHIP  
Conduct redeterminations and appeals |
| **Enrollment**          | Enroll consumers into QHPs  
Manage transactions with QHPs  
Ensure advance payments of premium tax credit and cost-sharing reductions |
| **Financial Management**| Manage user fees, financial integrity, and risk programs |
Consumer’s Path Through the Marketplace

1. **Applies for Coverage**
   - Applies on own via web, phone, mail, in-person
   - Applies with help of navigators, assistors, retailers and other consumer assistance entities

2. **Receives Eligibility Determination**

3. **Shops, Compares, & Chooses Plan**
   - Compares apples to apples to choose a health plan from one of the metal levels.
   - Consumers will be price sensitive:
     - Buy down to save on premium
     - Buy up to save on cost sharing

4. **Enrolls in Plan**
   - Must pay marketplace or health plan to begin coverage.

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Private exchanges have a similar structure except they substitute a defined contribution from the employer at step 2.
Step 1: Who Helps with Consumer Outreach?

Navigators: The ACA requires Marketplaces to establish a Navigator program to provide in-person education, as well as eligibility and enrollment assistance.

Assisters & Certified Application Counselors: Additional mechanisms for delivering in-person consumer assistance; proposed regulations require Marketplaces to certify volunteer “application counselors” to provide services similar to Navigators and Assisters.

Agents, Brokers & Issuers: Individuals and businesses will be permitted to help enroll through the Marketplace under certain conditions, including through issuer-specific and broker-based web sites connected to Marketplace for eligibility determinations.

Call Center: Toll-Free Hotline operated through the Marketplace to provide application assistance and referrals to the right entities.

Defining the respective roles of navigators and agents/brokers continues to be an issue in some states.
Step 2: No Wrong Door Under the Coverage Continuum

Children’s Health Insurance Program (CHIP) eligibility levels vary by state

Qualified Health Plans (QHPs)

Premium Tax Credits and Cost Sharing Reductions for Qualified Health Plans

Employer-Sponsored Coverage

In non-expansion states, there may be gaps in coverage for those under 100% of the federal poverty level
Step 2: What Subsidies are Available?

- Individuals with incomes from 100-400% of the federal poverty level (FPL) who are ineligible for Medicaid are eligible for premium tax credits and cost sharing reductions.

### Premium Tax Credits:

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Premium as Percent of Income</th>
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</thead>
<tbody>
<tr>
<td>Up to 133% FPL</td>
<td>2% of income</td>
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<tr>
<td>133 – 150% FPL</td>
<td>3 – 4% of income</td>
</tr>
<tr>
<td>150 – 200% FPL</td>
<td>4 – 6.3% of income</td>
</tr>
<tr>
<td>200 – 250% FPL</td>
<td>6.3 – 8.05% of income</td>
</tr>
<tr>
<td>250 – 300% FPL</td>
<td>8.05 – 9.5% of income</td>
</tr>
<tr>
<td>300 – 400% FPL</td>
<td>9.5% of income</td>
</tr>
</tbody>
</table>

### Cost Sharing Reductions:

<table>
<thead>
<tr>
<th>Income Level</th>
<th>Silver Plan Variation Actuarial Values</th>
</tr>
</thead>
<tbody>
<tr>
<td>100 – 150% FPL</td>
<td>94%</td>
</tr>
<tr>
<td>150 – 200% FPL</td>
<td>87%</td>
</tr>
<tr>
<td>200 – 250% FPL</td>
<td>73%</td>
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</table>

**An example:**

- Family of 4 at 200% of FPL: $47,100 income
- What family will pay for SLCSP (6.3%): $247/mo.
- Assume SLCSP premium for family of 4 is: $1,000/mo.
- Tax credit is: $753/mo. (fixed regardless of QHP chosen)
- If buy silver plan, cost sharing reduced so actuarial value (AV): 87%

Regardless of QHP selected, tax credit is difference between premium of second lowest cost silver plan (SLCSP) available to family and amount described above.
Step 3: What Products are Available?

Qualified Health Plans (QHPs) will be available to individuals and small employers in the Marketplace

**The Marketplace will:**
- Set standards for QHPs
- Certify participating plans, and
- Present uniform and standardized information on plans that range in metal level from bronze to platinum

**QHPs must:**
- Provide plans with actuarial values consistent with metal levels
- Provide “Essential Health Benefits” (EHBs)
- Ensure sufficient choice of providers with special rules for integrated delivery systems
- Be accountable for performance on clinical quality measures and patient satisfaction
- Implement a quality improvement strategy (delayed)
- Provide standardized consumer information

**Insurers must:**
- Offer at least a silver and gold plan

<table>
<thead>
<tr>
<th>Metal Level</th>
<th>Actuarial Value Coverage</th>
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<tbody>
<tr>
<td>Bronze</td>
<td>Covers 60% of actuarial value of benefits</td>
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<tr>
<td>Silver</td>
<td>Covers 70% of actuarial value of benefits</td>
</tr>
<tr>
<td>Gold</td>
<td>Covers 80% of actuarial value of benefits</td>
</tr>
<tr>
<td>Platinum</td>
<td>Covers 90% of actuarial value of benefits</td>
</tr>
<tr>
<td>Catastrophic</td>
<td>High-deductible plan for individuals up to age 30 or individuals exempted from the mandate to purchase coverage</td>
</tr>
</tbody>
</table>

EHBs and metal levels apply market-wide
Regulatory Framework
Key Insurance Regulation Under the ACA

- QHP Certification Standards
- Essential Health Benefits
- Insurance Market Reforms
- Small Business Health Options Program
- Transparency
- Risk Adjustment, Reinsurance, and Risk Corridors
# QHP Certification Standards

<table>
<thead>
<tr>
<th>Standards applicable to QHP issuers</th>
<th>Standards applicable to QHPs (products)</th>
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<tbody>
<tr>
<td>• Licensing and solvency</td>
<td>• Essential health benefits (EHBs)</td>
</tr>
<tr>
<td>• Marketing</td>
<td>• Drug formulary standards</td>
</tr>
<tr>
<td>• Service areas</td>
<td>• Non-discrimination in benefit design</td>
</tr>
<tr>
<td>• Quality disclosure and improvement (delayed)</td>
<td>• Actuarial value</td>
</tr>
<tr>
<td>• Accreditation (delayed)</td>
<td>• Cost sharing reductions</td>
</tr>
<tr>
<td></td>
<td>• Network adequacy</td>
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<td></td>
<td>• Essential community providers (ECPs)</td>
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QHP Certification and Plan Management

**Health & Human Services**
- Ongoing guidance
- Unified data template and automated tools
- Broader role in Federally-facilitated marketplace (FFM) states, potential for enforcement role in some states

**State Insurance Departments**
- Traditional rate and form review, solvency review
- Regulate market outside Marketplace
- Consumer assistance and market conduct oversight

**Exchanges**
- Additional review possible if active purchaser
- Transparency for consumers, new shopping tools
- Opportunities for narrow networks and other innovative products
The “Essential Health Benefits Package” (ACA § 1302) applies to all individual & small group markets both inside Marketplaces and in the traditional market and includes:

Coverage of the Essential Health Benefit set

Limits on cost sharing:
- Annual out-of-pocket (OOP) maximums must not exceed high deductible health plans (HDHP) OOP limits. For 2014, $6,350/$12,700 for individual/family
- Small group only: Annual deductibles to $2,000/$4,000 individual/family
- Deductible limits may be exceeded to achieve metal level actuarial values

A standard level of coverage at a metal level:
- Platinum, Gold, Silver, Bronze, or Catastrophic
- Defined by the concept of Actuarial Value

EHBs determined state-by-state for 2014-2015
EHBs included in each QHP

- Ambulatory Patient Services
- Emergency Services
- Hospitalization
- Maternity and Newborn Care
- Mental Health & Substance Use Disorder Services, Including Behavioral Health Treatment
- Prescription Drugs
- Rehabilitative & Habilitative Services & Devices
- Laboratory Services
- Preventive & Wellness Services & Chronic Disease Management
- Pediatric Services, Including Oral & Vision Care
Actuarial Value highlights the tradeoff between affordability and cost-sharing:

**High Actuarial Value** ➔ Richer Benefits/low cost sharing ➔ More Premium

**Low Actuarial Value** ➔ Leaner Benefits/high cost sharing ➔ Less Premium

The Center for Consumer Information and Insurance Oversight (CCIIO) Actuarial Value Calculator has limitations, including accounting for differences in network, which can have a large impact on pricing.
Insurance Market Reforms

Premium rate variation limited to 4 factors (Public Health Service Act § 2701)

**Age** (limited to 3:1)
- 0 – 20 years: Child age band
- 21 – 63 years: Single year age bands for adults
- 64+ years: One age band

**Tobacco** (limited to user/non-user ratio of 1.5:1)
- Some states have prohibited or further limited tobacco rating

**Geographic Area**
- Uniform areas for all carriers across the state
- Maximum # of areas as metropolitan statistical areas (MSAs) plus one; unless get exception
- States range from 1 – 67 areas (Florida has one for each county)

**Family composition**
- Capped at 3 oldest covered children under 21

*Single risk pool requirement will stabilize rates once new equilibrium is reached*
Small Business Health Options Program (SHOP)

Exchanges must include both an individual Exchange and a Small Business Health Options Program

- SHOP must offer group QHPs for businesses with 1-50 employees (2014-2015)
- ACA requires expansion to businesses with 51-100 employees in 2016
- ACA allows expansion to larger businesses (100+) in 2017 with separate risk pools

SHOP must offer employee choice

- Exchanges must offer one standard choice model (employer picks one metal level and employees can choose any plan on that level)
- Exchanges can offer additional choice models (broader or narrower)
- Exchanges can also offer traditional “employer picks one plan” model (dominant in market today)
- Federal exchange states not offering any choice models in 2015
- State Exchanges had option to delay but most are moving forward with choice in 2014

SHOP products and risk pool are separate and distinct from individual products and risk pool

- Exchanges can merge the two risk pools (Massachusetts did) but not popular for 2014
- Similar rating rules may lead to merged risk pools in future

SHOP enrollment projected to be fraction of individual enrollment; Dynamic to watch is whether employee choice models gain traction
Employers with up to 25 full-time employees (FTEs) + average wages of $50,000

Employer must pay at least 50% premium

10< FTEs + wages under $25,000 = Maximum credit

Maximum credit = 35% of employer premiums for 2010-2013

Maximum credit = 50% of employer premiums for 2014 and later

2014: employers must buy through exchange to qualify

Credit available for 2 years

Credit not advance-able, only available at tax time
Transparency Under the ACA

Summary of § 156.220 Transparency in Coverage

- A QHP issuer must make provide and make publicly available the following information in plain language in an accurate and timely manner.
  1) Claims payment policies and practices
  2) Periodic financial disclosures
  3) Enrollment data
  4) Disenrollment data
  5) Claim denial data
  6) Rating practice data
  7) Out-of-network cost sharing/coverage information
  8) Information on enrollee rights under title I of the ACA

- A QHP issuer must provide enrollee plan cost sharing amounts for a specific item or service by a participating provider in a timely manner upon the request of the enrollee. The requirement that this information be available through a Web site will drive real-time disclosures with consumer-friendly menus to promote comparison shopping for services that have a significant cost-sharing component.

Summary of § 155.1040 Transparency in Coverage

- The Exchange must: 1) collect information from QHP issuers relating to coverage transparency as described in §156.220 2) determine whether the information is provided in plain language, and 3) must monitor whether a QHP issuer has made cost-sharing information available in a timely manner upon the request of an individual as required by §156.220(d).
Risk Stabilization Programs

Along with tax credits and mandates, the ACA establishes three programs that are critical to stabilizing risk pools in short term (reinsurance and risk corridors) and long term (risk adjustment).

States can manage risk adjustment and reinsurance, but almost all states are deferring risk stabilization activities to HHS in 2014.

**Risk adjustment** is a permanent program that requires annual payments among insurers to adjust for differences in health risk.
- Insurers with better than average risk customers compensate insurers with worse than average risk customers.
- Federal risk adjustment model will use a “distributed” data approach, with age, gender, and certain diagnoses as key measures.
- Goal is to deter risk selection practices among insurers.

**Reinsurance** is a three year program to compensate insurers who serve the most expensive patients in the individual market.
- Broad-based funding mechanism used to spread costs of most expensive cases.
- HHS will collect all reinsurance contributions and limits state authority to modify attachment point (60,000), coinsurance (80%) and cap (250,000).
- Goal is to reduce market volatility and higher prices during transition to new equilibrium.

**Risk corridors** are a three year program designed to cushion the consequences of actuarial uncertainty.
- Insurers whose actual experience is substantially different than their projected claims costs (outside a plus or minus 3% corridor) receive or make payments.
- Risk corridor formula most important to insurers who price too low since MLR standards already limit profits from over-pricing.
- Goal is to limit actuarial tendency to price up in face of uncertainty.
Trends Entering 2014
**Marketplace Timeline**

- **Dec 16 2012:** 17 states and D.C. seek state-based Marketplaces (SBMs)
- **Feb 15 2013:** 7 states seek partnership
- **Feb/March 2013:** HHS finalizes rules on EHBs, market reforms, and 3Rs. Details on FFM released.
- **April-June 2013:** QHP issuers submit plans for review (April 1-30 for FFM)
- **July-Sept 2013:** QHPs certified. Navigators begin operations
- **Summer 2013:** Federal and state marketing campaigns go big
- **Oct 1 2013:** Open enrollment begins
- **Nov 18 2013:** States can apply for 2015 transitions to a Partnership or SBM

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- **Jan 1 2014:** Marketplace coverage begins
- **Nov 2014:** Last Exchange Establishment federal grant application deadline
### Three Marketplace Options for States

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<thead>
<tr>
<th><strong>STATE-BASED MARKETPLACE</strong></th>
<th><strong>STATE PARTNERSHIP MARKETPLACE</strong></th>
<th><strong>FEDERALALLY-FACILITATED MARKETPLACE</strong></th>
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<tbody>
<tr>
<td><strong>FEDERAL FUNCTIONS</strong></td>
<td>• Data hub</td>
<td>• Data hub</td>
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<td>• Rate stabilization</td>
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<td></td>
<td></td>
<td>• Eligibility and enrollment</td>
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<tr>
<td></td>
<td></td>
<td>• Financial management</td>
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<tr>
<td><strong>CORE STATE FUNCTIONS</strong></td>
<td>• Licensing and solvency</td>
<td>• Licensing and solvency</td>
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<td></td>
<td>• Rate and form review</td>
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<td>• Consumer complaints</td>
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<td></td>
<td>• Market conduct</td>
<td>• Market conduct</td>
</tr>
<tr>
<td><strong>STATE MARKETPLACE ROLES</strong></td>
<td>• Eligibility and enrollment</td>
<td>• Plan management</td>
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<td></td>
<td>• Financial management</td>
<td>• Consumer assistance</td>
</tr>
<tr>
<td></td>
<td>• Plan management</td>
<td>• Both</td>
</tr>
<tr>
<td><strong>STATE OPTIONS</strong></td>
<td>• Run risk adjustment and/or</td>
<td>• Run reinsurance</td>
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<td></td>
<td>reinsurance</td>
<td>• Medicaid determination</td>
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<td></td>
<td>• Delegate tax credit calculation</td>
<td>• Enhanced rate and form review for</td>
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<td></td>
<td>and certain other services to</td>
<td>QHPs</td>
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<td>HHS</td>
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**Federal Enforcement:** States have primary enforcement role under the ACA for market-wide insurance reforms, but HHS has authority to enforce the EHB rules and other ACA requirements directly against insurers if a state is not "substantially enforcing" the ACA.
Federally-Facilitated Marketplace will have many flavors of quasi-partnership.
Continuum of State Marketplace Visions

**Vermont**
Intends to evolve its exchange toward a single payer

**New York & California**
Have standardized benefit plans beyond ACA minimums

**Oregon**
Intends to integrate its exchange and Medicaid strategies through comprehensive community care organizations

**Maryland**
Will have a clearinghouse exchange but require all carriers in individual and small group markets to participate

**Massachusetts**
Has never excluded an interested carrier but still struggles with small business and non-subsidized enrollment

**Minnesota**
Is looking ahead to an innovation waiver to vary subsidies based on quality performance

**Idaho & Nevada**
Will operate clearinghouse exchanges with minimum regulation

**Utah**
Operates a SHOP Marketplace that it hopes to eventually privatize
Federally-facilitated Marketplace (FFM)

FFMs in 34 states in 2014 with much uncertainty about how many states will move to regain state control in 2015 or later

- HHS rules allow annual election but last application for start up grants is November 18, 2014
- Seven FFM states already are State Partnerships, which can be path to State-based Marketplace (SBM)
- FFM may be hard to displace if it gains a constituency (could vary by state)

FFM starting as “clearinghouse” that accepts all insurers meeting minimum standards

- HHS has been clear that this could change in future years
- Intermediate step is stricter QHP standards (meaningful difference, network adequacy), some discussion on rates

FFM may be clunky but on track to meet 2014 timeline

- QHP certification by mid Sept makes Oct 1 open enrollment challenging, but Jan 1 is key date
- Some longer term priorities falling to wayside (quality standards, employee choice in SHOP)

FFM is state friendly for now

- Broad discretion to states for plan management in FFM as well as Partnership States
- Deference to states on whether to empower Web-based brokers and private exchanges
- Network adequacy could be early testing ground for limits on flexibility
States can move from an FFM to an SBM model on an annual basis; most FFM states are playing a significant role in overseeing insurers in their State Marketplaces.
Medicaid Expansion is Key

• Medicaid expansion brings in a new adult group and mandates a new benefit package
• Twenty-five states and DC will expand in 2014, with potentially more to follow in 2015
  • CMS providing one year extensions of existing waivers in non-expansion states
• Medicaid enrollment will grow even in non-expansion states

State Approaches to Providing Benefits to Expansion Populations Differ

Medicaid Managed Care (MMC)
Illinois
State will expand managed care program to include newly eligible groups

Qualified Health Plans (QHPs)
Iowa
Arkansas
State will use Medicaid funds to purchase coverage for newly eligible group in Marketplace QHPs (premium assistance)

Cost Sharing
Michigan
State seeking to impose premiums or co-payments above historic Medicaid levels
**Growing & Changing Medicaid Population**

Medicaid is estimated to grow by 14-16 million new beneficiaries. Most of the new population will be non-disabled, non-elderly adults.

% Enrollment by Eligibility Group 2008

<table>
<thead>
<tr>
<th>Eligibility Group</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>Adults</td>
<td>25.3%</td>
</tr>
<tr>
<td>Children</td>
<td>49.1%</td>
</tr>
<tr>
<td>ABD</td>
<td>10.2%</td>
</tr>
<tr>
<td>Duals</td>
<td>15.4%</td>
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</tbody>
</table>

**The New Adult Eligibility Group**

- Under age 65
- Income below 133% FPL*
- Not pregnant
- Not entitled to or enrolled in Medicare Part A
- Not in any other mandatory Medicaid eligibility group

*The new adult eligibility group largely comprised of individuals with untreated chronic disease (e.g., diabetes and mental illness), as well as other socioeconomic factors which present challenges for care delivery.
1. **Woodwork Effect** – Marketplace marketing campaigns and streamlined eligibility determinations are expected to result in the enrollment of uninsured individuals currently eligible for Medicaid.

2. **Movement Between Medicaid and Marketplace** – A significant number of individuals whose income fluctuates regularly may shift between Medicaid and the exchange, potentially causing lack of coverage and care continuity.
   - Among a national sample of adults with family income <200% FPL, 35% would experience an eligibility change within six months, and 50% within one year. 24% would experience 2+ eligibility changes within a year.

3. **Options for addressing churn**
   - Basic Health Plan – delayed until 2015
   - Bridge Plans – e.g. California
   - Arkansas “Private Option” and Iowa variant

4. **Gaps and Coordination Challenges**: There will be gaps in coverage for those below 100% FPL in non-expansion states and eligibility hand-offs may be challenging, particularly in FFM states.

Broader Implications of Reform
## Broader Dynamics: Trends to Watch

<table>
<thead>
<tr>
<th>Category</th>
<th>Description</th>
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<tbody>
<tr>
<td><strong>Market in Transition</strong></td>
<td>• Insurer participation will evolve over time and rates will vary between states and within states as today</td>
</tr>
<tr>
<td><strong>Transparency and Direct Marketing</strong></td>
<td>• New opportunities to simplify the buying experience for the individual or employee, branding will be key</td>
</tr>
<tr>
<td><strong>Innovative Products</strong></td>
<td>• Tension between standardization and innovation, narrow network products will become one option on menu</td>
</tr>
<tr>
<td><strong>Skin in the Game</strong></td>
<td>• Consumers will become more price conscious with increased cost sharing in bronze/silver, higher premiums in gold/platinum</td>
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<tr>
<td><strong>Employer –based Coverage</strong></td>
<td>• Delay on employer mandate will not change basic dynamic of employers taking “wait and see” attitude toward changing current practices</td>
</tr>
<tr>
<td><strong>Private Exchanges</strong></td>
<td>• May take hold in large group market and grow more quickly than public Marketplaces</td>
</tr>
<tr>
<td><strong>Role of Government</strong></td>
<td>• Similarities between ACA-style premium support and Ryan-style Medicare reform may become more apparent, with continued clashes over what are appropriate levels of subsidy for distinct populations</td>
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</tbody>
</table>
Leading national commercial insurers are proceeding cautiously in individual and SHOP Marketplaces

- United has cut back its original plan to participate in up to half the state Marketplaces
- Aetna announced it would participate in 14 Marketplaces, but has since withdrawn from five Marketplaces
- Humana plans to participate in 14 Marketplaces
- Cigna plans to participate in 5 Marketplaces, including FL, TX and one state-based Marketplace (CO)

Nearly all of the nation’s 38 BlueCross BlueShield (BCBS) companies will participate in their states

- Blues have dominant market share in many of the smaller states and some larger ones
- Anthem/Wellpoint (14 states) intends to participate in all of its states, and will be the sole insurer in NH
- Other multi-state Blues (HCSC, Care First, Regence/Cambia and Premera) also likely to participate in all their states, though not always with the Blue brand
- Single state Blues are also likely participants, with announced exceptions in IA, MS and SD

Limited first-year participation by leading national carriers opens up opportunities for regional carriers

- Community-based carriers with integrated provider networks will be key players (ACHP)
- Multi-state plans uncertain for 2014, Coops are price competitive, but may struggle
- National and local Medicaid managed care organizations active in some states
- Interesting mix of local carriers active in large and small states
- Local carriers have expanded market share in MA

Rate Variation in 2014

Rates are available for most state exchanges and some federal exchange states
- Broad variations among states, within regions of states, among carriers for same plan
- Many uncertainties for actuaries in pricing plans (new populations, rate reforms)
- General trend is lower than expected rates for cheapest plans but also higher rates for gold and platinum plans
- Many studies have been selective in how they use data, but more comprehensive surveys starting to appear

Avalere – 12 states (8 SBMS, 4 FFMs)
- Looked at minimum, average, and maximum premiums
- Average bronze was $274 and average silver was $336 ($62 savings for buying down)
- Lowest silver ranged from $197 in MD to $383 in VT
- Silver plans from $276 to $694 in NY (16 plans and 8 regions)

Kaiser – largest cities in 17 states and DC (11 SBMs, 7 FFMs)
- Looked at premiums for 25, 40 and 60 yr olds, with and without subsidies
- 15 of 18 cities had lower premiums for 2nd lowest cost silver than CBO projection ($320)
- Lowest bronze ranged from $146 in Baltimore to $336 in Burlington (all but two bronze under $150 after subsidies)
- 2d lowest silver premiums range from $158-$413 (25 yr), $201-$413 (40 yr), and $390-$697 (60 yr)

Manhattan Institute – 13 states and DC (10 SBMS, 4 FFMs)
- Interactive site for finding specific premiums and subsidies
- 24% average premium increase (increases in 9 states and decreases in 5 states)
- 43% average premium increase for 27 yr olds, younger women fare better than older ones
- OH rates down by 30% vs. earlier prediction of 41% increase (comparing five cheapest rather than all plans)
Transparency & Direct Marketing in a Web-Based World

All exchange models will create new opportunities for empowering the consumer.

Exchanges face regulatory requirements and powerful market incentives to break down the opaqueness of the current marketplace.

Web-based selling will require an Amazon-style focus on the consumer that will foster new forms of competition.

Successful exchanges will go well beyond minimum requirements to offer state of the art shopping tools based on the latest consumer behavior research.

Marketplaces can be a testing ground for new consumer education strategies, such as tools that allow consumers to better understand premium vs. out-of-pocket costs.
Payment Reform, ACOs and Narrow Networks

Inexorable movement from fee for service to risk-based payments (volume to value) will be amplified by exchanges

- 488 ACOs in various stages of formation, more on commercial than public side

Challenge will be to avoid 1990s-type consumer backlash with new approaches that vest more control with providers and rely on better measurement tools

Focus on risk collaboration with potential for “general contractor” to manage multiple subcontractors taking narrow layers of risk

ACOs with significant scale in a local market can become narrow network products

ACA provides exception to narrow network adequacy rules for certain ACO-type products offering a single integrated care system

Marketplaces offer ideal market for testing narrow network products with consumers in a marketplace where they are just one option among many
## Federal v. State Roles

<table>
<thead>
<tr>
<th>Federal Role</th>
<th>State Role</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Federal role will continue to be significant in all states</strong></td>
<td><strong>State role likely to grow over time</strong></td>
</tr>
<tr>
<td>Ongoing responsibility for regulatory standards (national EHBs in 2016)</td>
<td>Most FFM states played key role in QHP process this year</td>
</tr>
<tr>
<td>HHS has secondary enforcement obligations in states that do not enforce the ACA (six on list today)</td>
<td>Could put more states on path to State Exchange</td>
</tr>
<tr>
<td>FFM could be permanent presence in many states</td>
<td>States will be laboratories for innovation on Exchanges and other HHS programs</td>
</tr>
</tbody>
</table>

### The balance of power between federal and state authorities is in flux

- States could lose the control envisioned by the Senate approach that won in 2010
- But most ACA policy-making still tilts toward giving states additional time and opportunity
**Expected Employer Response to Exchanges**

- **-30%**
  30% of employers of all sizes will definitely or probably stop offering ESI in the years after 2014 (McKinsey, survey, 2011).

- **-1%**
  In 2013, less than 1% of employers reported that they “definitely will not” continue coverage in 2014 (IFEBP, survey, 2013).

- **-4%**
  By 2018, 4% fewer workers (7M) will have ESI as compared to projections in absence of the law (CBO, microsimulation, 2013). According to Rand, the ACA will lead to an increase in employers offering insurance from 59.4% to 61.6% in 2016 due to the ACA (Rand, microsimulation, 2012).

- **+6%**
  The number of Massachusetts firms offering coverage increased by 6% between 2007-2008, with a 4% increase in small firms offering coverage (Gabel, 2009).

---

<table>
<thead>
<tr>
<th>Firm Size</th>
<th>Estimated Change in ESI</th>
<th>Source</th>
</tr>
</thead>
<tbody>
<tr>
<td>Small</td>
<td>-13%</td>
<td>Deloitte, Firm survey (50-100 -ees), 2012</td>
</tr>
<tr>
<td></td>
<td>-0.4%</td>
<td>Urban Institute, Microsimulation of full ACA implementation based on 2010 data, Firms &lt;100 -ees</td>
</tr>
<tr>
<td>Medium</td>
<td>+0.7%</td>
<td>Urban Institute, Microsimulation of full ACA implementation based on 2010 data, Firms 100-1000 -ees</td>
</tr>
<tr>
<td>Large</td>
<td>-1%</td>
<td>Deloitte, Firm survey (1,000+ -ees), 2012</td>
</tr>
<tr>
<td></td>
<td>0%</td>
<td>Towers Watson, Firm survey (+1,000 -ees), 2012</td>
</tr>
<tr>
<td></td>
<td>+2%</td>
<td>Urban Institute, Microsimulation of full ACA implementation based on 2010 data, Firms 1000+ -ees</td>
</tr>
</tbody>
</table>

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## Growth of Private Exchanges

**GROWTH OF PRIVATE EXCHANGES**

- Key brokers (Towers Watson, Mercer, Aon Hewitt) are targeting large employer market for expansion of multi-insurer exchange marketplace using defined contribution model
- Key insurers (Blues with Bloom exchange) are developing capacity to offer large and small employers a single insurer private exchange option
- Biggest plays will be in large urban cities and states
- Uncertain role for private exchanges in small group and individual market

### Federal Guidance

<table>
<thead>
<tr>
<th>HHS rules allow web-based brokers or private Exchanges to enroll consumers in QHPs if “permitted” by state</th>
</tr>
</thead>
<tbody>
<tr>
<td>Private Exchanges must meet “fair play” rules (display all QHPs, no steering), meet registration and training requirements, and disclose availability of public Marketplace (155.220)</td>
</tr>
<tr>
<td>Nineteen web brokers have signed standardized contracts with FFM</td>
</tr>
</tbody>
</table>

### Implications

- Opens up new access options for consumers but also creates competition for public Marketplace
- Limits option to multi-insurer Exchanges which remain rare
- Exception for issuer-specific websites who can qualify without displaying all QHPs
- HHS says as many as 50 web brokers may sign contracts
Convergence of Medicaid and Exchange Marketplaces

**Market Segmentation Must Break Down for Expanded Coverage to Succeed**

- Substantially different coverage rules cannot persist given coverage continuum and level of churn
- Major insurers moving to be players in both markets (e.g., United, Wellpoint, Aetna)
- Medicaid MCOs looking toward exchanges (e.g., Molina, Fidelis)
- Product differentiation will move to a continuum

**Market Integration May Expand or Contract the Medicaid Model**

- Some states will put income-eligible Medicaid enrollees into Exchange (AR private option, IA)
- Some states will expand Medicaid-like approach above 138%FPL (CA Bridge Plan, Basic Health Plan)

**But All Models Will Force Market and Regulatory Convergence**

- Reimbursement rates in new models will move to new equilibrium
- Regulators will find common ground in regulating same players across markets
Regulatory Approaches v. Market Approaches

**How Exchange Marketplaces Evolve Will be a Litmus Test**

- Exchanges could become a third public program along the lines of traditional Medicare and Medicaid
- Exchanges could become a vehicle for delivering public benefits along the lines of Medicare Advantage and Part D drug coverage

**Policy Implications of Regulatory and Market Approaches**

- Is Exchange coverage subject to Medicaid-style regulation or commercial regulation?
- Where is the right balance on price transparency?
- What is role of government in evolution of new care models?

Effective engagement will balance short and long term interests as regulatory vs. market dynamics play out through the next several election cycles at the state and federal level.
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IMPLEMENTATION OF THE AFFORDABLE CARE ACT:
REDEFINING THE U.S. HEALTH CARE SYSTEM

LEAD AUTHORS

- Joel S. Ario, William S. Bernstein, and Melinda J. Dutton from Manatt, Phelps & Phillips LLP

COVERAGE

- Market Reforms and Coverage Mandates
- Exchanges and Qualified Health Plans
- Share Responsibility
- Public Programs

TARGET PUBLICATION DATE

- September 30, 2013
<table>
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<tr>
<th>Jurisdiction</th>
<th>Status</th>
<th>Topic</th>
<th>Summary Date</th>
<th>Citation Date</th>
<th>Final Rule Effective Date</th>
<th>Summary</th>
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<tr>
<td>California</td>
<td>Final Rule</td>
<td>Insurance</td>
<td>08/12/2013</td>
<td>08/02/2013</td>
<td>07/24/2013</td>
<td>Risk Adjustment for Health Care Premiums. Final rule of the Public Employees' Retirement System amends regulations under 2 CCR 999.800 and .805 regarding risk adjustment for health care premiums. The rule defines “risk adjustment,” “risk assessment,” and “risk adjusted premium.” The rule also describes risk adjustment procedures. The rule is effective July 24, 2013. Contact: Anthony Martin, CalPERS (510-795-9247)</td>
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<tr>
<td>Montana</td>
<td>Final Rule</td>
<td>Insurance</td>
<td>08/12/2013</td>
<td>08/08/2013</td>
<td>08/09/2013</td>
<td>Children’s Special Health Services. Final rule of the Department of Public Health and Human Services amends regulations under ARM 37.57.102, .106, .111 and .116 regarding Children’s Special Health Services. The rule revises provisions concerning definitions, financial assistance eligibility, payment limits and program records. The rule is effective Aug. 9, 2013. Contact: Kenneth Morland, DHHS, Office of Legal Affairs, (406-444-1271)</td>
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<tr>
<td>Texas</td>
<td>Final Rule</td>
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<td>08/14/2013</td>
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<tr>
<td>Federal</td>
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<td>Health Insurance Exchanges</td>
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Affordable Care Act Implementation Monitor

This table tracks the implementation of the Patient Protections and Affordable Care Act, as amended by the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). Organized by type of reform, the table provides a brief explanation of the provisions of the act, with a link to the text of each provision discussed. The Analysis & Commentary column links to explanations by the Congressional Research Service in Report R41165, "Medicare Provisions in the Patient Protection and Affordable Care Act (PPACA)" Summary and Timeline (1/24/11), and the Health Law Resource Center's collection of BNA Insights. The Implementing Regulations & Agency Guidance column provides links to full text.

Acknowledgment: Attorneys at Barnes and Gray contributed the timeline and descriptions of the statutory provisions included in the Affordable Care Act Implementation Monitor, which was later expanded to track implementing regulations and agency guidance and provide links to the CRS Report cited above and BNA analysis & commentary.

The table groups the statutory provisions by the year in which action must be taken within the following broad categories:

- Insurance Reforms and Exchanges [Go directly to 2013]
- Public Coverage Programs [Go directly to 2013]
- Delivery System Reform [Go directly to 2013]
- Provider and Plan Payment Changes [Go directly to 2013]
- Financing [Go directly to 2013]
- Compliance and Transparency [Go directly to 2013]

Other

<table>
<thead>
<tr>
<th>DATE</th>
<th>PROVISION</th>
<th>IMPLEMENTING REGULATIONS &amp; AGENCY GUIDANCE</th>
<th>ANALYSIS &amp; COMMENTARY</th>
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<tr>
<td>CY 2010</td>
<td>For tax years beginning in 2010, 2011, 2012, and 2013: small employers with 25 or fewer “full-time equivalent” employees and average annual wages of no more than $50,000 may be eligible for a tax credit of 35% (22% for tax-exempt small employers) of the employer's contribution to the cost of providing health insurance to their employees so long as the employer contribution meets or exceeds 90% of the total cost of coverage. Full credit available to employers with 10 or fewer employees and wages less than $25,000. (§5145(f), 10105 PPACA)</td>
<td>IRS, Proposed Rule for Information Reporting for Affordable Insurance Exchanges 78 FR 39644 (7/2/13)</td>
<td>IRS Notice 2013-42, Transition Relief for Employees and Related Individuals Eligible to Enroll in Eligible Employer-Sponsored Health Plans for Non-Calendal Plan Years that Begin in 2013 and End in 2014</td>
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<tr>
<td></td>
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<td>IRS Notice 2013-41, Eligibility for Minimum Essential Coverage for Purposes of the Premium Tax Credit</td>
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<tr>
<td></td>
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<td>IRS, Final Rule on the Health Insurance Premium Tax Credit, 78 FR 7264 (2/1/13)</td>
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<td></td>
<td>IRS Notice 2010-83, Guidance on Tax Credit for Small Businesses and Tax-Exempt Organizations</td>
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