MERCER

CONSULTING. OUTSOURCING. INVESTMENTS.

DISTRICT OF COLUMBIA HEALTH INSURANCE EXCHANGE

BACKGROUND RESEARCH REPORT

DEPARTMENT OF HEALTH CARE FINANCE

DECEMBER 21, 2011

Government Human Services Consulting

MARSH & McLENNAN COMPANIES

CONTENTS

1

Executive Summary

The Affordable Care Act of 2010 (ACA) provides funding assistance for the planning and establishment of the American Health Benefit Exchanges (Exchanges). Under the ACA, each state may elect to set up an Exchange that will create a new marketplace for heath insurance. Mercer Government Human Services Consulting (Mercer) was engaged by the District of Columbia (District) Department of Health Care Finance (DHCF) to assist in conducting planning tasks related to the development of the District's Health Insurance Exchange (DC HIX). The DC HIX would include the individual Exchange and Small Business Health Options Program (SHOP) Exchange. As part of our work, one of the first tasks was to conduct background research required to assess the District's current population and health insurance marketplace. Much of this research will serve as a basis for subsequent phases of our work.

For the report, we have relied on numerous data sources both to present as estimates as well as to validate our conclusions. For much of the demographic research, we relied on the American Community Survey (ACS). The ACS is conducted by the United States (US) Census Bureau and participation in it is required by law for those who are selected. We felt it important to rely on a primary data source to ensure consistency of estimates, and we chose the ACS because, among other reasons, the US Census Bureau attempts to correct a well-documented phenomenon of population surveys called the Medicaid undercount. For these analyses, we have relied on estimates from calendar year 2009. In addition, we relied on publicly available financial statements from insurer participants in the District's insurance market, as well as commercial rate filings, information from carrier's websites, and information provided by the DHCF and the District's Department of Insurance, Securities and Banking (DISB).

Based on the ACS data and information from the DHCF, we estimate that District residents are covered by the following modes of insurance. (Please note that the estimates of persons and standard deviations are in 1,000's.)

	District of Columbia			Nation		
	Persons	**Dist**	**Standard Dev +/-**	**Persons**	**Dist**	**Standard Dev +/-**
Employer (Active)	295	49.2%	2.9	150,097	49.0%	69.4
Employer (Retired)	27	4.5%	0.8	12,878	4.2%	18.0
Military (Active)	8	1.3%	0.6	7,144	2.3%	23.2
Military (Retired)	2	0.3%	0.2	1,926	0.6%	7.7
Direct Purchase	22	3.7%	1.2	16,722	5.5%	28.1
Medicare	21	3.5%	0.8	20,499	6.7%	25.3
Medicaid	156	26.0%	3.0	40,687	13.3%	52.7
Dual	27	4.5%	0.9	9,902	3.2%	18.9
No Coverage	42	7.0%	1.4	46,660	15.2%	47.2
Total	**600**	**100.0%**		**306,515**	**100.0%**	

From these data, we estimate that approximately 50.5% are active employees covered by employer-sponsored insurance (ESI) in either the small group, fully insured large group or self insured markets, 30.5% are covered by Medicaid or other low-income assistance, and 7.0% are uninsured. Assessing factors that might influence a person or business to change insurance modes was one of our chief goals in evaluating the District's population. Specific provisions of the ACA drove decisions to examine certain population characteristics (those provisions are addressed generally in Section 4 and more fully throughout the remainder of the report). Actual modeling the potential migration between these modes was not part of this phase of research.

The majority of District residents are insured by ESI. However, two dynamics make the District unique from other states: 1) a far larger percentage of the District's workers are employed by the government than are workers from other states and 2) the majority of workers in the District do not reside there. As employers assess health benefit options for their employees, they must consider options available to employees residing in other states, such as Virginia and Maryland (MD), as well as options available to District residents. Insurers will also need to consider these dynamics when deciding whether to participate in the DC HIX.

Few segments of the population are affected by provisions of the ACA like those individuals who purchase their own coverage. These individuals will see changes in premium rates, an entirely new domain of additional incentives and a new venue for purchasing coverage. However, most of these incentives are expected to drive people into the direct purchase market rather than out of it. This is important for the viability of a District-sponsored Exchange because the direct purchase segment of the population is also currently one of the smallest. However, many of these residents will not qualify for premium subsidies as the lower-income individuals are likely already enrolled in the District's Health Care Alliance (Alliance) program.

The District has spent considerable sums to ensure that it has a robust Medicaid program for its low-income population. In particular, it has implemented the Alliance program to address the coverage needs of its low-income childless adults. Because of these efforts, the District covers over 30% of its population with these forms of public coverage. Under the ACA, Medicaid will be substantially expanded beyond its current scope. Because the District already has expanded Medicaid coverage, there are only minor indicators that the District's Medicaid program will expand much further. However, the District will receive additional funding from the Federal Government to cover these program costs; these funds should mitigate some of the budgetary pressure on the District.

Because of the District's expanded Medicaid program, the uninsured population in the District is 7%, which is lower than the national average. The ACA provides incentives in the form of tax penalties and credits for these individuals to enter the insurance market. Through the analysis, the data showed that a large proportion of the uninsured are between the ages of 18 and 34, and many of these people have incomes that would seem to provide the means to purchase coverage in today's market (assuming it would be offered). The data also showed that a large part of the uninsured population would appear to qualify for coverage through the District's Medicaid or Alliance program. There are no clear indications of why these people do not obtain coverage through the District and it is difficult to assess their likelihood of obtaining coverage once it becomes a requirement.

The basic health plan (BHP) is expected to support provisions of the ACA to stabilize coverage for the low-income population. There is evidence that a significant portion of the population under 200% of the federal poverty level (FPL) (non-Medicaid and Medicaid eligible) will gain or lose their Medicaid eligibility with some frequency. The BHP is intended to smooth the transition from Medicaid eligibility to non-Medicaid eligibility without the burden of re-enrollment or potential change in providers. Because the District has already made the decision to cover many of these people, there may be little reason not to pursue a BHP. Under the BHP, the District will receive additional funds and continue to offer the continuity of coverage to many of the enrollees that meet the income eligibility requirements.

The viability of a District-sponsored DC HIX will depend on the number of people that use it. In this phase of the project, we have not considered the likely enrollment in a DC HIX, but we have been able to identify those residents that could be eligible for incentives directing people to the DC HIX. We estimate that there are approximately 19,100 District residents (12,800 uninsured and 6,300 direct purchasers) that would be primary candidates for coverage through the DC HIX. However, some employers with many low-income workers may decide that it makes more sense to have their employees seek coverage through the DC HIX. This is particularly true for those employers with lower-income workers who would qualify for premium subsidies.

We identified 125,000 individuals currently enrolled in small group coverage in the District. The employers of these individuals would be eligible to enroll in the SHOP DC HIX. Several factors,

including potential relationships with their agent or broker, will impact their decision to participate in the SHOP DC HIX.

Finally, we reviewed existing Exchanges (e.g., Massachusetts (MA) and Utah (UT)) and the progress of other states as they prepare for the implementation of their Exchanges and SHOP Exchanges. Of the states we reviewed, we examined their approach for addressing the following considerations:

- Governance (i.e., balancing independence from state government versus integration with other governmental agencies)
- Conflict of interest provisions in selecting Board members (i.e., balancing experience with the ability to act primarily in the public's interest)
- Procurement and personnel practices (i.e., provisions designed to attract the best workers to operate the Exchange)
- Financing (i.e., weighing the viability of the Exchange through insurer assessments with the effect such fees might have on the market)
- Integration with Medicaid (i.e., processes to satisfy the ACA's Medicaid eligibility and enrollment requirements within the Exchange)
- Merging of the individual and small group markets (i.e., balancing consistency between merged markets and disruption to the existing markets)
- Geographic considerations (i.e., weighing the flexibility of an independent Exchange versus the scale available to sponsoring states that partner)

This background research is one of the first steps in the District's efforts to plan for and implement a successful DC HIX. In future analysis, we will examine how the District's insured and uninsured populations could migrate across the available modes of coverage. The conclusions in this report will provide a basis for that analysis. This report also gives a thorough review of the District's insurance marketplace before major provisions of the ACA are implemented.

2

Introduction

The ACA provides funding assistance for the planning and establishment of the Exchanges. Under the ACA, each state may elect to set up an Exchange that will create a new marketplace for heath insurance. The Exchanges will offer consumers a choice of health plan options, oversee the pricing and certification of health plans offering coverage within the Exchanges, calculate premium subsidies and provide information to assist consumers in their purchasing decisions.

Mercer was engaged by the DHCF to assist them in conducting planning tasks related to the development of the District's DC HIX, which includes the individual Exchange and SHOP Exchange. As part of our work, one of the first tasks was to conduct background research required to assess the District's current population and health insurance marketplace and prepare this report. This research serves multiple purposes. First, it will provide the DHCF and other key stakeholders and decision makers with a view of the District's market, prior to the implementation of significant reforms. Second, it will serve as the basis for many of the inputs into our modeling that will occur in a subsequent phase of our work.

In the sections that follow, we first provide a general overview of the District's current market composition by payer type, including the uninsured. Next, we in turn look at each of the key payer types in more detail, examining distributions by various demographic, socioeconomic, and in some cases, geographic categories. For the commercial markets, we include information on current benefit offerings and associated premiums. We also present a summary of the rating factors and methodologies currently utilized by carriers offering coverage in the District's individual and small group markets and provide some initial, high-level indications as to the impact that changes required under the ACA could have on rates in these markets in the District. We then provide a primer on the BHP, an optional program that the District may elect to set up for individuals with incomes between 138% and 200% FPL. In the second to last section, we summarize the number of individuals from each of the payer groups that could potentially be eligible to enroll in the DC HIX, the SHOP DC HIX and a BHP. An estimate of those expected to enroll under various scenarios will not be presented until we have completed the actuarial modeling phase of our work. Finally, we include a discussion of existing Exchanges and progress made by other states, as well as key decisions the District will need to make.

Mercer has prepared these projections exclusively for the District, to estimate the range of the impact of Federal Health Care Reform. These estimates may not be used or relied upon by any other party or for any purpose other than for which they were issued by Mercer. Mercer is not responsible for the consequences of any unauthorized use.

All projections are based on the information and data available at a point in time, and the projections are not a guarantee of results which might be achieved. The projections are subject to unforeseen and random events and so must be interpreted as having a potentially wide range of variability from the estimates.

Further, the estimates set forth in this report have been prepared before all regulations needed to implement the ACA have been issued, including clarifications and technical corrections, and without guidance on complex financial calculations that may be required. (For example, some Health Care Reform provisions will likely involve calculations at the individual employee level.) Accordingly, these estimates are not actuarial opinions. The District is responsible for all financial and design decisions regarding the ACA. Such decisions should be made only after the District's careful consideration of alternative future financial conditions and legislative scenarios, and not solely on the basis of the estimates illustrated here.

Lastly, the District understands that Mercer is not engaged in the practice of law and this report, which may include commenting on legal issues or regulations, does not constitute and is not a substitute for legal advice. Accordingly, Mercer recommends that the District secures the advice of competent legal counsel with respect to any legal matters related to this report or otherwise.

The information contained in this document and in any attachments is not intended by Mercer to be used, and it cannot be used, for the purpose of avoiding penalties under the Internal Revenue Code or imposed by any legislative body on the taxpayer or plan sponsor.

3

Data and Reliance

For this report, we have reviewed numerous sources of information on participants in the District's health insurance marketplace. The information included reports from the DHCF, rate filing information from the DISB, presentations of the District's estimated uninsured population, reports from the Centers for Medicare and Medicaid Services (CMS), data from the US Census Bureau, the Medical Expenditure Panel Survey, Dun and Bradstreet, annual statutory financial statements of insurers issuing policies in the District, and various other sources. As a simplified characterization of these data, we can best classify them as representing either the District's population or an insuring entity covering the District's residents and workers. In the sections below, we discuss our primary data sources for these two classifications of information.

Population Data

We relied on various data sources from the US Census Bureau in estimating both the overall size of the population in the District as well as in segmenting the market by characteristics such as type of insurance coverage, age, gender and income. Our primary source for these data was the ACS.

As we reviewed potential data sources, we felt it important that we have one primary data source as a starting point for our analysis. Had we instead relied on data from various different sources as the basis for various aspects of our analysis, we would have faced potential inconsistencies in definitions, time periods and data collection techniques among these various sources. As such, we found two primary data candidates for our analysis: the Current Population Survey (CPS) and the ACS. The CPS is conducted by the US Census Bureau and the Bureau of Labor Statistics. It includes interviews of 60,000 households and is primarily focused on reviewing employment levels. The ACS is also conducted by the US Census Bureau. It is sent to approximately 2.9 million housing units per year and gathers information that is only contained in the long form of the decennial census.

Ultimately, we chose to rely on the ACS data for several reasons. First, there is a documented bias in most survey data where Medicaid enrollment is substantially lower than administrative counts. ACS applies logical edits to the data to adjust for this 'Medicaid undercount.'[1] Second, the ACS questionnaire includes the question: "Is this person CURRENTLY covered by any…health insurance or health coverage plans?"[2] (Emphasis is from the survey). In contrast,

[1] http://www.census.gov/hhes/www/hlthins/publications/coverage_edits_final.pdf.

[2] http://www.census.gov/acs/www/Downloads/questionnaires/2009/Quest09.pdf.

the CPS assesses insured status over an entire year. The first presentation of the question is more consistent with our approach to the forthcoming migration modeling, as it examines a population at a point in time. Third, enrollees are legally obligated to respond to the ACS so, the response rate is quite high (i.e., 98% in 2009).[3] Fourth, and finally, the ACS includes measures that permit the calculation of standard errors from the sample. We may find these capabilities helpful once we begin developing assumption ranges for the model.

Along with those advantages, the ACS data will pose several challenges. We identify some of those challenges here. First, the ACS data are drawn from a small subset of the District's households. The US Census Bureau then assigns weights to each respondent so that they are intended to characterize the entire population. The data present a less reliable picture of the population as questions become more specific. For example, if we wish to review broad income ranges for the District's entire population, the ACS data queried 5,580 individuals from whom we can assess those levels of income in 2009. We can be fairly certain that the income reported from those 5,580 individuals will be representative of the income for all of the District's 599,657 residents in that year. However, if we wish to examine the income for the privately employed, uninsured population between the ages of 18 and 30, we have only 59 respondents during that same year from which to draw our conclusions. If only a few of these respondents have incomes that are very different from the population they are intended to represent, our conclusions could be skewed. As our questions become more specific the data become less reliable.

Second, because of these credibility issues and because the US Census Bureau includes an allocation methodology for those questions that a respondent might not address in the questionnaire, the estimates will often differ from other credible data sources. For example, the following table shows several estimates of the District's uninsured population as a percent of the total in 2009.

Survey	Uninsured
DC Health Insurance Survey (DCHIS)*	6.2%
ACS	7.0%
CPS	12.4%

**Urban Institute*

As the table above shows, determining the number of uninsured in the District could largely depend on the data source reviewed. Between DCHIS and ACS, there is a difference of roughly 4,800 individuals. It will require the reader understands that the data in some cases are subject to this degree of uncertainty. There will be no perfect picture of the District's population at the end of the report. As we proceed with modeling the migration of these individuals across different modes of insurance, it will be our task to assess the range of possible responses to the

[3] http://www.census.gov/acs/www/methodology/response_rates_data/.

ACA's incentives. It will also be our task to assess the range of possible error in the starting assumptions.

Additional Medicaid Edits

As we reviewed the ACS data, there were clear inconsistencies with two external sources. First, the DHCF identified Medicaid enrollment at the beginning of 2010 totaling 220,000 (with 2008 enrollment at 192,000[4]); the ACS data only accounted for 161,000 Medicaid enrollees. Second, statutory financial statements filed by insurers in the District's market suggest that the ACS overstated those residents with direct purchase coverage by approximately 20,000.

Regarding the Medicaid inconsistencies, we first note that the DHCF's reports reflect the upper limit of possible Medicaid enrollment. The DHCF does not necessarily receive notification when an enrollee obtains health coverage from another source. Because of this dynamic, it is difficult to assess how many individuals are covered by the District's Medicaid program at any one point in time. Based on the DHCF's report, we estimate that an undocumented monthly lapse rate of 2% to 3% could reduce the DHCF's total reported Medicaid enrollment from 220,000 to below 200,000.[5]

The challenge of the first Medicaid issue is highlighted by two other independent and alternative data sources. The data from DHCF (when unadjusted and coupled with Medicare eligibility data from CMS[6]) suggest that publicly funded coverage is provided to approximately 43% to 47% of the District's residents.[7] The Urban Institute's analysis of insurance coverage in the District show that only 32.8% are insured by public coverage[8]; the Urban Institute's number is much closer to our initial ACS estimate of 35.2%. (Please note that our hierarchical mapping of enrollees to insurance modes from the ACS aggressively assigns individuals to Medicaid.) However, HealthLeaders data suggest that enrollment in publicly funded programs is consistent with the estimates implied by the DHCF data.[9]

There are several potential sources for these differences. First, in the ACS, the US Census Bureau attempts to address the Medicaid undercount phenomenon identified above. However, their edits do not account for coverage of low-income childless adults. Although the ACS may do a good job of adjusting those enrollees that would traditionally qualify for Medicaid (e.g., Temporary Assistance for Needy Families (TANF), Supplemental Security Income (SSI)), they

[4] https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/1225.

[5] Appendix A.

[6] http://www.cms.gov/DataCompendium/14_2010_Data_Compendium.asp#TopOfPage.

[7] Appendix B.

[8] Ormond, Palmer, and Phadera, "Health Insurance Coverage in the District of Columbia," Urban Institute (2010).

[9] HealthLeaders InterStudy, Mid-Atlantic, Winter 2011, Vol. 11, No. 1.

have no edits for non-traditional enrollees (e.g., those that would qualify for the Alliance program). In addition, there may be enrollees in the Medicaid program that are not District residents that have Alliance coverage. As we understand it, a resident could obtain Alliance coverage, move to an adjacent state, and retain that Alliance coverage. It would be difficult for the District to track these types of coverage errors. Third, with the disruption to the economy in 2008 and 2009, the DHCF's January 2010 enrollment figures are almost certainly higher than the corresponding enrollment numbers for the ACS reporting period.

Although we were unable to fully reconcile these Medicaid enrollment inconsistencies, we did reclassify a number of people in the ACS data into Medicaid that were not originally identified in that program. Specifically, we revised the insurance classification to Medicaid for those individuals who indicated they had both direct purchase coverage as well household earnings below 200% FPL (or whose income was not identified). This process reclassified approximately 19,000 individuals. To support this modification, we note (as indicated above) that the direct purchase counts in the ACS data were approximately 20,000 enrollees higher than what was shown in the publicly available financial statements for commercial carriers. Second, we moved any unemployed person who was identified as having ESI whose household income was below 200% FPL. As a consequence, we increased Medicaid enrollment by an additional 3,000 individuals. These changes are also reasonable given that it would be far less costly for these people to obtain coverage through the Alliance program (for which, with their incomes, they should be eligible) than it would be to obtain commercial coverage.

In any other cases, when we have become aware of clear inconsistencies between the ACS data and an alternative, reliable source, we have presented that source and the possible consequences of these inconsistencies.

Medical Expenditure Panel Survey (MEPS)

We also used the Agency for Health Care Research and Quality's MEPS data from 2009 to develop characteristics of the District's small employer market. MEPS identifies key statistics for the small employer market by state, including employer offer rates, employee take-up rates and premiums by tier. All statistics in the MEPS data are available by various group sizes.

In areas where certain statistics were common to other data sources, we compared the values in this survey data to those sources. For example, the MEPS showed 7,364 small groups in the District that offered coverage in 2010; statutory financial statement data showed 7,495 small group policies at the end of 2010. The consistency of the MEPS data with other known sources increases its validity.

Annual Financial Statement Data

Annual financial statements were used to identify total enrollment, premium, claims and other data for the District's individual and small group insurance markets. Although prior years' data were also reviewed, the primary source for this work was the 2010 Annual Statutory Financial Statements filed on the Health blank or the Life, Accident and Health (LAH) blank. To support

new insurer reporting requirements, 2010 Annual Statements include a new schedule, the Supplemental Health Care Exhibit. Insurers are required to report this schedule separately for each state in which they write comprehensive major medical business.[10] The Supplemental Health Care Exhibit reports detailed income statement data based on individual, small group employer, large group employer, government business, other business, other health and uninsured plans. Small group employer is defined as groups with up to 100 employees, except in states exercising an option under the ACA to define small groups as those with up to 50 employees until 2016.[11] The large group employer category includes the Federal Employees Health Benefit (FEHB) program and state and local fully insured government programs. Access to the Annual Statutory Financial Statement data was obtained through a subscription service. Because of the newness of the Supplemental Health Care Exhibit, data extraction from these forms was somewhat manual for carriers that file the LAH blank. As a result, it is possible that tables that follow later in this report may not capture a few carriers that write very little business in the District. It is also possible that there may be some reporting inconsistencies among insurers in the first year of completing this schedule.

When using the financial statement information to estimate the number of District residents with direct purchase coverage, we removed those policies written by Health Right, Inc. It is our understanding that these policies represent coverage of individuals enrolled in the Alliance program. Likewise, in estimating the number of individuals who receive group coverage through an employer located in the District, we removed the group policies reported by DC Chartered Health Plan and Unison Health Plan of the Capital Area. Again, it is our understanding that these policies represent individuals enrolled in the Alliance program.

We also note that in responding to carrier questions related to an outstanding data call issued as part of a subsequent phase of our work, we were notified that all of the individual business of Aetna Health Inc. and Aetna Health Insurance Company represents conversion policies. We did not remove these policies as we felt that these individuals are just as likely to enroll in the DC HIX as those with individual policies.

The District's Rate Filings with the DISB

In order to review the current product offerings, premiums and rating structures utilized by carriers offering coverage in the individual and small group markets, we obtained copies of the most recent rate filings for individual and small group products filed with DISB for the six carriers

[10] Experience for individual plans sold through an association or trust is allocated to the state issuing the certificate of coverage. Experience for employer business issued through an association or trust is allocated based on the location of the employer. Experience for group plans with employees in more than one state is allocated to state based on situs of contract.

[11] District carriers appear to have used a 50-employee threshold for reporting small employer group in the 2010 Supplemental Exhibit.

with the largest market share in the District. Most filings contained rating formulas and tables of rates and/or actuarial benefit factors by type of coverage.

This information enhanced several aspects of our background research related to the individual and small group markets. First, the benefit information included in the filings was used to assess the range of products currently offered (e.g., deductibles, copayments). We note that in these assessments we supplemented this information with other information such as product brochures gathered from carrier's websites. Second, most filings contained rates and/or actuarial values by benefit plan. This allowed us to assess the range of premiums that are currently offered. Finally, information on various rating factors currently used (e.g., age, gender, industry, group size) allowed us to provide initial, high level assessments of the impact that new rating restrictions in 2014 could have on premiums.

As none of the data sources described above contains a complete picture of the current market, data from each of the sources were combined to establish the 2010 baseline profile of the District's insurance marketplace and individuals expected to be eligible for coverage through the DC HIX and the SHOP DC HIX in 2014. To ensure the data used to establish the baseline profile were consistent, various components of the data were compared across different data sources to validate and triangulate data stratifications. This facilitated an understanding of where the various sources overlap and/or fit together and ensured the combined data source on which the modeling is based made sense. Where necessary, results were smoothed such that the final baseline profile presents a coherent, internally consistent picture of the current environment.

Throughout this report, distributions based on FPL are based on FPL definitions utilized within the ACS data. Starting in 2014, a new definition of family size based on the number of personal exemptions that an individual claims on his or her tax return will be used in determining eligibility for premium credits. However, we do not believe this change will have a material impact on our findings.

While we have reviewed each of these data sources for reasonableness, and where discrepancies arose we performed further investigation to reconcile any differences, we have not independently audited any of this data.

4

Overview of the District's Current Health Insurance Market

The District's geographic size, population density, economy, and existing public programs make it unique among the states and how it will be affected by the ACA. In this section, we will discuss in more detail some of those qualities that make the District unique. We will provide an estimate of how prevalent modes of coverage are employed among the District's residents, and finally, we will introduce those components of the ACA that we expect will most influence the viability of a DC HIX and a SHOP DC HIX.

The DC HIX is intended to provide a robust marketplace where individuals and small employers will be able to shop for health coverage. Additionally, it is expected to provide greater transparency for these purchasers by grouping plans with similar actuarial values and clearly indentified premiums. The viability of the DC HIX will depend both on the number of participants and the willingness of carriers to offer coverage through them.

There are numerous distinguishing features that make the District unique among the states. Although we will explore some of these features in later sections, there are three features of the District's health insurance market that we introduce here. First, the uninsured population is much smaller than the rest of the country. As of 2009, the ACS data show that the district had an uninsured rate of 7.0%, while the country as a whole had an uninsured rate of 15.2%. Much of this difference results from the presence of the Alliance program, which is a District-funded initiative to cover low-income individuals that do not qualify for Medicaid. A person must have an income between 138% and 200% FPL to qualify for the Alliance program.

Second, the District has a very high percentage of its workforce employed by the government. Approximately 34% of workers in the District are employed in governmental positions. Approximately 17% of workers for the country as a whole are employed by the government.[12] It is expected that government workers are less likely to change their insurance coverage as a result of the ACA or, more specifically, the presence of a DC HIX.

Third, a number of workers in the District are residents of other states. According to the ACS data, approximately 32% of the District's workforce resides in the District while the remaining 68% reside outside of the District.[13] For the country as a whole, approximately 96% of all

[12] http://www.census.gov/compendia/statab/2011/tables/11s0630.pdf.

[13] Please note that this estimate includes non-civilian individuals, individuals residing in group quarters, and those who may be eligible for ESI through someone else in their family who is employed by the government.

workers live in their state of employment. As we prepare models to estimate migration across modes of coverage, it will be critical that we address these three characteristics.

In addition to understanding those characteristics, any migration model will also have to address the population's existing modes of coverage. The following table shows our estimates of enrollment in 2009 for both the District's residents and the country as a whole. (Please note that the estimates of persons and standard deviations are in 1,000's)

	District of Columbia			Nation		
	Persons	**Dist**	**Standard Dev +/-**	**Persons**	**Dist**	**Standard Dev +/-**
Employer (Active)	295	49.2%	2.9	150,097	49.0%	69.4
Employer (Retired)	27	4.5%	0.8	12,878	4.2%	18.0
Military (Active)	8	1.3%	0.6	7,144	2.3%	23.2
Military (Retired)	2	0.3%	0.2	1,926	0.6%	7.7
Direct Purchase	22	3.7%	1.2	16,722	5.5%	28.1
Medicare	21	3.5%	0.8	20,499	6.7%	25.3
Medicaid	156	26.0%	3.0	40,687	13.3%	52.7
Dual	27	4.5%	0.9	9,902	3.2%	18.9
No Coverage	42	7.0%	1.4	46,660	15.2%	47.2
Total	**600**	**100.0%**		**306,515**	**100.0%**	

Based on our hierarchy and the ACS data, the table shows that approximately 42,000 residents of the District are uninsured. As a percentage of the population, the 7.0% estimate of the uninsured also compares favorably with an estimate prepared by the Urban Institute in 2009.[14] Next, the table shows that approximately 75,000 residents are covered by Medicare (i.e., retirees with employer administered benefits, those with Medicare alone and those residents dually eligible for Medicare and Medicaid). We do not expect the presence of the DC HIX to substantially affect the coverage for those residents under Medicare or TriCare. Also, the estimate is consistent with estimates of the Medicare eligible population as identified by CMS (i.e., 77,000).[15] The table shows that the number of residents covered by directly purchased insurance is approximately 22,000. This is similar to the membership (i.e., 19,000) reported in 2010 statutory financial statements by insurance companies with products in the District. Finally, the table shows that the District's Medicaid enrollment was approximately 183,000 in 2009 (Medicaid eligible and dually eligible residents). As discussed in the Data section, this estimate

[14] Ormond, Palmer and Phadera, "Uninsurance in the District of Columbia," Urban Institute (2010).

[15] http://www.cms.gov/DataCompendium/14_2010_Data_Compendium.asp#TopOfPage, Table VII.3 – Medicare Enrollment by State, 2009.

is lower than what is directly reported by the DHCF, but higher than what is reported in other survey data.

Because residents can reflect multiple modes of insurance through the ACS, we must classify these individuals into a single category to ensure that we do not double count them. Our hierarchy is very aggressive in assigning enrollees to Medicaid.[16] That is, the hierarchy automatically assigns enrollees to Medicaid if they show any indication of Medicaid coverage. We have not removed anyone from these estimates so they may be somewhat different than what is shown on the US Census Bureau's website. Finally, in addition to best estimates, we have included estimates of standard deviation; the ACS provides the tools to prepare these estimates. As we model migration, we will employ ranges implied by these statistics to reflect potential statistical error in our starting assumptions.

Key Provisions

There are several key elements of the ACA that we expect will affect how individuals move between their current coverage (or non-coverage) and other coverage modes. As we reviewed the District's population, we tried to identify those characteristics that would most likely interact with the provisions of ACA. The provisions on which we put particular weight follow.

The ACA introduces a number of new rating requirements for insurers offering coverage in the individual and small group markets beginning in 2014. Specifically, insurers will no longer be allowed to deny coverage for pre-existing conditions, they will no longer be allowed to rate based on morbidity, gender, industry or group size, and they will be limited in how they are allowed to vary rates based on age. We note that the District's recently passed "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010" resulted in the early adoption of some of these rating requirements. For example, effective July 1, 2011, carriers were no longer allowed to rate by gender, and carriers must use one-year age bands where the standard rate for any age shall not be more than 104% of the standard rate for the previous age and the highest standard rate may not be more than 300% of the lowest standard rate.

In general, these restrictions will have the effect of increasing rates for the young, for males in younger age ranges and for the healthy. They will likely also lower rates for the elderly, for females in younger age ranges, for the unhealthy and for those in very small groups or industries that tend to exhibit higher average morbidity. These restrictions will limit the extent to which carriers can reflect differences in risk when setting premium rates. (Over time, and in the absence of other requirements, these new restrictions may drive the young and the healthy out of the market or to alternative sources of coverage. The Department of Health and Human Services (HHS) is attempting to correct for these dynamics in the individual and small group markets by implementing a risk sharing mechanism that will require insurers with healthy enrollees to subsidize insurers with less healthy enrollees. From 2014-2016 a transitional

[16] Appendix C.

reinsurance program is also being implemented in the individual market to help reduce rate shock that might otherwise occur due to high risk individuals entering. These programs will be available for plans in the individual and small group markets.)

In addition, the District will now levy annual fees on health insurers of $8 billion starting in 2014 and increasing to $14.3 billion by 2018. The fees will be apportioned based on the insurer's market share, with tax exempt insurers considering only 50% of premium in calculating market share and self funded plans excluded. State Medicaid programs and Medicare Advantage plans will also be subject to these fees. Much of the ultimate cost of these fees will likely be passed on to the insurers' members and put pressure on state Medicaid budgets. Some parties have estimated the effect of these fees on premiums to be in the range of 2% to 3%[17].

Central to the recently enacted ACA is an individual mandate that imposes a penalty for those individuals who do not maintain coverage. The mandate is not universal and provides a penalty exception for certain low-income individuals who cannot afford coverage (those where the cost of coverage is more than 8% of their income). The penalty is a flat payment of $95 in 2014, $325 in 2015 and $695 in 2016 (on an individual basis), or alternatively, it is a percentage of the household income (1.0% in 2014, 2.0% in 2015, and 2.5% in 2016) with the penalty reflecting the larger amount. For a single individual earning $25,000 per year (or approximately 225% FPL in 2009), the penalty would be the following:

	2014	**2016**	**2016**
Income	$25,000	$25,000	$25,000
Flat Penalty	$95	$325	$695
Percentage	1.0%	2.0%	2.5%
Dollar Amount	$250	$500	$625
Resulting Penalty	$250	$500	$695

**Assumes no wage inflation*

Ultimately, the model will have to reflect potential individual preference regarding the value of coverage and its cost relative to fees for being uninsured.

The ACA provides tax credits to eligible individuals and families with incomes up to 400% FPL toward the purchase of a qualified health insurance plan through the DC HIX. Credits will be determined based on the "Silver" plan in the DC HIX with the second lowest premium. The credits will be set so that the premium will be limited to a certain percentage of income (on a sliding scale). The following table shows sample income and tax credit levels for an individual related to a theoretical plan level with a monthly premium of $430:

[17] http://americanactionforum.org/sites/default/files/Case%20of%20the%20Premium%20Tax.pdf.

Sample FPLs	Income	Plan Cap %	Plan Cap $	Plan Cost	Tax Credit
133%	$14,844	2.0%	$297	$5,160	$4,863
175%	$19,532	5.2%	$1,006	$5,160	$4,154
225%	$25,112	7.2%	$1,802	$5,160	$3,358
275%	$30,693	8.8%	$2,693	$5,160	$2,467
325%	$36,273	9.5%	$3,446	$5,160	$1,714

Ultimately, the individuals are not obligated to participate in a certain plan level. They may participate in a plan with additional benefits or lower cost sharing, but the tax credit will be calculated relative to the plan index cost (i.e., the "Silver" plan in the DC HIX with the second lowest premium).

The ACA requires an annual assessment from large employers (those with 50 or more full-time employees) that do not offer health coverage to their employees. This assessment is equal to $2,000 per employee with a disregard for the first 30 employees. For example, an employer that did not provide coverage to its 250 employees would face a penalty of $440,000 = (250 – 30) x $2,000. Similarly, large employers that do offer coverage and whose employees enroll through the Exchange (as a result of eligibility for tax credits) will face an assessment of $250 per month for each month the employee receives coverage through the Exchange.

Beginning in 2014, the ACA will extend Medicaid coverage to individuals who are not Medicare eligible and have incomes below 138% FPL (133% FPL with a 5% disregard). The Federal Government will pay the entire cost for covering these enrollees from 2014 through 2016 (with funds decreasing to 90% by 2020). Effective July 2010, the District implemented an early expansion of their Medicaid program under a State Plan Amendment (SPA) to cover a number of these low-income, non-Medicaid eligible adults. Roughly 35,000 individuals transferred from the Alliance program into the newly created SPA. The District should realize decreased budgetary pressure as a result of these additional federal funds.

There are a number of other changes to the Medicaid program in the ACA. In particular, it requires that the District be able to enroll Medicaid eligible residents in Medicaid through the DC HIX (if that person is found to be eligible as a result of application for coverage through the DC HIX). So, if a person applies for coverage through the DC HIX and is found to be Medicaid eligible, the District must have the capacity to enroll them in Medicaid through the DC HIX.

The ACA also includes the establishment of a BHP under which a state may enter into contracts for offering one or more health plans providing at least the essential health benefits to eligible individuals.[18] The BHP is intended to smooth the transition between Medicaid and commercial

[18] Eligible individuals are those with incomes between 133% and 200% FPL (below 133% FPL for legal aliens), are not eligible for Medicare and do not have access to affordable ESI that provides minimum essential coverage.

coverage for those enrollees between 138% and 200% FPL (or below 133% FPL for legal aliens). There is evidence that this population transitions in and out of Medicaid eligibility with some frequency — the BHP ensures that there is limited disruption in coverage or access.

5

The District's Private Employer Market

This section takes a closer look at the District's private employer market. Characteristics of District employers and their employees are first examined, regardless of insurance coverage status. Given the unique characteristics of the District, and the fact that a large number of individuals that work in the District do not also reside in the District, the workforce was examined separately for those individuals that reside in the District and those that do not.

A closer look is then taken at the subset of workers that have ESI coverage. Unlike Medicaid and individual direct purchase, where eligibility for coverage is based on whether the individual resides in the state, the fully insured employer group's employees and their dependents are eligible for coverage in the state in which the employer is located. This means that District residents are covered by group policies issued and regulated both inside and outside the District. Likewise, non-District residents working in the District and receiving coverage through their employer are currently covered by group policies issued and regulated within the District. Therefore, various characteristics of the subset of the population covered by ESI were examined from these two different perspectives.

Employer Incentives

The ACA introduces a number of new rating requirements for insurers. We have discussed these requirements in a previous section, and we will discuss these specific requirements in detail later in this section. In general though, these requirements are expected to increase premiums for some groups and decrease them for others. The disruption to premiums will depend on the demographic composition of the group and the group's current morbidity load, as well as the efficacy of a new risk sharing mechanism that will require small group insurers with healthy enrollees to subsidize insurers with less healthy enrollees.

There are several additional aspects of the ACA that will impact premiums in the group market. First, new fees will be assessed against insurers. As previously discussed, these are estimated to be in the range of 2% to 3% of premium. In addition, there are several other new taxes and fees (such as fees assessed on pharmaceutical manufacturers and a 2.3% excise tax on medical devices).

In the short term, small employers will receive incentives in the form of tax credits to offer coverage to their employees. Employers with fewer than 25 employees who have an average annual salary of less than $50,000 and pay at least 50% of the premium for health insurance can receive a tax credit up to as much as 35% of the employer's contribution (25% if the employer is a non-profit) in 2010 through 2013. The maximum credit is available to employers

with less than ten employees and an average annual salary of less than $25,000. The credit is phased out as the number of employees increases to 25 and the average annual salary increases to $50,000. In 2014 and later, employers can take the tax credits for two consecutive years, after which no additional credits are available. In these years the maximum credit is increased to 50% of the employers' contribution, with a similar phase out schedule used between 2010 and 2013.

In addition to providing incentives to employers to cover their workers, the ACA will also provide some employers with incentives to drop coverage. For example, most low-income individuals will be eligible for tax credits if they purchase coverage directly through the DC HIX. An employer with many low-income employees may find that it is less costly to pay the penalty and provide their employees with additional compensation to cover the cost of the unsubsidized portion of the premium. In this case, these subsidy-eligible employees that purchase individual coverage in the DC HIX would also qualify for cost-sharing subsidies. An employer's willingness to drop coverage will also depend on their trust in the stability of the DC HIX. Although the financial outlook might support an elimination of ESI, employers will weigh these advantages against potential inconvenience to their employees. They will also weigh the impact that it may have on their ability to attract and retain talented employees if their competition does not also eliminate coverage. These tax credits for individuals are discussed further in later sections.

The District's Private Employer Market

There is a clear income difference among all 483,000[19] individuals that work for private employers in the District (both workers that commute into the District and those that live there). According to the ACS data, income is much higher for workers that live outside the District and commute into the District to work. The following table shows private workers by household income and residency status (regardless of insurance coverage status).

District of Columbia — Private Employees by Income and Residence

FPL	DC	Percent	Non-DC	Percent
0 to 100%	10,000	6%	8,000	2%
101% to 138%	7,000	4%	5,000	2%
139% to 200%	12,000	8%	14,000	4%
201% to 300%	20,000	13%	30,000	9%
301% to 400%	16,000	10%	35,000	11%
401% +	89,000	57%	235,000	72%
N/A	2,000	1%	-	-
Total	**156,000**		**327,000**	

[19] Please note that this estimate includes non-civilian individuals, individuals residing in group quarters and those who may be eligible for ESI through someone else in their family who is employed by the government.

The previous table shows that a substantial number of workers in the District are residents of other states. Approximately 32% of the District's private workforce resides in the District, while the remaining 68% reside outside of the District. For the country as a whole, the corresponding estimate is much different (i.e., approximately 96% reside in the state in which they work).

The table also shows that non-District residents have approximately 72% among their ranks with income above 400% FPL, while the District has 57% above 400% FPL. This table does not make a distinction between full-time and part-time workers. By pooling both classifications of workers, it likely skews the result, as individuals with part-time jobs are less likely to be willing to commute for their job. So, although the District residents show lower income than their non-resident coworkers, we suspect there are also likely more part-time workers among the District residents.

A District employer with lower-income workers would have several unique challenges in assessing the viability of dropping coverage. For example, differences in cost or convenience between Exchanges in the District, MD or Virginia would likely influence the decision for those employers with workers who reside in each area.

Of the employees that work in the District, almost 50% work either in professional, scientific and technical industries (e.g., in law firms) or in arts, entertainment and food service. The following table shows the distribution of workers by industry and residency status.

District of Columbia — Private Employees by Industry and Residence

Industry	DC	Percent	Non-DC	Percent
Agr, Mining, Util	-	-	2,000	1%
Const & Manu	6,000	4%	28,000	9%
Trade	11,000	7%	15,000	5%
Transp, Info, Finan	17,000	11%	45,000	14%
Real Estate	5,000	3%	7,000	2%
Prof, Sci, Tech	36,000	23%	87,000	27%
Mang, Admin Srv	7,000	4%	15,000	5%
Education	14,000	9%	22,000	7%
Health & Soc Srv	20,000	13%	39,000	12%
Arts, Ent, Food, Other	40,000	26%	67,000	20%
Public Admin	-	-	-	-
Total	**156,000**	**100%**	**327,000**	**100%**

The observation noted above regarding full-time and part-time workers that reside in and out of the District applies for this table as well. For example, District residents are more likely to be employed in the arts, entertainment and food industries (industries that tend to employ many

part-time workers) and less likely to hold professional, scientific and technical jobs (industries that tend to be comprised of mostly full-time workers) than workers that reside outside the District.

Finally, we looked at the age and gender composition of individuals working in the District. The following table shows this distribution separately for workers living within the District and those who commute from outside the District

District of Columbia — Private Employees by Age, Gender and Residence

	District Residents				Non-District Residents			
Age	**Male**	**Percent**	**Female**	**Percent**	**Male**	**Percent**	**Female**	**Percent**
0 to 17	-	-	-	-	-	-	-	-
18 to 24	8,000	1.7%	11,000	2.3%	10,000	2.1%	14,000	2.9%
25 to 29	12,000	2.5%	14,000	2.9%	20,000	4.1%	16,000	3.3%
30 to 34	10,000	2.1%	11,000	2.3%	24,000	5.0%	20,000	4.1%
35 to 39	10,000	2.1%	9,000	1.9%	22,000	4.6%	20,000	4.1%
40 to 44	9,000	1.9%	6,000	1.2%	25,000	5.2%	18,000	3.7%
45 to 49	6,000	1.2%	6,000	1.2%	23,000	4.8%	18,000	3.7%
50 to 54	6,000	1.2%	7,000	1.4%	22,000	4.6%	15,000	3.1%
55 to 59	6,000	1.2%	7,000	1.4%	15,000	3.1%	12,000	2.5%
60 to 64	4,000	0.8%	5,000	1.0%	10,000	2.1%	9,000	1.9%
65+	5,000	1.0%	4,000	0.8%	9,000	1.9%	5,000	1.0%
Total	**76,000**	**15.7%**	**80,000**	**16.6%**	**180,000**	**37.3%**	**147,000**	**30.4%**

The average age is only slightly different (actually, higher) between those workers that commute to the District and those that reside there. Among District residents, there are slightly more females working in the District than males — the workers who commute are predominantly male.

District Residents with ESI Coverage

This section further examines the characteristics of the District residents (employees and their eligible dependents) that have ESI coverage, regardless of whether the coverage is through a District employer or an employer outside of the District. As may be expected, the District residents covered with ESI far outnumber those covered by other means. We estimate that approximately 49.2% of District residents are covered by ESI provided by a non-military employer. For the District's privately employed residents and their dependents covered by ESI, the distribution by age and gender is generally consistent with that of the nation as a whole. The following table shows that distribution. (Please note that the following tables show non-working residents as well as those individuals that work. Also, please note that we have attempted to

remove those with government coverage by removing anyone where the primary person or spouse of the household is identified as a government worker.)

District of Columbia — Employer Sponsored Coverage (Private)

	District of Columbia		Nation	
Age Band	**Male**	**Female**	**Male**	**Female**
0 to 17	6.5%	6.8%	12.7%	12.1%
18 to 24	6.2%	8.3%	5.0%	5.1%
25 to 29	6.8%	7.5%	3.7%	3.8%
30 to 34	5.1%	6.2%	3.9%	3.9%
35 to 39	5.2%	5.3%	4.2%	4.3%
40 to 44	4.4%	4.2%	4.4%	4.5%
45 to 49	3.8%	3.1%	4.7%	4.9%
50 to 54	3.3%	3.5%	4.4%	4.6%
55 to 59	2.8%	3.0%	3.6%	3.8%
60 to 64	2.5%	3.5%	2.8%	3.1%
65+	0.7%	1.3%	0.2%	0.2%
Total	**47.2%**	**52.8%**	**49.6%**	**50.4%**

There are two primary differences from the rest of the nation. First, the District has fewer children (which is expected, given that the District is a metropolitan area). Second, the District has a slightly higher proportion of females than males. This observation is consistent with other population estimates of the District.[20, 21].

The following table shows the distribution by household income of District residents with ESI provided by a private employer.

[20]http://www.factfinder.census.gov/servlet/ACSSAFFFacts?_event=Search&_name=&_state=04000US11&_county=&_cityTown=&_zip=&_sse=on&_lang=en&pctxt=fph&_submenuId=factsheet_1.

[21] Ormond, Palmer and Phadera, “Health Insurance Coverage in the District of Columbia,” Urban Institute (2010).

District of Columbia — ESI (Private)

FPL	District	Nation
0 to 100%	4.2%	4.0%
101% to 138%	1.1%	3.1%
139% to 200%	5.1%	7.9%
201% to 300%	12.1%	17.0%
301% to 400%	12.3%	16.5%
401% +	57.7%	49.7%
N/A	7.6%	1.8%

District residents with ESI have more households earning over 400% FPL than the nation as a whole. Again, since the District is a metropolitan area, it would be expected that salaries are somewhat higher than the national average. Further, since there are fewer children in the District than nationwide, the average household size is likely smaller. This, in turn, results in higher income as a percentage of FPL as the FPL will be lower for these smaller households.

ESI Coverage Issued in the District

It is of interest to examine the characteristics of District residents covered by ESI. However, when attempting to estimate potential enrollment in a SHOP DC HIX, it is more important to look at the characteristics of small groups domiciled in the District and their employees. Regardless of the residency of their employees, these District and non-District workers are the individuals that would be eligible to enroll. In this section, we examine characteristics of individuals employed within the District that receive private ESI coverage.

According to MEPS data, most private employers in the District offer health insurance coverage to their full-time employees. By examining the ACS data, we found that approximately 71% of all privately employed District employees receive coverage. This rate of coverage is 77% among all full-time employees, while only 41% of part-time workers receive coverage. We suspect that many of the part-time workers that indicate they have ESI coverage receive it through their spouse’s employer.

District of Columbia — District Employees with Private Employment by Industry

Industry	Priv in DC w/Cov FT	Priv in DC Total FT	Priv in DC w/Cov PT	Priv in DC Total PT	Priv in DC 'w/Cov Total	Priv in DC Total
Agr, Mining, Util	2,000	2,000	-	-	2,000	2,000
Const & Manu	17,000	27,000	1,000	4,000	18,000	31,000
Trade	11,000	18,000	2,000	6,000	13,000	24,000
Transp, Info, Finan	42,000	49,000	2,000	5,000	44,000	54,000
Real Estate	6,000	9,000	-	1,000	6,000	10,000
Prof, Sci, Tech	84,000	99,000	4,000	10,000	88,000	109,000
Mang, Admin Srv	9,000	16,000	1,000	6,000	10,000	22,000
Education	21,000	24,000	6,000	8,000	27,000	32,000
Health & Soc Srv	34,000	44,000	3,000	8,000	37,000	52,000
Arts, Ent, Food, Other	53,000	74,000	10,000	23,000	63,000	97,000
Public Admin	-	-	-	-	-	-
Total	**279,000**	**362,000**	**29,000**	**71,000**	**308,000**	**433,000**
Percent with ESI		**77%**		**41%**		**71%**

The following table shows coverage rates of District employees by industry, separately for District residents and non-District residents.

District of Columbia — Rate of Coverage Among District Employees by Industry and Residency

	District Residents			Non-District Residents		
Industry	**Priv in DC w/Cov**	**Priv in DC Total**	**Total**	**Priv in DC w/Cov**	**Priv in DC Total**	**Total**
Agr, Mining, Util	-	-	-	2,000	2,000	100%
Const & Manu	4,000	6,000	67%	14,000	25,000	56%
Trade	4,000	11,000	36%	9,000	13,000	69%
Transp, Info, Finan	11,000	15,000	73%	33,000	39,000	85%
Real Estate	3,000	5,000	60%	3,000	5,000	60%
Prof, Sci, Tech	26,000	34,000	76%	62,000	75,000	83%
Mang, Admin Srv	2,000	7,000	29%	8,000	15,000	53%
Education	11,000	14,000	79%	16,000	18,000	89%
Health & Soc Srv	12,000	19,000	63%	25,000	33,000	76%
Arts, Ent, Food, Other	23,000	38,000	61%	40,000	59,000	68%
Public Admin	-	-	-	-	-	-
Total	**96,000**	**149,000**	**64%**	**212,000**	**284,000**	**75%**

When examining the rate of coverage among District employees that are also residents of the District, we find that 64% have ESI coverage. At the same time, non-District residents working in the District receive ESI coverage 75% of the time. The prior comments regarding District residents who also work in the District being more likely to have part-time jobs than those commuting from outside the District apply here as well and support this difference in coverage rate among District employees. While 23% of individuals that both work and live in the District have part-time employment, only 13% of individuals that work in the District but live outside the District do.

Please note that from the estimates in the two preceding tables we have excluded anyone identified as having ESI in the same household where the principal person or their spouse is employed by the government. (It is this exclusion that causes the aggregate differences between the tables above and the tables in a preceding section entitled “The District’s Private Employer Market.”) Estimates of this kind only provide a very rough picture of the private ESI market. The potential for coverage through a spouse’s employer could produce some bias in the above table.

As the size of the establishment increases, the likelihood that the employer offers health coverage also increases. The following tables summarize the offer rates for private employers by group size. These data are taken from the 2009 MEPS.

Employee Contribution Rates

District of Columbia

	% of Establishments Offering Coverage	Employee		Family	
		$ Contribution	% of Total	$ Contribution	% of Total
Less than 10%	55.0%	$650	11.9%	$1,933	13.8%
10 to 24	74.0%	$449	8.6%	$3,931	31.2%
25 to 99	87.0%	$1,004	19.8%	$5,006	34.2%
100 to 999	100.0%	$886	17.2%	$3,046	21.3%
1,000 or more	100.0%	$1,013	20.4%	$3,800	26.6%

Nation

	% of Establishments Offering Coverage	Employee		Family	
		$ Contribution	% of Total	$ Contribution	% of Total
Less than 10%	34.0%	$752	15.0%	$2,986	24.8%
10 to 24	63.0%	$818	18.0%	$3,767	31.7%
25 to 99	82.0%	$915	20.0%	$4,124	33.4%
100 to 999	94.0%	$988	21.0%	$3,921	30.0%
1,000 or more	99.0%	$1,005	22.0%	$3,242	24.3%

In total, 74% of employers in the District offer coverage, while only 55% of employers nationwide do. This difference is attributable to the fact that small employers in the District are more likely to offer coverage than small employers nationwide. For example, 55% of District employers with less than ten employees offer coverage to their employees, while only 34% of employers this size nationwide do. This means that, all else equal, a larger percentage of all employees working for small employers in the District will be eligible to enroll in a SHOP DC HIX than will employees of small employers in other states. However, the ultimate decision of whether to enroll in the SHOP DC HIX lies with the employer. Or, put differently, even if the potential market for the SHOP DC HIX is relatively large, the SHOP DC HIX's ultimate enrollment is not guaranteed to be strong. The enrollment will ultimately depend on its appeal to employers.

In addition to showing offer rates, the previous table also shows employee contribution rates for single and family coverage. The table shows that the contribution rates do not necessarily change upward or downward with the size of the establishment. Even when we examine the nationwide data, the family contributions initially increase with group size and then decrease. Much of the group premium will depend on the demographic composition of the group, the rating laws of the state in which the employer resides and the expected morbidity of the group during the rating period.

According to the MEPS data, 95% of all employees working for a private employer in the District work for an employer that offers coverage. Of those employees, only 79% are eligible for

coverage, and of those that are eligible, only 82% enroll in the plan. This means that 65% (= 79% x 82%) of employees working for a private employer offering coverage are actually enrolled in the plan. This compares to 61% nationwide. While 79% of employees working for employers that offer coverage are also eligible nationwide, only 77% nationwide enroll, as compared to the 82% in the District that do.

There are several possible reasons why only 82% of the employees in the District who are eligible for coverage are enrolled. First, some may find that coverage offered through their spouse's employer is more affordable or provides benefits that are more attractive. Further, some employees may find that the required premium contributions are unaffordable. Still others, particularly those in good health, may perceive the value of coverage to be less than the cost.

The table below shows the distribution of the 65% enrollment rate in the District and the 61% enrollment rate nationwide by group size. The table shows that among large groups, the enrollment rate among private sector employees in the District who are offered ESI coverage is roughly the same as the nation as a whole. However, among employees working for small employers, District employees are more likely to be enrolled than their counterparts nationwide. The higher rate of enrollment among employees of small employers in the District is due to both a higher rate of eligibility (88% in the District vs. 79% nationwide) and a higher take up rate among those who are eligible for coverage (83% in the District vs. 75% nationwide).

ESI Coverage by Group Size Among Private Sector Employees

	District of Columbia		Nation	
Group Size	**Distribution of Employees**	**% Covered by Employer**	**Distribution of Employees**	**% Covered by Employer**
0 to 9	7%	71%	12%	63%
10 to 24	6%	81%	9%	59%
25 to 99	13%	61%	14%	59%
100 to 999	29%	60%	17%	59%
1,000 or more	45%	66%	48%	63%
SG & LG				
0 to 49	19%	73%	27%	60%
50 or more	81%	63%	73%	62%

In addition to take up rates, the table above shows the distribution of employees by group size. The District workforce is comprised of fewer employees working for small employers as a percentage of all employees (19%) than is observed nationwide (27%).

According to the same MEPS data, there were approximately 12,000 firms in the District with fewer than 50 employees in 2009. Some of the employees in these small groups are not residents of the District. However, their employers may choose to purchase coverage for them

through the SHOP DC HIX. Therefore, it is important that we explicitly recognize these employers and their non-resident workers in our analysis. The following table summarizes ESI offerings in the small group market in 2005 and 2009.

Small Group (< 50 EEs) — Contributions — Private Employers

	District of Columbia		Nation	
	2005	2009	2005	2009
Single				
Employee	$598	$717	$641	$834
Employer	$3,973	$4,560	$3,480	$3,818
Total	$4,571	$5,277	$4,121	$4,652
Growth		4%		3%
Family				
Employee	$2,879	$3,616	$2,930	$3,630
Employer	$8,991	$9,773	$7,702	$8,411
Total	$11,870	$13,389	$10,632	$12,041
Growth		3%		3%
Average Deductible	$499	$813	$929	$1,283
% Firms Offering	62%	61%	43%	41%
% EEs Covered*	73%	73%	60%	60%
Firms	11,496	12,252	4,754,597	4,878,345
Total EEs	92,372	85,006	31,274,563	29,804,923
EEs/Firm	8.0	6.9	6.6	6.1

** Among firms offering coverage*

According to the MEPS data, the number of small group firms has increased for both the District and the rest of the nation between 2005 and 2009; however, the number of employees per firm has decreased. We expect that the economic downturn has only perpetuated these trends over the period since the survey was conducted. During this same period the average premium has increased at an annual rate of 3% to 4% per year. These increases are net of any reductions in benefits (e.g., through increased cost sharing).

Small group employers in the District offer health coverage to their employees at a much higher rate (61%) than similar small group employers in the rest of the country (41%). However, the average cost of coverage is also higher for the District's small group employers, which is in part driven by the fact that the average deductible is lower. The percentage of employers that offer coverage has declined slightly from 2005 to 2009, and during that period, the percentage of employees taking coverage from firms that offer it has not changed.

Fully Insured Group Coverage Offered in the District

Beginning in 2011, carriers are required to meet new minimum loss ratio requirements, separately for the small group and large group markets. Carriers must refund premiums to policyholders if the loss requirements are not met. To test whether carriers have met this requirement, a new Supplemental Health Care Exhibit has been added to the Statutory Financial Statement and was required to be completed as part of the 2010 Annual Statement.

This new exhibit allowed for separation of the fully insured group market between small and large group based on the District's current definition of small group (2 to 50), and further by carrier. The following table summarizes the fully insured small group market in 2010 based on information from these publicly available financial statements. We note that recently released 2010 MEPS data shows that 7,364 employers with fewer than 50 employees offered coverage to their employees in 2010. This figure is consistent with the number of small groups reported in the financial statements of these carriers as offering coverage in 2010 (7,495), as shown in the table.

District of Columbia — 2010 Small Group Experience

	Member Months	Groups	Premium PMPM*	Claims PMPM	Loss Ratio
Aetna Health Inc PA Corp	13,540	118	321.73	286.49	89%
Aetna Health Ins Co	6,354	60	24.49	6.46	26%
Aetna Life Insurance Co	13,045	115	392.56	181.07	46%
Carefirst Bluechoice Inc	363,550	2403	303.88	199.89	66%
Graphic Arts Benefit Corp	2,907	N/A**	338.89	249.58	74%
Group Hospitalization and Med Services	584,980	3,300	389.07	298.15	77%
Guardian Life Insurance Co	26,116	84	616.18	336.62	55%
Kaiser Foundation Health Plan Mid Atl	317,801	272	340.03	305.24	90%
Kaiser Permanente Insurance Co	641	69	2407.80	745.20	31%
Mamsi Life & Health Insurance Co	10,675	8	593.82	329.77	56%
Optimum Choice Inc	41,770	325	411.70	289.16	70%
Principal Life Insurance Co	1,024	8	633.82	385.05	61%
Time Insurance Co	476	6	378.40	136.97	36%
United Healthcare Insurance Co	100,762	642	414.01	206.43	50%
United Healthcare Mid Atlantic Inc	17,614	85	324.20	242.52	75%
Total	**1,501,255**	**7,495**	**363.82**	**267.44**	**74%**
Average Members	125,105				

** Per member per month*

*** This carrier did not complete the field on the Supplemental Health Exhibit that contains the number of groups*

The table above shows that roughly 125,000 individuals were covered under a group policy issued to a small group in the District in 2010. As previously noted, not all of these individuals reside in the District. While there are several carriers offering coverage to small employers, the market is dominated by only a few. In 2010, 76% of all small employers in the District that offered coverage to their employees were covered by a policy issued by an affiliate of CareFirst, Inc. (either CareFirst Bluechoice or Group Hospitalization & Medical Services Corporation). Almost 90% of the market is represented by the top four carriers.

Reported premiums vary widely by insurer; however, it is important to note that the premiums in the table above reflect the underlying differences in demographics and benefits for each carrier. A pending data call to the major carriers writing small group coverage in the District will allow for a closer look at variation in premiums by carriers, and the drivers of the differences.

Across the entire small group market, the observed loss ratio in 2010, calculated as incurred claims divided by premium, was 74%. Regulators will allow several adjustments to this loss ratio prior to determining whether it meets the minimum federal 80% requirement. For example, claims in the numerator may be increased by expenses associated with quality improvement activities while premium in the denominator may be reduced by certain taxes and fees. Both of these adjustments are carrier specific and will work to increase the “adjusted” loss ratio. Further, an adjustment is applied for credibility based on a carrier’s enrollment which will also increase the “adjusted” loss ratio. Therefore, some carriers that show loss ratios in the table above that fall short of 80% may not owe policyholders a premium refund.

CareFirst BlueChoice shows a loss ratio of only 66%, and had 2010 membership that would only result in a little over 1% being added per the Medical Loss Ratio (MLR) credibility table. It is unlikely that the other numerator and denominator adjustments described above will bring the adjusted loss ratio to 80%. Likewise, United Healthcare Insurance Company’s reported 50% loss ratio would only be increased by about 3% as a result of a credibility adjustment, and it is also likely that the adjusted loss ratio will still be below 80%. Therefore, had the MLR requirements been in place in 2010, it is likely that these carriers would have been required to issue a premium refund. While there are other small carriers in the table above that have loss ratios well below 80%, we did not focus on these carriers due to their size, and since roughly 90% of the market is defined by four carriers.

On page 31, the MEPS data showed that the average monthly premium for single coverage in 2009 for groups with less than 50 employees was $439. The recently released 2010 MEPS data shows that the average monthly single premium increased to $487 in 2010, an increase of roughly 11%. In the industry we typically observe an average conversion factor (a factor representing the ratio of costs for a single contract to costs for the same population on a per member basis) of 1.25. This factor can be multiplied times the average premium on a per member per month (PMPM) basis of $364 (from the table above) to estimate an average single premium of $455. This compares very well with the average monthly single premium from the MEPS data and supports the validity of using this survey data.

As with the small group market, there are a number of carriers writing fully insured coverage in the large group market. Unlike the small group market, the large group market is not as concentrated. In 2010, the top three carriers insured 41% of all large groups offering fully insured ESI coverage, and the top six carriers insured 81% of large groups. The following table summarizes the 2010 results from the statutory financial statements for carriers' large group fully insured business.

District of Columbia — 2010 Large Group Experience (excluding FEHB)

	Member Months	Groups	Premium PMPM	Claims PMPM	Loss Ratio
Optimum Choice Inc	52,561	3	407.45	309.86	76%
Aetna Health Inc PA Corp	237,567	97	362.75	252.57	70%
MD Individual Practice Assn Inc	112,766	3	279.06	214.30	77%
Carefirst Bluechoice Inc	354,020	252	283.12	199.87	71%
Kaiser Foundation Health Plan Mid Atl	471,157	150	347.68	265.38	76%
CIGNA Healthcare Midatlantic Inc	2,121	N/A	354.68	210.76	59%
United Healthcare Mid Atlantic Inc	8,319	2	385.88	515.37	134%
Aetna Life Insurance Co	1,340,068	23	316.95	239.38	76%
United Healthcare Insurance Co	355,222	134	473.61	268.36	57%
Guardian Life Insurance Co	38,018	14	503.26	285.82	57%
Connecticut General Life Insurance	451,140	55	210.41	124.54	59%
Unicare Life & Health Insurance Co	34,448	16	322.20	256.87	80%
Mamsi Life & Health Insurance Co	2,503	N/A	1,433.46	327.24	23%
Kaiser Permanente Insurance Co	27,145	34	121.23	79.87	66%
Group Hospitalization & Med Services	529,438	292	363.31	259.59	71%
Total	**4,016,493**	**1,075**	**329.75**	**232.40**	**70**%
Average Members	**334,708**				

The table above shows that roughly 335,000 individuals were covered under a fully insured group policy issued to a large group in the District. Again, not all of the individuals covered reside in the District. A majority of these 335,000 individuals would not be anticipated to participate in the DC HIX, at least initially, for multiple reasons. First, large groups are not eligible to enroll in the Exchanges. However, starting in 2017 states may expand the SHOP to include large employers. Second, if their employer finds that it is advantageous for them to drop their offer of coverage and pay the employer penalty, these individuals could participate in the Exchange. However, as previously discussed, roughly two thirds of employees working in the District live in another state, and these individuals would be eligible for the individual DC HIX in their state of residence and not the District's individual Exchange. Third, some individuals that reside in the District will lose coverage because their employer chooses to discontinue it. Those

individuals that do not qualify for a subsidy may see no additional value in participating in the Exchange and may prefer working with a broker that sells coverage outside of the Exchange.

As with the small groups, there is significant variation in premiums among insurers. We note that premiums are on average 10% lower in the large group market than they are in the small group market. There are several potential reasons for this difference in premiums between these two markets. The reasons include but are not limited to differences in demographics and benefit offerings, differences in mix by industry, greater anti-selection in the small group market, and lower administrative expenses on a per member basis in the large group market.

Rate Development in the Small Group Market

The small group market within the District is currently defined as employers with two to 50 employees. We note that the ACA defines small group as at least one but no more than 100 employees on business days during the preceding calendar year. The ACA allows states to substitute “50 employees” for “100 employees” in the definition until 2016. Therefore, the District can continue to use its current definition of small group until 2016. We also note that while the ACA definition of small group includes groups of one, recently released regulations related to establishment of Exchanges indicate that coverage for only a sole proprietor would not constitute a group health plan under theEmployee Retirement Income Security Act, and would not be entitled to purchase coverage in the small group market under federal law. Therefore, it appears that these groups of one would not be eligible to participate in a District-run SHOP DC HIX.

There are a number of provisions within the ACA that will change either the average premium or the premium charged to a specific small group, or both. First, health plans will no longer be allowed to rate small groups based on their health status. This provision will tend to lower premiums for those groups with employees in poor health, while increasing premiums for those employees in good health. Given the distribution of medical loads typically observed in the small group market, many more groups will receive increases than will receive decreases. However, the size of the increases will, on average, be smaller than the size of the decreases. That said, many healthy groups will see increases well into the double digits as a result of the elimination of rating based on health status.

Second, health plans will be limited in their ability to rate groups based on the age of their employees, and will no longer be able to rate based on gender, group size or industry. These provisions will tend to lower premiums for older employees and smaller groups, while increasing premiums for younger employees — especially younger males — and larger small groups.

Third, new minimum benefit and coverage requirements will tend to put upward pressure on small group premiums. According to the CBO, premiums in the small group market in 2016 are estimated to increase by as much as 3% as a result of required increases in benefits.[22] Finally,

[22] http://www.cbo.gov/ftpdocs/107xx/doc10781/11-30-Premiums.pdf.

new annual fees levied on health insurers, along with fees assessed against pharmaceutical manufacturers and an excise tax on medical devices, will place upward pressure on premiums if passed along to policyholders.

Under the ACA, beginning in 2014 insurers must adopt an adjusted community rating methodology as described above. These restrictions will limit the extent to which carriers can reflect differences in risk when setting premium rates. The impact that these restrictions will have on premiums in the District will depend upon the degree to which carriers are currently using these rating factors. Within the District, carriers have historically been afforded flexibility in their rating and allowed to vary premiums based on age, gender, geography, industry, group size and morbidity. A new District law effective July 1, 2011 will prohibit variation in rates by gender. The law requires that carriers use one-year age bands where the standard rate for any age may not be more than 104% of the standard rate for the previous age. The law also requires that the highest standard rate may not be more than 300% of the lowest standard rate.

In an effort to develop broad, high-level indications of the effect that these rating changes required under the ACA could have on small group rates in the District, we reviewed recent rate filings for six carriers representing 86% of all small groups and 88% of all members covered by a small group policy in the District. The information in these filings only allowed for a review of the range of the potential impact, separately for each variable. Offsetting impacts due to changes in multiple rating factors must be measured on a group by group basis and could not be ascertained from the information in the filings. We stress that the estimated premium impacts that follow are illustrative and a direct function of the assumptions outlined for each rating variable. The actual range of potential impacts may vary significantly if the assumptions outlined do not hold. Further, the impact for a specific small group will surely vary from these estimates. A pending data call to the major carriers writing small group coverage in the District will provide a much more robust set of data. These data will allow for a more refined look at the impact of these changes. They will also ultimately allow us to consider actual distributions of premium by rating variable.

Since the rate filing information reviewed is not in the public domain, carriers are referred to as Carrier A through Carrier F in the information that follows in order to maintain confidentiality. We note that none of the carriers reviewed varied rates by geography, which is expected given the District's small geographic size.

Coverage Tier

Of the filings reviewed, all carriers currently develop small group rates that vary by coverage tier; however, the tiers utilized differ by carrier. Carriers E and F vary premium rates charged to small groups by gender while the other carriers do not. The following table shows the tiers currently utilized.

Coverage Tiers Utilized by Carriers in the Small Group Market

Carrier A	Carriers B, C & D	Carriers E & F
Single	Single	Single
Couple	Couple	Couple
Employee + Child	Employee + Child(ren)	Employee + Child
Employee + Children	Family	Family
Family		

The ACA, as passed by Congress, defined allowable coverage tiers for developing rates as "single" and "family." It is quite common in the industry for carriers today to use four or five tier structures similar to those in the table above.

The recently released draft regulations titled "Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans" propose a revision to allow for the use of four tier rates. The regulations prescribe the allowable tiers as Individual; Two Adults; One Adult + Child or Children; and a catch-all Family category for two adults + child or children, and other family compositions that do not fit into the first three categories. Under this revised structure, Carriers B, C and D would not be required to make any changes to the tiers they currently utilize. Carrier A would need to combine the current Employee + Child and Employee + Children categories into one. Carriers E and F would need to combine Employee + Children contracts (currently in the Family tier) with the current Employee + Child tier. As we do not know the current distribution of contracts by coverage tier, we are unable to estimate the impact that these changes will have. However, we can confirm that the change will result in an increase in rates to the Employee + Child contracts and a decrease to rates for the Employee + Children contracts. Carriers E and F will experience an increase in the Family rate.

Age/Gender

All District carriers currently use age and gender when setting premiums and have historically been allowed to set their own range of factors. In 2014, the ACA requires that age factors will need to be within a 3-to-1 band and rating differentials by gender will need to be eliminated. Further, the District's recently passed reform law implements this same requirement effective July 1, 2011. Note that the ACA is not clear as to whether the 3-to-1 requirement applies to the member factor or the composite factor applied to the group. Our understanding is that the ACA was modeled from the MA law, and we note that in MA the restrictions on age are applied to the composite group factor. Therefore, our understanding is that the ACA requirements will also apply to the composite group factor.

The following table summarizes the ratio of the highest age factor to the lowest age factor currently utilized within each coverage tier found in the filings reviewed. We note that for Carriers A through D this ratio is the same for all coverage tiers but for Carriers E and F this ratio varied by tier.

Ratio of Highest to Lowest Age Factor

Carrier	Single	Couple	Employee + Child	Employee + Children	Family
Carrier A	4.55	4.55	4.55	4.55	4.55
Carrier B	2.64	2.64	2.64	2.64	2.64
Carrier C	2.57	2.57	2.57	2.57	2.57
Carrier D	2.96	2.96	2.96	2.96	2.96
Carrier E	4.95	3.42	3.62	2.05	2.05
Carrier F	4.95	3.42	3.62	2.05	2.05

Carriers B, C and D already meet the new requirement in that their ratios for all tiers in the table above are less than 3.0. Carriers E and F meet the new requirement for their Employee + Children and Family tiers. (Note, as mentioned above the Employee + Children tier will need to be combined with the Employee + Child tier, which could result in the combined new tier having a ratio of 3.0 or less.) Carriers A, E and F will need to revise the age factors utilized so that the ratios for the remaining tiers become 3.0. Our understanding is that carriers will have flexibility in adjusting their age factors as long as the 3:1 ratio is satisfied, and in the District, the requirement that factors for consecutive ages be no more than 4% apart. The filings reviewed did not contain a distribution of current premium by age and tier. We will require these data for a detailed analysis.

To provide a high-level estimate of what the impact on premiums might be, we assume that the premium weighted average age factor for each tier is equal to the midpoint of the range, and that carriers would elect to preserve the midpoint of the current range as the midpoint of the revised range with factors adjusted equally at both ends of the range. The following table shows the maximum impact on rates that would result under this scenario.

Range of Premium Impacts as a Result of Compressed Age Rating

Carrier	Single	Couple	Employee + Child	Employee + Children	Family
Carrier A	+/- 23%	+/- 23%	+/- 23%	+/- 23%	+/- 23%
Carrier B	N/A	N/A	N/A	N/A	N/A
Carrier C	N/A	N/A	N/A	N/A	N/A
Carrier D	N/A	N/A	N/A	N/A	N/A
Carrier E	+/- 28%	+/- 7%	+/- 10%	N/A	N/A
Carrier F	+/- 28%	+/- 7%	+/- 10%	N/A	N/A

As noted, the values in the table above represent the maximum change in rates that a group might see under the scenario we have outlined, with the large increases applying to groups comprised of all young individuals and the large decreases applying to groups comprised of

individuals at only the oldest ages. For example, a group comprised of two 20 year-old single males could see roughly a 23% increase in their rates from Carrier A, all else equal. At the same time a group comprised of two 64 year-old males would see roughly a 23% decrease. Many groups will be comprised of individuals varying in age, such that the average of their age factors will fall within the 3-to-1 range, and the impact on rates due to this required change in rating will be minimal.

Industry

All carriers with the exception of Carrier A currently use industry (defined by the Standard Industrial Classification (SIC) code) as a case characteristic when setting premiums. These carriers have historically been allowed to set their own range of factors. In 2014, the ACA requires that this rating variable be eliminated. The filings reviewed did not contain a distribution of current premium by industry or indicate the average factor currently in force. The following table shows the ratio of the highest factor currently utilized to the lowest, by carrier. The table also reflects the impact on premiums that could be expected from the elimination of industry rating, assuming the premium weighted average factor is equal to the midpoint factor of the current range.

Ratio of Highest to Lowest Industry Factor

Carrier	Ratio	Highest Cost Industry	Lowest Cost Change
Carrier A	N/A	N/A	N/A
Carrier B	1.35	-14%	16%
Carrier C	1.35	-14%	16%
Carrier D	1.41	-16%	19%
Carrier E	1.22	-10%	11%
Carrier F	1.22	-10%	11%

We note that many times carriers will effectively use industry to rate up only a relatively small number of industries, resulting in an average industry factor that is well below the median factor. If this is true in the District, the decreases for the highest cost industries will be larger than those shown in the table above, and the increases for the lowest cost industries will be smaller. Again, information gathered through the pending data call should allow for more refined analysis in this area.

Group Size

The table below shows that four of the six carriers we examined currently vary rates based on the number of employees covered. The table shows the ratio of the highest group size load relative to the lowest, with the underlying factors decreasing as group size increases. This variation in rates is usually attributed to two key items. First, a portion of administrative expenses are fixed, meaning that they do not vary with the size of the group; premium billing and collection are examples of these fixed expenses. Therefore, these costs represent a larger

percentage of total premium for small groups than they do for large groups. Second, smaller groups tend to exhibit more adverse selection than larger groups. Therefore, a risk premium that decreases with group size is typically applied.

Ratio of Highest to Lowest Group Size Factor

Carrier	Ratio	Smallest Groups	Largest Groups
Carrier A	1.10	-4%	5%
Carrier B	N/A	N/A	N/A
Carrier C	N/A	N/A	N/A
Carrier D	1.15	-7%	7%
Carrier E	1.35	-14%	16%
Carrier F	1.35	-14%	16%

Assuming the average group size factor is equal to the median factor, the table above shows the range of the impact on premiums that the elimination of group size as a rating variable could have.

Health Status

Given that District regulations require that small group coverage be sold on a guaranteed issue basis, one of the most frequently discussed changes to small group rating methodology under the ACA is the prohibition of variation in premiums based on health status. All six of the carriers examined currently use an underwriting load to vary rates; however, the application of the loads differs widely amongst the carriers. Carrier D rates the least preferred groups only 30% higher than the most preferred groups; Carriers B and C rate the least preferred groups 641% higher than the most preferred groups.

Ratio of Highest to Lowest Underwriting Factor

Carrier	Ratio
Carrier A	6.15
Carrier B	7.41
Carrier C	7.41
Carrier D	1.30
Carrier E	3.30
Carrier F	3.30

The filings did not contain the detail necessary to examine how often groups receive the highest underwriting load on file with DISB from Carriers B and C, and it is possible that the highest load is only used in very few cases. Given the wide range of underwriting loads, we have not attempted to estimate the potential impact that the elimination of health status as a rating factor

could potentially have on premium rates. We do note that, since many other states currently restrict the range of factors that may be used to adjust for health status, the impact of its elimination in the District could be significantly larger than in most other states. The large changes could potentially cause significant disruption in the market. Healthy groups faced with significant rate increases could drop coverage.

As mentioned at the beginning of this section, the range of estimated premium changes is dependent upon the assumptions as outlined. Further, we examined the impact of the restriction on the use of each factor independently. In most cases, groups will experience a premium adjustment due to changes in all of these factors, and in many cases, the effect of some factors will be directionally opposite of the effect of others. Therefore, it is highly unlikely that a given group will observe a cumulative change based on the maximum increase shown for each factor independently.

Benefit Offerings in the Small Group Market

Starting in 2014, individuals must obtain minimum essential coverage for themselves and their dependents. There are a variety of ways in which individuals may fulfill this requirement such as being covered under Medicaid or Medicare, or by purchasing a Qualified Health Plan (QHP) through the individual or small group market. QHPs must provide a minimum essential benefit package as defined by HHS, and they provide benefits with an actuarial value of at least 0.60. All plans sold in the SHOP DC HIX must be QHPs.

Actuarial values represent the average share of medical expenditures paid by the plan. They are used to determine how overall cost sharing differs across plans with different cost-sharing provisions. The ACA requires that actuarial values be used to assess plans offered at each level within the DC HIX. The ACA requires that these actuarial values be calculated from a standard population so that differences in plan characteristics such as premium, provider network, customer service, quality and care management programs are consistent. These plan characteristics may be important to customers, but they will not be reflected in the actuarial values.

Previous sections presented average premiums and benefits offered within the District. Using the rate filing information provided by DISB, we extracted detail on the range of benefits and premiums currently offered in the District. In most cases where benefit information was included it was limited to a summary of basic benefit provisions (e.g., deductible, coinsurance, out-of-pocket (OOP) limit and copayments) for common services (e.g., office visits, emergency room visits, outpatient surgery and prescription drugs) for each plan. This information was not included in the filings for Carriers A and D. The rate filing information was supplemented with benefit brochures, plan summaries and rate information found on the carrier’s websites, where possible.

This information revealed that a wide range of product offerings are currently available in the District, despite its small geographic size. Products offered include Health Management

Organization (HMO), Preferred Provider Organization (PPO), traditional Comprehensive Major Medical (CMM) and High Deductible Health Plan (HDHP) coverages. The following table summarizes the coverages that we found to be offered by each carrier.

Carrier	Coverages Offered
Carrier A	HMO/POS/HDHP
Carrier B	HMO/POS/HDHP
Carrier C	PPO/CMM/HDHP
Carrier D	PPO/CMM/HDHP
Carrier E	HMO
Carrier F	HMO

In addition to a variety of products, a wide range of cost-sharing options and premiums are available. The following table summarizes the deductible, coinsurance and OOP limit for single coverage from one of the richest plans (high actuarial value) and one of the leanest plans (low actuarial value) offered by each carrier.

	Rich Plan			Lean Plan		
	Single Deductible	**Coins. Percentage**	**OOP Maximum**	**Single Deductible**	**Coins. Percentage**	**OOP Maximum**
Carrier A	$0	0%	$3,500	$10,000	0%	$11,250
Carrier B	$0	0%	$1,900	$4,000	0%	$5,250
Carrier C	$0	0%	$1,000	$5,000	0%	$20,000
Carrier D	$0	0%	$1,000	$2,000	20%	$4,000
Carrier E	$0	0%	$1,000	$1,200	30%	$4,200
Carrier F	$0	0%	$1,000	$2,500	30%	$7,500

All carriers offer a similar rich plan with no deductible or coinsurance when services are rendered by a network provider. For Carriers C and D this represents a PPO plan and the in-network benefits are shown. Deductible and coinsurance apply when non-network providers are utilized. For all other carriers this represents an HMO plan. The OOP maximum for copayments offered on these plans varies by carrier from $1,000 to $3,500. The cost sharing on these plans is generally comprised of copayments for office visits, emergency room, outpatient surgery, inpatient admissions and prescription drugs. A range of copayments observed for these services is as follows. It is common that the copayment for specialist office visits is twice the copayment for PCP visits. Most plans included a mail order prescription drug program.

Type of Service	Common Copayments
Primary Care Office Visits	$10–$20
Emergency Room	$100–$200
Inpatient Admission	$250–$500
Outpatient Surgery	$100–$200
Generic Prescriptions	$10–$20
Preferred Brand Prescriptions	$20–$40
Non-Preferred Brand Prescriptions	$30–$60

The leanest plans offered varied significantly by carrier. The lean plans from carriers that offered only HMO products had much lower deductibles than those that offered HDHP plans, as would be expected. Plans with deductibles as high as $10,000 are offered; OOP maximums as high as $20,000 are offered.

The benefit relativities and/or plan specific premiums included in the rate filings can be used as a proxy for actuarial values. We note they would not meet the exact definition of actuarial value under the ACA, as they reflect items such as differences in provider networks and differences in utilization patterns specific to the plan. The following table summarizes the ratio of the premium for the lowest cost plan to the highest cost plan offered by each carrier, as presented in the rate filings reviewed.

Ratio of Lowest to Highest Cost Plan

Carrier	Ratio
Carrier A	0.20
Carrier B	0.39
Carrier C	0.33
Carrier D	0.53
Carrier E	0.59
Carrier F	0.46

We note that the filings for several carriers included a table of medical plans and a separate table for prescription drug plans (rather than packaged medical and prescription drug benefits), with no restrictions noted as to the combinations of medical and prescription drug plans that could be elected. Therefore, in determining the lowest cost plan offered for these carriers, we combined the lowest cost medical plan with the lowest cost prescription drug plan. Likewise, in determining the highest cost plan offered, we combined the highest cost medical and prescription drug plans. The table above shows that a wide range of premiums are offered, with the premium for the lowest cost plan offered by each carrier being half or less than the premium of the highest cost plan. Since these ratios are in many cases significantly less than 0.60, this

indicates that even if the richest plan had an actuarial value of 1.00 there are plans being sold today that likely would not meet the definition of a QHP.

6

The District's Individual Direct Purchase Market

In this section, we take a closer look at the District's direct purchase market. We examine various characteristics of this market including segmentation based on the prevalence of insurance coverage by age, income, average insurance premiums and certain benefit characteristics. Finally, as we have in the section on ESI, we present a summary of carriers currently offering coverage in the direct purchase (or individual) market, their current market share and current premium levels. We also present a summary of factors currently used to develop rates in the individual market, along with an initial impression of the potential impact that rate compression required under the ACA may have on premiums.

Individual Incentives

Of the provisions that the ACA introduces, the direct purchase market may be affected by more changes than any other market. It is affected by new rating requirements for insurers, new fees for insurers and ancillary providers, tax credits to purchase coverage in the DC HIX for certain low-income individuals, the expansion of Medicaid and various other characteristics. In this section, we will provide discussion of the market's demographics and new rating requirements for insurers; however, many of these other topics are either covered in more depth in other sections or they are less likely to affect enrollee behavior in this market than in other markets.

Demographics

There are four principle populations that we are concerned with in our analysis: the ESI, direct purchase, Medicaid and uninsured. The direct purchase population is the smallest of these four. As we present estimates from the 2009 ACS data, it is important that the reader be aware that these estimates may lack credibility due to the small size of this market.

The direct purchase market (composed entirely of District residents) has the following age and gender distribution.

District of Columbia — Direct Purchase Rates

	District of Columbia		Nation	
Age Band	**Male**	**Female**	**Male**	**Female**
0 to 17	11.4%	8.8%	12.0%	11.6%
18 to 24	5.2%	3.6%	7.9%	7.5%
25 to 29	5.5%	8.1%	4.1%	3.7%
30 to 34	5.0%	4.0%	2.7%	2.7%
35 to 39	8.7%	2.2%	3.0%	3.1%
40 to 44	5.0%	3.9%	3.5%	3.6%
45 to 49	5.3%	3.0%	4.0%	4.2%
50 to 54	3.0%	3.4%	4.2%	4.4%
55 to 59	2.3%	4.8%	4.0%	4.5%
60 to 64	2.0%	3.7%	3.5%	5.1%
65+	0.2%	0.9%	0.2%	0.4%
Total	**53.7%**	**46.3%**	**49.2%**	**50.8%**

The ACS data show that the District's direct purchase market is generally consistent with the direct purchase market for the rest of the country. There are slightly fewer children covered in the District, but this may also be a reflection that the District has proportionally fewer children than other states. We note that this same observation was made when examining the employer market. We also note that there are more males covered by direct purchase in the District than in other states. This could be due to the fact that, among the population that is not provided access to coverage through their employer, more females than males qualify for Medicaid. In fact, the following chapter will show that the Medicaid population is comprised of significantly more females than males.

The ACS data show that participants in the direct purchase market have the following income levels.

District of Columbia — Direct Purchase

FPL	District of Columbia
201% to 300%	14.9%
301% to 400%	13.6%
401% +	71.5%

(As mentioned in the Data section, we have assumed that anyone in the ACS data identified as a direct purchaser and with income below 200% FPL is better classified as a Medicaid enrollee.) As the table shows, the majority of direct purchase enrollees have incomes above 400% FPL. These people will not have access to tax credits through the DC HIX, and they could see their

premiums increase as a result of required benefit increases, participation of new policyholders in the individual market and a new insurer tax beginning in 2014. In addition, rate compression due to the elimination of gender rating and the use of no more than a 3:1 difference in rates by age could lead to increases in rates for certain demographic cells. If these people question the value of their health coverage relative to its cost, they may choose to go without coverage or purchase a catastrophic policy that does not meet the requirements to qualify as minimum essential coverage. Under this scenario, they would pay the individual penalty, rather than pay premiums they perceive as burdensome. However, the individual penalty for these higher earners will increase with their income. Forgoing coverage may be a less attractive option with these increasing penalties.

Rate Development in the Individual Direct Purchase Market

As mentioned in the previous chapter, beginning in 2011, carriers are required to meet new minimum loss ratio requirements. A new Supplemental Health Care Exhibit has been added to the Statutory Financial Statement to help test whether or not this requirement has been met. The following table summarizes the direct purchase market in 2010 based on information from these publicly available financial statements.

District of Columbia — 2010 Direct Purchase Experience

	Member Months	Premium PMPM	Claims PMPM	Loss Ratio
Carefirst Bluechoice Inc	31,395	$193.71	$106.49	55%
Aetna Health Inc PA Corp	211	$552.16	$2,258.40	409%
Kaiser Foundation Health Plan Mid Atl	15,796	$330.45	$286.23	87%
Health Care Svc Corp A Mut Leg Res	521	$49.94	$62.76	126%
Golden Rule Insurance Co	10,601	$159.96	$80.70	50%
Aetna Life Insurance Co	21,272	$186.46	$99.25	53%
United Healthcare Insurance Co	5,325	$1,337.34	$1,158.24	87%
Time Insurance Co	5,521	$228.70	$83.63	37%
Unicare Life & Health Insurance Co	76	$175.86	$106.89	61%
Group Hospitalization & Med Services	140,593	$252.71	$209.96	83%
Total	**231,311**	**$263.85**	**$205.34**	**78%**
Average Members	**19,276**			

The table above shows that at any point in time roughly 19,000 District residents were covered under an individual policy 2010. These were not necessarily the same 19,000 people each month. These results compare to roughly 22,000 individuals that reported having direct purchase coverage in the ACS data. One likely source for this difference may be in the underlying type of insurance coverage. The figures in the table above from the Supplemental Health Care Exhibit represent comprehensive health coverage. The ACS asks respondents if they have “insurance purchased directly from an insurance company by this person or another

family member." Therefore, someone with a hospital indemnity or other limited benefit policy may appear in the ACS data as having direct purchase coverage depending upon how they interpret the question. For this reason, we believe the figures in the table above better represent the District's current population covered by a comprehensive individual policy. In turn, we believe the figures in the table better represent those who may purchase the type of coverage that would be sold in the individual DC HIX.

While there are several carriers offering coverage to individuals, the market is dominated by only a few. In 2010, 74% of all District residents purchasing individual coverage were covered by a policy issued by an affiliate of CareFirst, Inc. (either CareFirst Bluechoice or Group Hospitalization & Medical Services Corporation). Almost 90% of the market is represented by the top four carriers. This level of market concentration is similar to that previously observed in the small group market.

Reported premiums vary widely by insurer. It is important to note that the premiums in the table above reflect the underlying differences in demographics, benefits and morbidity of the population for each carrier and as a result are not directly comparable. A pending data call to the major carriers writing small group coverage in the District will allow for a closer look at variation in premiums by carriers, and the drivers of those rate differences.

Across the entire individual market the observed loss ratio in 2010, calculated as incurred claims divided by premium, was 78%; however a few of the carriers with large market share observed loss ratios significantly lower. For example, CareFirst BlueChoice and Aetna Life Insurance Company had loss ratios in the range of 50% to 55%. We previously described adjustments that regulators allow when determining whether the federal minimum loss ratio requirement has been met. Even after making these adjustments, it is highly likely that these two carriers would not have met the minimum requirement of 80% had it been in place in 2010. Had the federal minimum loss ratio requirements been in place, these two carriers would have likely owed policyholders a premium refund.

The table also shows that the average monthly premium on a PMPM basis was $264 in 2010. We note that there are a few outliers, however most of these outliers are for products from carriers with very little market share. Our review of the filing for United Healthcare appears to indicate that those policies are sold to AARP members, which could explain the relatively high premium on a PMPM basis. The average premium in the table above is significantly lower than the average premium of $364 PMPM premium that we observed in the small group market. There are several reasons that could explain this difference. First, coverage in the small group market in the District must currently be sold on a guarantee issue basis, per federal law. At the same time, carriers are allowed to medically underwrite and reject individuals for coverage entirely on the basis of medical conditions in the individual market. This ability to decline coverage to high risk individuals will lead to a more select population being insured in the individual market and therefore lower premiums, all else equal. This effect alone can have a substantial impact on the difference in premium levels observed between these two markets.

Second, benefits are typically less rich in the individual markets so that premiums can remain affordable. Deductibles are typically higher, and in many cases, services such as maternity or prescription drugs are sold as riders. Finally, there are likely differences in average demographics underlying the two populations.

Under the ACA, beginning in 2014 insurers will no longer be allowed to deny coverage for pre-existing conditions; they will no longer be allowed to rate based on morbidity or gender; they will be limited in how they are allowed to vary rates based on age in the individual market, as previously discussed. These restrictions will have the effect of increasing rates for the young, for males in some age ranges, and for the healthy. They will likely also lower rates for the elderly, for females in some age ranges and for the unhealthy. These restrictions will limit the extent to which carriers can reflect differences in risk when setting premium rates.

In an effort to develop broad, high-level indications of the effect that these rating changes required under the ACA could have on rates, we reviewed recent rate filings for four carriers representing 90% of all members covered by an individual policy in the District in 2010. The information in these filings only allowed for a high-level review of the range of the potential adjustment. We conducted the review separately for each variable. Offsetting adjustments due to changes in multiple rating factors could not be ascertained from the information in the filings. We stress that the estimated premium impacts that follow are illustrative and a direct a function of the assumptions outlined for each rating variable. The actual range of potential adjustments may vary significantly if the assumptions outlined do not hold. Further, the adjustment for a specific individual will surely vary from these estimates. A pending data call to the major carriers writing individual coverage in the District will provide a much more robust set of data. These data will allow a more refined look at the effect of these changes, while allowing us to consider actual distributions of premium by rating variable.

Since the rate filing information reviewed is not in the public domain, carriers are referred to as Carrier A through Carrier D in the information that follows in order to maintain confidentiality. We note that Carrier A in this analysis is not necessarily the same carrier as Carrier A in the preceding small group analysis. We note that none of the carriers reviewed varied rates by geography, which is not unexpected given the District's small geographic size.

Coverage Tier

Of the filings reviewed, all carriers currently develop individual rates that vary by coverage tier; however, the tiers utilized differ by carrier. Carrier D varied premium rates by gender while the other carriers did not. The following table shows the tiers currently utilized.

Coverage Tiers Utilized by Carriers in the Individual Market

Carrier A	Carrier B	Carrier C	Carrier D
Single	Single	Single	Single Male
Couple	Couple	Couple	Single Female
Adult + Child(ren)	Adult + Child(ren)	Adult + Child(ren)	Couple
Family	Family	Family	Male + Child(ren)
			Female + Child(ren)
			Family

As mentioned in the review of small group rates, recently released draft regulations appear to allow for the use of four tier rates. The regulations prescribe the allowable tiers as individual, two adults, one adult + child or children and a catch-all family category for two adults + child or children and other family compositions that do not fit into the first three categories. Under this revised structure, only one of the carriers would be required to make any changes to the tiers. Carrier D's tier categories fall outside the prescribed design and will have to be modified.

Age/Gender

All carriers currently use age and gender when setting premiums and have historically been allowed to set their own range of factors. In 2014, the ACA requires that age factors will need to be within a 3:1 band and rating differentials by gender will need to be eliminated. The District's recently passed reform law implements this same requirement, and it is anticipated that carriers have already made these changes to their rates, effective July 1, 2011.

The following table summarizes the ratio of the highest age factor to the lowest age factor within each coverage tier from the filings. We note that for Carriers A through C this ratio is the same for all coverage tiers, but for Carrier D this ratio varied by tier.

Ratio of Highest to Lowest Age Factor

Carrier	Single	Couple	Adult + Child	Adult + Children	Family
Carrier A	5.41	5.41	5.41	5.41	5.41
Carrier B	4.57	4.57	4.57	4.57	4.57
Carrier C	4.57	4.57	4.57	4.57	4.57
Carrier D	5.83	4.97	3.33	3.33	3.90

None of the carriers met the new age rating requirements. Their ratios for all tiers in the table above are greater than 3.0, and their factors require revision. Our understanding is that carriers will have flexibility in adjusting their age factors as long as the 3:1 ratio is satisfied and, in the District, the requirement that factors for consecutive ages be no more than 4% apart. Since the filings we were provided were effective prior to the effective date of the District's new law (i.e., July 1, 2011), it is anticipated that these changes have already been made. The filings we

reviewed did not contain a distribution of current premium by age and tier. We will require this information for a detailed analysis.

To provide a high-level estimate of what the impact on premiums might be, we assume that the premium weighted average age factor for each tier is equal to the midpoint of the range. We further assume that carriers would elect to preserve the midpoint of the current range as the midpoint of the revised range. Or, put differently, we assume that carriers would adjust the minimum and maximum age factors equally, at both ends of the range. These assumptions are the same as those utilized in the previous small group analysis. The following table shows the maximum adjustment to rates that would result under this scenario.

Range of Premium Impacts as a Result of Compressed Age Rating

Carrier	Single	Couple	Employee + Child	Employee + Children	Family
Carrier A	+/- 34%	+/- 34%	+/- 34%	+/- 34%	+/- 34%
Carrier B	+/- 23%	+/- 23%	+/- 23%	+/- 23%	+/- 23%
Carrier C	+/- 23%	+/- 23%	+/- 23%	+/- 23%	+/- 23%
Carrier D	+/- 39%	+/- 29%	+/- 5%	+/- 5%	+/- 14%

As noted, the values in the table above represent the maximum change in rates that a group might see under the scenario we have outlined. Under that scenario, large increases would apply to young individuals, and large decreases would apply to individuals at only the oldest ages.

Health Status

Given individual coverage in the District is currently underwritten, prohibition of variation in premiums based on health status under the ACA will have an impact on rates. All four of the carriers we examined currently use an underwriting load to vary rates. However, the range of loads varies by carrier from a minimum load difference of 35% for Carrier A to a maximum load difference of 100% for Carrier D. Carriers also differ in whether they use interim load factors. For example, Carrier A issues either a standard rate, a rate with a 35% load or they decline coverage. On the other hand, Carrier B uses standard rates and rates with a 10%, 25% or 50% load.

Range of Highest to Lowest Underwriting Factor

Carrier	Ratio
Carrier A	1.35
Carrier B	1.50
Carrier C	1.50
Carrier D	2.00

The maximum loads in the individual market are much lower than those used in the small group market. This is likely because carriers have the ability to decline coverage in the individual market and presumably do so when the risk(s) presented are above some threshold. Small group carriers are required to guarantee issue coverage and therefore utilize a wider range of loads. The filings did not contain the detail necessary to examine how often individuals receive the various loads. In this report, we do not present an estimate of the potential effect that elimination of morbidity load will have on rates; however, information from the pending carrier data call will allow for such an estimate in the next phase of the project.

As mentioned at the beginning of this section, the range of estimated premium adjustments are dependent upon the assumptions as outlined. Further, we have examined the potential change for each factor independently from the rest. In most cases, individuals will experience a premium revision due to changes in all of these factors, and in many cases, the adjustment from some factors will be directionally opposite from the adjustment of others. Therefore, it is highly unlikely that an individual will observe a cumulative change based on that maximum increase we have shown for each factor independently.

Benefit Offerings in the Direct Purchase Market

We previously discussed the requirement that individuals must obtain minimum essential coverage for themselves and their dependents beginning in 2014. We also described the purchase of a QHP in the individual market as one option to satisfy this requirement, thus avoiding a tax penalty.

Previous sections presented average premiums offered within the District. Using the rate filing information provided by DISB, we assessed the range of benefits and premiums currently offered in the District. In most cases, the benefit information for each plan was limited to a summary; this information was supplemented with benefit brochures, plan summaries and rate information found on the carrier's websites, where possible.

In general, there were fewer choices available in the individual market as compared to the small group market. The following table summarizes the coverages that we found to be offered by each carrier.

Carrier	Coverages Offered
Carrier A	PPO/HDHP
Carrier B	HMO/HDHP
Carrier C	PPO/HDHP
Carrier D	PPO/HDHP

In addition to a variety of products, various cost-sharing options and correspondingly premiums are available. The following table summarizes the single deductible, coinsurance and OOP limit

from one of the richest plans (high actuarial value) and one of the leanest plans (low actuarial value) offered by each carrier.

	Rich Plan			Lean Plan		
	Single Deductible	**Coins. Percentage**	**OOP Maximum**	**Single Deductible**	**Coins. Percentage**	**OOP Maximum**
Carrier A	750	80%	3,500	8,000	100%	10,000
Carrier B	0	0%	2,000	2,700	100%	5,250
Carrier C	100	90%	2,500	10,000	100%	10,000
Carrier D	1,500	80%	4,000	5,000	80%	10,000

The rich plans with no deductible and no coinsurance that were available in the small group market were not available in the individual market. Only Carrier B offered a plan with no deductible. The lean plans available in the individual market are comparable to those that are available in the small group market. The higher cost sharing (lower actuarial value) among plans in the individual market is consistent with the lower premiums that were discussed previously.

Most plans' coverage for office visits and emergency room visits were subject to a copay, with the deductible not applying to these services. Most plans covered prescriptions drugs subject to copayments, after a separate drug deductible. Some plans only covered generic drugs. We found that Carriers B and C offered maternity coverage as an optional rider; however, it appeared the other two carriers did not allow for the option to carve-out maternity.

The benefit relativities and/or plan specific premiums included in the rate filings can be used as a rough proxy for actuarial values. We note they would not meet the exact definition of actuarial value under the ACA as they reflect items such as differences in provider networks and differences in utilization patterns specific to the plan. The following table summarizes the ratio of the premium for the lowest cost plan to the highest cost plan offered by each carrier, as presented in the rate filings reviewed.

Ratio of Lowest to Highest Cost Plan

Carrier	**Ratio**
Carrier A	0.50
Carrier B	0.42
Carrier C	0.23
Carrier D	0.52

The table above shows that a wide range of premiums are offered, with the premium for the lowest cost plan being half or less than the premium of the highest cost plan. As with the small group market, since these ratios are in many cases significantly less than 0.60, this indicates

that even if the richest plan had an actuarial value of 1.00 there are plans being sold today that likely would not meet the definition of a QHP.

7

The District's Low-income Market

The District spent $1.6 billion in fiscal year (FY) 2008[23] on providing a robust health care safety net for its low-income residents. These efforts have helped to keep the District's uninsured population below the national average. These efforts have also meant that the District provides some level of Medicaid coverage to nearly one-third of its population. Provisions within the ACA will help ease some of the budgetary pressure on the District.

The District provides public coverage to low-income individuals through several fee-for-service (FFS) (26% of enrollment) and managed care programs (74% of enrollment). The majority of Medicaid enrollees are children, new or expecting mothers, and qualifying families with children. These individuals qualify under the TANF program. In addition to these enrollees, the medically needy, non-citizens and aged, blind and disabled (ABD) individuals that receive SSI may qualify. The District's criteria for eligibility include status as a District resident and income and asset tests.

Families in the District that qualify for publicly funded insurance are covered under managed care in the Healthy Families Program. Individuals eligible under SSI are covered under FFS. The District's programs (including the Alliance) provide coverage for some low-income individuals that are not eligible for Medicaid. In particular, the Alliance program covers low-income childless adults. Both the Alliance program and the District's Children's Health Insurance Program (CHIP) are also covered through managed care. These programs require no premium, but enrollees must live in the District, have no other health insurance coverage and meet certain income requirements. The District's Alliance program is currently funded by the District with no help from the federal government.

Within the District, there are low-income individuals that are dually eligible for Medicare and Medicaid. In addition to these "dual eligible" individuals, the District has a handful of other waiver programs addressing the health care coverage needs of other members of the low-income population.

The District also has two participating health plans for those individuals that are covered through managed Medicaid: the DC Chartered Health Plan and Unison Health Plan. The District's composition of enrollment across its various Medicaid programs is shown in the following table.

[23] https://www.dc-medicaid.com/dcwebportal/documentInformation/getDocument/1225.

District of Columbia — Medicaid Programs (1/2010)

Program	Enrollment
FFS	
SSI	18%
Duals	6%
QMB	2%
FFS Total	26%
Managed Medicaid	
Child & Families	42%
CHIP	3%
Other Managed	4%
Managed Total	48%
Alliance Total	26%
Grand Total	**100%**

(DHCF is the source for these data.) Roughly half of the District's Medicaid enrollees are in managed care Medicaid programs, while the remaining enrollees are in FFS or in the Alliance program.

As we noted in the Data section, the DHCF's reports reflect the upper limit of Medicaid enrollment. The DHCF does not necessarily receive notification when an enrollee obtains health coverage from another source. Because of this dynamic, it is difficult to assess how many individuals are covered by the District's Medicaid program at any one time using the DHCF data.

As we review the population estimates that result from the ACS survey data, we note that the total Medicaid enrollees identified in those data are fewer than the enrollment identified by the DHCF. There are several possible sources for the inconsistency. First, as noted in previous sections, the US Census Bureau attempts to correct for a systematic bias of underreported Medicaid participation in the ACS data. Despite these efforts, the US Census Bureau may not have fully accounted for all publicly financed health coverage, especially those with coverage through the Alliance program. Second, there may be enrollees in the Medicaid program who are not District residents that have Alliance program coverage. As we understand it, a resident could potentially obtain Alliance program coverage, move to an adjacent state, and retain that Alliance coverage. It would be difficult for the District to track these types of coverage errors.

The ACS data are from surveys conducted in the District during 2009. Since then, we know that the overall enrollment in the District's public programs has increased by at least 5%. The following table shows the demographic composition of those enrolled in the District's Medicaid program in 2009 as identified by the ACS data.

District of Columbia — Medicaid Rates

	District of Columbia		Nation	
Age Band	**Male**	**Female**	**Male**	**Female**
0 to 17	16.2%	16.6%	24.8%	23.7%
18 to 24	6.0%	9.0%	2.9%	4.5%
25 to 29	2.9%	3.9%	1.7%	3.1%
30 to 34	2.3%	3.1%	1.5%	2.5%
35 to 39	1.6%	3.2%	1.5%	2.2%
40 to 44	1.5%	2.5%	1.6%	2.1%
45 to 49	2.1%	3.5%	1.8%	2.1%
50 to 54	2.9%	3.2%	1.7%	2.1%
55 to 59	2.2%	2.8%	1.6%	1.9%
60 to 64	1.4%	2.4%	1.3%	1.9%
65+	3.9%	7.0%	5.0%	8.5%
Total	**42.9%**	**57.1%**	**45.3%**	**54.7%**

The table shows that the demographic composition of the District's Medicaid enrollees is generally consistent with the rest of the country. The primary difference is that the District's Medicaid enrollment is older, on average, than the nation's Medicaid enrollment. Based on the District's efforts to cover childless adults through the Alliance program, these numbers look reasonable. The data are also generally consistent with enrollment distributions from the District's FY 2008 Medicaid Annual Report.

Beginning January 1, 2014, the ACA will expand Medicaid, requiring that states cover all individuals under age 65 who are not entitled to Medicare and have incomes below 138% FPL.[24] This expansion will principally be comprised of two groups. The first group consists of parents or caregivers of children, where the children are already eligible for either Medicaid or CHIP. The second — and much larger — group will consist of non-elderly, non-disabled adults without dependent children. The District has already expanded Medicaid coverage from 100% FPL to

[24] Although the language of the ACA specifies that low-income individuals eligible for Medicaid are those with a Modified Adjusted Gross Income at or below 133% FPL, the ACA also includes a five percentage point disregard in determining eligibility. With this five percentage point disregard, the Medicaid eligibility threshold is effectively 138% FPL.

138% FPL with a SPA in July of 2010. As a result of that action, about 60% of the Alliance program members moved into the managed Medicaid program.
Funding from the Federal Government will supplement the District's costs for these childless adults (under 138% FPL) who were previously covered under the Alliance programs, taking some budgetary pressure (for the coverage of low-income individuals) off of the District.

The following table shows the distribution of Medicaid covered enrollees by household income as identified by the ACS data.

District of Columbia — Medicaid

FPL	District	Nation
0 to 100%	45.0%	40.8%
101% to 138%	11.7%	14.6%
139% to 200%	14.7%	15.1%
201% to 300%	9.5%	11.9%
301% to 400%	3.5%	5.5%
401% +	9.1%	7.1%
N/A	6.4%	4.9%

The District's Medicaid-covered residents show an income profile that is similar to the Medicaid residents of the rest of the country. As expected, the majority of enrollees (71.5%) are under 200% FPL. Approximately 16% of Medicaid enrollees are identified as privately employed. (In the following section on the uninsured, we provide some discussion of the employment status of that uninsured population, with particular emphasis on the young adults.) The following chart shows the distribution of industries among the privately employed Medicaid enrollees.

District of Columbia — Medicaid

Industry	Distribution
Agr, Mining, Util	0%
Const & Manu	4%
Trade	13%
Transp, Info, Finan	5%
Real Estate	2%
Prof, Sci, Tech	5%
Mang, Admin Srv	12%
Education	6%
Health & Soc Srv	20%
Arts, Ent, Food, Other	32%
Public Admin	0%
Total	**100%**

About half of all privately employed workers with Medicaid are either in the arts, entertainment and food service industry or in the health and social services industry. Approximately 25% are in trade (e.g., retail) and temporary and service firms (e,g., in management and administrative services).

We have estimated that approximately 7% of the District's population is uninsured. It is unclear at this time what forces are preventing them from seeking coverage through the District. Changes resulting from the ACA will likely induce some of these eligible individuals to obtain coverage for which they may already be qualified.

One possible reason that the program has not reached all of the people who are eligible is that there may be a perceived stigma associated with obtaining health care financing from programs for low-income people. As Medicaid is expanded more broadly, this effect, if present, should deteriorate to some degree. The expected single seamless enrollment process for Medicaid and the DC HIX could also help in this regard.

Approximately half of the uninsured population in DC below 200% FPL is under the age of 35. This group is often referred to as the "Young Invincibles." The following table provides the distribution of the uninsured by age and income range.

	FPL		
Age	**0% to 200%**	**201% to 400%**	**401% +**
0 to 17	3.3%	1.9%	2.2%
18 to 34	19.7%	12.6%	12.7%
35 to 64	18.4%	17.2%	11.0%
65+	1.0%	0.0%	0.0%
Total	**42.4%**	**31.7%**	**25.9%**

Almost half of these younger individuals (or 23% of the total) would appear to qualify for coverage under the District's existing programs. It is unclear to what degree incentives from the ACA would compel the young and uninsured population to obtain coverage, either financed privately or from the District.

The District has already taken some key steps towards ACA implementation for the Medicaid program. As previously mentioned, the managed Medicaid program was expanded to individuals up to 138% FPL in July 2010. The remaining members in the Alliance program are believed to be mostly undocumented workers who are not eligible for Medicaid or a BHP option. There are a few categories of members in Medicaid that could qualify for a BHP option, but would need to be strongly augmented by other population categories such as the currently uninsured, possible migration from small employers and non-group population under the appropriate income levels.

There may be some opportunities under the ACA to look at medical homes and other innovative programs for some of the populations under FFS Medicaid programs today. These innovative programs highlighted under the ACA may mitigate some of the program costs and contribute towards financial sustainability.

The ACA also requires Exchanges to establish a single integrated process to determine eligibility for various subsidies and to assist with enrollment for coverage within the Exchange or for Medicaid programs. Placement of Medicaid enrollment within the DC HIX will be an option that the District should strongly consider, both for continuity of coverage and for administrative efficiencies. It will also make outreach and education of consumers much easier and may aid in capturing more of the uninsured into various health insurance coverages.

8

The District's Uninsured Population

One of the central goals of the ACA is to lower the number of uninsured among the population. In this section, we examine characteristics of those individuals residing in the District who have no health insurance.

As discussed in an earlier section, the ACA includes a mandate that all individuals who can afford health insurance be covered by at least some minimally comprehensive level of insurance.[25] It strives to draw the uninsureds into the market with several incentives. Also, the ACA eases the eligibility requirements for Medicaid. Because the District already funds programs to cover low-income adults that do not qualify for Medicaid, these initiatives may not change the ranks of the uninsured as much as they are expected to change them in other states. However, the Federal Government will provide funding for this Medicaid expansion. For states that implement the expansion early, the Federal Government will provide payment earlier than 2014, but for less than 100% of the additional cost. As we understand it, the District does not fully qualify for this early adopter status and will receive 100% funding from the Federal Government from 2014 to 2016, with funds decreasing to 90% by 2020.

Uninsured Purchase Decision

The ACA's individual mandate imposes a penalty for those individuals who do not maintain coverage. The mandate is not universal and provides a penalty exception for certain low-income individuals who cannot afford coverage. The penalty is a flat payment of $95 in 2014, $325 in 2015 and $695 in 2016 (on an individual basis), or alternatively, it is a percentage of the household income (1.0% in 2014, 2.0% in 2015 and 2.5% in 2016). Ultimately, the penalty reflects the larger amount; however, it is capped at the national average premium for Bronze coverage. Returning to our example from an earlier section, a single uninsured individual earning $25,000 per year (or approximately 225% FPL in 2009) would incur a penalty equal to that listed in the following table.

[25] Certain exemptions apply to individuals who either cannot afford insurance or are not permitted due to religious beliefs. The ACA defines individuals who cannot "afford health insurance" as those for whom the minimum policy will cost more than 8% of their monthly income and whose income is greater than 100% FPL.

	2014	2016	2016
Income	$25,000	$25,000	$25,000
Flat Penalty	$95	$325	$695
Percentage	1.0%	2.0%	2.5%
Dollar Amount	$250	$500	$625
Resulting Penalty	$250	$500	$695

**Assumes no wage inflation and that the national average Bronze premium is less than the resulting penalty*

Also as discussed in an earlier section, the ACA provides tax credits to eligible individuals and families with incomes up to 400% FPL for the purchase of a QHP through the DC HIX. The government will ultimately determine the credits based on the premium for the second lowest cost Silver plan in the DC HIX and how that premium cost relates to an individual's household income. The premium for any taxpayer whose household income is within a given income tier will be restricted to the percent of income as identified in the following table. Those percentages will increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage.

Household Income	Initial Premium Percentage	Final Premium Percentage
Up to 133%	2.00%	2.00%
133% to 150%	3.00%	4.00%
150% to 200%	4.00%	6.30%
200% to 250%	6.30%	8.05%
250% to 300%	8.05%	9.50%
300% to 400%	9.50%	9.50%

Subsidy-eligible individuals are not obligated to participate in the second lowest cost Silver plan. They may participate in a plan with additional benefits or lower cost sharing, but the tax credit and cost-sharing subsidies will be calculated relative to that Silver plan's premium.

If we extend the example given above, our theoretical person with an income equal to $25,000 in 2014 would face the following incentives in assessing whether or not to purchase coverage. First, they would face a penalty of $250 for not obtaining coverage. Second, they would be eligible for a tax credit. Assuming this person is a single individual, the premium for the second lowest cost Silver plan in the District is equal to $430 PMPM, and that FPL is calculated from the 2009 basis, the person would be eligible for the following credit.

Sample FPL	Income	Plan Cap %	Plan Cap $	Plan Cost	Tax Credit
224%	$25,000	7.1%	$1,785	$5,160	$3,375

The incentives for the person would be the following:

Purchase Coverage	Do Not Purchase Coverage
Plan Cost — $5,160	Penalty — $250
Tax Credit — $3,375	
Realized Cost — $1,785	

** Subject to the theoretical assumptions identified above*

In this theoretical example, the marginal gross cost of purchasing insurance is $1,535 (= $1,785 - $250) (assuming the FPL from 2009). A key question becomes "what is the likelihood that this person values health insurance coverage at more than $1,535?" Also, the marginal gross cost of purchasing insurance will decrease over time as the penalty grows.

Population Characteristics

As with many other states, the District currently covers low-income individuals that qualify through Medicaid or CHIP. As discussed in the previous section, the District also has the Alliance program in place. This program covers certain low-income adults that do not meet Medicaid's eligibility requirements.

The following table shows the distribution of the uninsured by age and gender, based on data from the ACS.

District of Columbia — Uninsured Rates

	District of Columbia		Nation	
Age Band	**Male**	**Female**	**Male**	**Female**
0 to 17	5.1%	1.9%	6.9%	6.4%
18 to 24	11.8%	8.4%	11.0%	7.9%
25 to 29	9.3%	5.7%	8.3%	5.4%
30 to 34	7.4%	3.3%	6.4%	4.3%
35 to 39	6.8%	2.4%	5.5%	4.0%
40 to 44	4.4%	1.9%	5.0%	3.9%
45 to 49	5.4%	3.3%	4.7%	3.9%
50 to 54	4.6%	3.8%	3.7%	3.3%
55 to 59	3.6%	6.0%	2.5%	2.5%
60 to 64	1.6%	2.0%	1.7%	2.0%
65+	0.5%	0.4%	0.3%	0.5%
Total	**60.7%**	**39.3%**	**55.9%**	**44.1%**

The District appears to have a lower percentage of uninsured females than the rest of the country. This gender disparity may result from the fact that the District is more effective in enrolling Medicaid eligible individuals into its program than are other states.[26] (The dynamic is also particularly evident between the ages of 18 and 40.) However, this observation is in contrast to our expectations based on the presence of the Alliance program. Generally, we would expect that a program targeting low-income adults would be more successful in enrolling males, as many low-income females are eligible for coverage through Medicaid. This gender disparity is even more surprising given that there are more females residing in the District than males, and that males are not a disproportionately larger share of the low-income population than females. However, these results are directionally consistent with the DCHIS (from the Urban Institute), which identifies the percentage of males and females among the uninsured as 67% and 33%, respectively.[27]

Given the potential for tax credits for low-income residents, we must also consider the income of those without coverage. The following table identifies the 2009 income levels for those without coverage.

District of Columbia — Uninsured Individuals

FPL	District	Nation
0 to 100%	21.3%	25.4%
101% to 138%	5.0%	12.5%
139% to 200%	14.3%	17.0%
201% to 300%	18.7%	18.7%
301% to 400%	11.7%	10.0%
401% +	24.8%	12.6%
N/A	4.1%	3.9%

As the ACS data show, the District has a far larger percentage of uninsured that are above 400% FPL than the rest of the nation. Correspondingly, there is a lower percentage of uninsured below 200% FPL. There are several questions that arise from these distributions. First, what are the characteristics of these residents earning more than 400% FPL and what drives their decision not to purchase insurance? And second, why are there individuals who would seem to be eligible for the Alliance program with the District, but remain uninsured, particularly given the high rate at which individuals below 200% FPL were enrolled in Medicaid?[26]

[26] http://www.shadac.org/files/shadac-access-profile-jan11.pdf.

[27] Ormond, Palmer and Phadera, “Uninsurance in the District of Columbia,” Urban Institute (2010).

If we first examine those residents without coverage by income and age, the ACS data show the following:

	FPL		
Age	**0% to 200%**	**201% to 400%**	**401% +**
0 to 17	3.3%	1.9%	2.2%
18 to 34	19.7%	12.6%	12.7%
35 to 64	18.4%	17.2%	11.0%
65+	1.0%	0.0%	0.0%
Total	**42.4%**	**31.7%**	**25.9%**

(As we review these data at a more specific level, it is important that the reader be conscious that we lose credibility as the questions become more specific.) The table shows that of the 25.9% of uninsureds who are above 400% FPL, nearly half of these individuals are between the ages of 18 and 34. As we consider the potential migration of these “Young Invincibles” to modes of insurance in 2014, we will have to weigh the value they might place on coverage in the face of a penalty alone without the benefit of a tax credit. We also have to consider that this segment of the population is particularly comfortable making purchases online; the availability of coverage through the DC HIX may encourage enrollment.

Of those young uncovered individuals who are privately employed, most work in the arts, entertainment and food service industries, with a significant share of employees in trade (e.g., retail) as well as professional, scientific and technical industries. There are also large shares of individuals working for temporary and service firms (e.g., in management and administrative services). The following chart shows the distribution of industries for those who are both uninsured and privately employed.

Industry	Distribution
Agr, Mining, Util	0%
Const & Manu	5%
Trade	20%
Transp, Info, Finan	5%
Real Estate	0%
Prof, Sci, Tech	15%
Mang, Admin Srv	9%
Education	3%
Health & Soc Srv	5%
Arts, Ent, Food, Other	38%
Public Admin	0%
Total	**100%**

Because many of these individuals work in industries where health insurance coverage is less common, they may find access (along with cost) to be a significant driver of their decision not to obtain coverage. If access and affordability is improved as a result of the DC HIX, these people may be more inclined to apply for coverage.

We also note that about half of all uninsured individuals are privately employed, and they generally show the same distribution as the young uninsured. That is, they are predominantly employed in retail trade and arts, entertainment and food service. These industries also employ many part-time workers. As these workers may not be eligible for coverage, the distribution identified here may not be reflective of a particular industry's likelihood to provide coverage to its workers. Rather, the distribution may reflect the likelihood of a particular industry to employ part-time workers.

An unusual observation from the ACS data relates to the number of uninsured adults with incomes below 200% FPL. The District's Alliance program is intended to provide a safety net for those who do not qualify for Medicaid or CHIP and have limited resources to purchase private coverage, particularly those with incomes lower than 200% FPL. Returning to the table on the previous page, approximately 42% of those without coverage are below 200% FPL. These people would seem to qualify for the Alliance program and it is unclear why they would remain without coverage. Perhaps they feel there is a stigma attached to publicly sponsored coverage. Perhaps they are healthy and unaware of the program, or perhaps there is some other unknown dynamic. The Urban Institute's DCHIS indicates a number of reasons that uninsured respondents gave for not having coverage:[27] of those respondents, 55.1% were not aware of the programs, 32.4% were not sure how to enroll. Understanding how these individuals might respond to the incentives in ACA will be a challenge as we estimate future enrollment scenarios across different modes of coverage.

Effective September 2010, insurers were required to offer coverage for dependents under the age of 26.This requirement differs for grandfathered and non-grandfathered plans. [28] Based on estimates published in the Congressional Research Service,[29] we estimate that this provision of the ACA could affect between 1% and 3% of the uninsured population.

[28] For grandfathered policies until 2014, coverage is only required to be extended to dependent children to age 26 if the dependent child does not have another offer of ESI.

[29] Chaikind and Fernandez, "Preexisting Exclusion Provisions for Children and Dependent Coverage under the Patient Protection and Affordable Care Act (PPACA)," Congressional Research Service (2011).

9

Basic Health Plan

With the expansion of Medicaid and the introduction of tax credits for some low-income participants in the DC HIX, provisions of the ACA are expected to stabilize coverage for the low-income population. In this section, we discuss the BHP option and how it will support these provisions, we introduce some of its requirements and we address how it might affect residents of the District.

Tax credits (through the purchase of insurance in the DC HIX) are the ACA's basic approach to compel non-Medicaid eligible individuals to maintain coverage when their income is less than 200% FPL. There is evidence though that a significant portion of the population under 200% FPL (non-Medicaid and Medicaid eligible) will gain or lose their Medicaid eligibility with some frequency. The BHP is intended to smooth the transition from Medicaid eligibility to non-Medicaid eligibility without the burden of re-enrollment or potential change in providers. Effective January 1, 2014, states will be permitted to offer a BHP to non-Medicaid individuals that meet the following criteria:

- They are not eligible for Medicaid
- They are under 65 years old at the beginning of the plan year and not eligible for Medicare
- Their income falls between 133%[30] and 200% FPL for US citizens and below 133% FPL for legal aliens
- If they have access to ESI coverage, it does not provide coverage for essential benefits or is deemed unaffordable based on their income

Because the District has already made the decision to cover many of these people through the Alliance program, there may be little reason not to pursue a BHP, as significant savings may be realized. Under the BHP, the District will receive additional funds and continue to offer the continuity of coverage to many of the enrollees that meet the income eligibility requirements.

Within the BHP, states contract with health plans to provide essential health benefits for these non-Medicaid eligible low-income individuals. However, there are numerous requirements for participating plans, including:

- The health plans must maintain a minimum medical loss ratio of 85%
- Contacts must be awarded through a competitive bidding process (as much as such an approach is possible)

[30] A 5% disregard applies when determining Medicaid eligibility; therefore, the effective value is 138%.

- Coverage must be coordinated with Medicaid and CHIP
- The plan must provide essential health benefits

If the District were to contract with a plan, the Federal Government will provide the District 95% of the premium tax credits and cost-sharing subsidies that would have been provided for those individuals had they been enrolled in the DC HIX. This is critical: reimbursement to the District is not based on the cost of the covered enrollees, but rather the average cost of those covered in the individual market (both inside and outside the DC HIX). If costs are lower than the received tax credit, the District would be required to reduce premiums, reduce cost sharing, reimburse providers at a higher rate or provide additional benefits. Also, any benefits that the District wishes to cover that are not included in the essential benefits package (and not covered by additional enrollee premiums or through cost sharing) must be paid for by District if no excess funds are available from the Federal Government.

Individuals enrolled in the BHP will only be required to pay premium; no more than that they would have had to pay for the second lowest cost Silver plan in the DC HIX (i.e., net of any tax credits). There will be some level of cost-sharing subsidization for BHP participants. Those individuals between 138% and 150% FPL will receive cost-sharing subsidies so that their cost sharing is roughly equivalent to what they would pay for Platinum level benefits. Those individuals with income between 150% and 200% FPL would receive cost-sharing subsidies so that their cost sharing is roughly equivalent to Gold level benefits.

If we again look at the ACS data and estimate who might be eligible for the BHP, we find that they have the following distribution:

District of Columbia — Potential BHP Eligibles

	Estimate from ACS	Revised Estimate
ESI	10,000	10,000
Medicaid	25,500	4,000
Uninsured	6,000	6,000
Total	**41,500**	**20,000**

The table above shows two alternative estimates of potential BHP eligible individuals. The first column shows the raw potential enrollment as it is characterized by the ACS data. The Medicaid row in the second column reflects individuals currently enrolled in the District's Waiver program, covering those with income between 138% and 200% FPL. This revised cell also reflects some current Medicaid FFS enrollees that may qualify for the BHP, as identified by DHCF. There are other people who may qualify for assistance from the District, and are therefore classified as Medicaid in the first column, but would not be eligible to enroll in the BHP. Please note that we have not included dual eligible enrollees or those that are currently covered under Medicare, as they are not eligible to participate in the BHP. Finally, the table above does not recognize legal aliens below 133% FPL who would qualify for the BHP.

Because of uncertainty around the population that would potentially be eligible for the BHP, the District may wish to consider additional feasibility analyses for this program.

10

Exchange Eligibility Estimates

The viability of a DC HIX will depend directly on the number of people that use it. In this phase of the project, we have not considered the likely enrollment in the DC HIX, but we have been able to identify those residents that could be eligible for incentives designed to direct people to the DC HIX.

The following table shows the individuals that could be eligible for subsidies through the DC HIX by coverage mode. From the group with ESI, we have removed anyone that is employed by the government. Qe have also excluded anyone identified as having ESI in the same household where the principle person or their spouse is employed by the government. We note that the 435 members of Congress, 100 Senators and their staffs will no longer be able to obtain coverage through the FEHB program beginning in 2014. The Federal Government may only make coverage available to these individuals through the DC HIX or other similar program created under the ACA.[31] These individuals and their state of residence were not separately identifiable in the data sets used; therefore, our estimates in the following table are likely to be slightly understated. We will pursue further in the next phase of our work alternate sources of data to try and quantify these individuals.

We have also removed everyone below 200% FPL, assuming that they would receive coverage through Medicaid, the BHP or the Alliance program. Please note that some people that are not eligible for credits through the DC HIX may decide to purchase it there anyway. Some segments of the population (especially younger workers) may be more comfortable purchasing coverage online than they would through an agent.

[31] Liu, Lunder, Staman and Thomas, “Questions Regarding Employer Responsibility Requirements and Section 1312(d)(3)(D) of the Patient Protection and Affordable Care Act,” Congressional Research Service (2010).

District of Columbia — Insured Status by Income

	Residents	**+/- SE**
Uninsured		
201% to 400%	12,800	820
400% +	10,500	810
Direct Purchase		
201% to 400%	6,300	570
400% +	15,700	1,060
ESI		
201% to 400%	48,000	1,240
400% +	113,300	1,500

By these estimates, there are approximately 19,100 District residents (12,800 uninsured and 6,300 direct purchasers) that would be primary candidates for coverage through the DC HIX. However, some employers with many low-income workers may decide that it makes more sense financially to terminate coverage and have their employees seek subsidized coverage through the DC HIX. It is important to note that not all of these employees losing coverage would be eligible to enroll in the DC HIX. Those workers who are residents of others states would be eligible to enroll in the Exchange of their home state. Also, many uninsured, or those with direct purchase coverage who also have household income above 400% FPL, might purchase insurance through the DC HIX. If the DC HIX provides a more accessible or transparent view of available products, those individuals may decide that the DC HIX is the best venue for their purchase.

The segment of the population that creates the greatest uncertainty is the small group employers that could receive coverage through a SHOP DC HIX. We have identified approximately 125,000 individuals enrolled in fully insured small group coverage in the District in 2010. Although there are differences in the demographic and socioeconomic profiles of MA and the District, the MA' SHOP experience does not suggest a robust market for group coverage purchased through the Exchange. Through March 2011, the State has only been able to attract 3,644[32] workers through the Business Express (MA’ equivalent of the SHOP).

In addition, employees with work coverage (who are also eligible for subsidies through the DC HIX) will have to decide if coverage through the DC HIX is a more affordable option than their employer coverage. These people will base their decision to acquire coverage through the DC HIX based on the financial incentives in place. They will also base their decision on potential network changes, perceived carrier quality, and the long term viability of coverage through the DC HIX.

[32] http://www.economist.com/node/18867268.

Participating Carriers

There are numerous considerations that carriers will have to make when deciding whether or not to participate in the DC HIX. In the District, the health insurance market is dominated by one carrier. When assessing the potential affect of a merger or acquisition, the Department of Justice will sometimes assess the market impact of these transactions by reviewing the market's Herfindahl Index before and after the transaction. The Herfindahl Index measures the relative size of a market's largest firms. The index ranges from 0 to 1, with lower values representing market diversity and higher values representing market concentration. A Herfindahl Index above 25% is considered a concentrated market; the District's health insurance market has a Herfindahl Index of 51%.

Any carrier wishing to participate in the DC HIX is going to explicitly recognize the effect of a potential presence from the District's largest carrier. Plans considering participation in the DC HIX will also consider the size of the potential market. As the number of subsidy-eligible people participating in the market increases, so will the attractiveness of offering plans in the DC HIX. Conversely, the presence of a BHP will lower the size of the subsidy-eligible market, and consequently, it may make the market less attractive.

Smaller carriers may be attracted to the DC HIX because it could lower some of their administrative costs. This cost reduction would allow them to offer products that are more competitive with the larger plans in the market. Also, these smaller carriers will presumably be presented as options on the DC HIX alongside the larger carriers. Any marketing advantage the larger carriers have would likely be mitigated on the DC HIX platform. Finally, the risk adjustment mechanism will help moderate gains and losses for these smaller carriers, which should help alleviate any concerns related to selection within the DC HIX.

Some plans may choose not to participate in the DC HIX if they have a competitive disadvantage on provider contracts, administration, etc. Or, put differently, if plans must compete on price, carriers may decide to withdraw themselves from the DC HIX, not reveal their disadvantages and compete for enrollees outside of the DC HIX. This is particularly true under the scenario where the benefit designs inside the DC HIX are standardized. (Requirements around benefit offerings is one of many decisions the District would need to make in designing the DC HIX.)

Lastly, carriers may decide not to participate in the DC HIX if they are concerned that other costs do not justify the market's potential. For example, if the District requires that benefit designs in the DC HIX be at specific actuarial values (e.g., 0.70, 0.80, etc.) rather than ranges, or even small tolerances around these values, carriers may decide that compliance with these requirements is too costly. Also, carriers may decide not to participate in the SHOP DC HIX if employees are provided too much flexibility in muti-benefit choice situations (e.g., similar metals from different carriers). The potential exposure to anti-selection would be very difficult to consider in pricing. Also, if fees used to fund the DC HIX are only levied against market participants, it raises another barrier to participation in the DC HIX.

11

Analysis of Existing Exchanges and National Landscape

The ACA requires that state-based Exchanges be established and fully operational by 2014. States may establish one or more state or regional Exchange, partner with another state in setting up an Exchange, or they may choose not to set up an Exchange at all and defer to the Federal Government to set up an exchange in their state. States are starting from very different points with regard to establishing an exchange. Some states, such as MA and UT, already have operational Exchanges. Others, such as the District, are in the early stages of studying how an Exchange might work in their jurisdiction.

There are many features associated with establishing and operating an Exchange that must be considered in planning and developing one. In this chapter we present background information related to the infrastructure of setting up and maintaining an Exchange. We first discuss steps that have been taken by five of the early adopter states,[33] those that have already passed Exchange legislation since the passage of the ACA.[34] We then present information from other states.

[33] Quoted text from the early adopter state legislation is from:
California — SB 900
(see:http://www.healthexchange.ca.gov/Documents/SB%20900,%20Elaine%20Alquist.%20California%20Health%20Benefit%20Exchange.pdf)
AB 1602
(see:http://www.healthexchange.ca.gov/Documents/AB%201602,%20John%20A.%20Perez.%20California%20Health%20Benefit%20Exchange.pdf)
Colorado — SB 11-200
(see:http://www.leg.state.co.us/clics/clics2011a/csl.nsf/fsbillcont3/7233327000DC9A078725780100604CC4?open&file=200_enr.pdf)
Maryland — HB 166 (see: http://mlis.state.md.us/2011rs/chapters_noln/Ch_2_hb0166T.pdf)
Washington State — SB 5445 (see: http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Senate%20Passed%20Legislature/5445-S.PL.pdf)
West Virginia — SB 408
(see:http://www.legis.state.wv.us/Bill_Status/bills_text.cfm?billdoc=SB408%20SUB2%20ENR.htm&yr=2011&sesstype=RS&i=408)

[34] Vermont has also passed exchange legislation. It is part of a larger law intended to create a single-payer health system rather than simply implement the provisions of ACA. Given this different goal than other states, we do not discuss Vermont's legislation in this chapter.

Early Adopters

Governance

The ACA states, “An Exchange shall be a governmental agency or non-profit entity that is established by a State.”[35] If a state chooses to establish the Exchange as a governmental agency, it could be established within an existing — or as a new — governmental agency, or as an independent quasi-governmental body.

The primary challenges related to creating a public entity are around flexibility, particularly in procurement and personnel practices. These issues may be resolved by legislating that certain provisions of state law do not apply to the Exchange. Some states have taken this approach in setting up a public entity. These states may prefer having a direct link to other governmental agencies such as the Medicaid agency, the Department of Revenue or the insurance regulatory agency, while providing some additional flexibility by legislating exemptions from certain state requirements.

Other states, perhaps preferring greater independence from state government and political influences, are moving toward quasi-governmental entities. These entities may have more flexibility in procurement and personnel issues, while maintaining some accountability to the state. However, there may be additional complexities in coordinating with public agencies such as the Medicaid agency.

Non-profits may have the greatest flexibility and lack of political influence. However, it is also possible that there would be less accountability to state government.

In each of the early adopter states that follow, we discuss the make-up of the Governing Board. Additional information about the make-up of each of these boards is shown in Appendix D.

California

California’s (CA’s) SB 900 established the CA Health Benefit Exchange as “an independent public entity not affiliated with an agency or department.” The Exchange is governed by a five member Board, made up of residents of CA.

The board shall also consult with stakeholders including but not limited to:

- Health care consumers
- Individuals and entities with experience in facilitating enrollment in health plans
- Representatives of small businesses and self-employed individuals
- The State Medi-Cal Director
- Advocates for enrolling hard-to-reach populations

[35] 1311(d)(1).

Colorado

Colorado's (CO's) Exchange is created as a "non-profit unincorporated public entity." The Exchange is "an instrumentality of the State; except that the debts and liabilities of the Exchange do not constitute the debts and liabilities of the State, and neither the Exchange nor the Board is an agency of the State."

There is a Governing Board of Directors comprised of 12 members, of which nine have voting rights. In making appointments, the persons making the appointments are to consider the "geographic, economic, ethnic and other characteristics of the state." In addition, there is to be broad representation of the following skill sets:

- Individual health insurance coverage
- Small employer health insurance
- Health benefits administration
- Health care finance
- Administration of a public or private health care delivery system
- The provision of health care services
- The purchase of health insurance coverage
- Health care consumer navigation or assistance
- Health care economics or health care actuarial sciences
- Information technology
- Starting a small business with 50 or fewer employees

The Board shall "create technical and advisory groups as needed."

In addition to the Board of Directors, the legislation establishes the "Legislative Health Benefit Exchange Implementation Review Committee." The Review Committee's responsibilities include reviewing grants applied for by the Board and reviewing the financial and operational plans of the Exchange. The Committee is made up of members of the State Senate and House of Representatives. It is possible the committee was established in this way to create accountability of the non-profit entity to the State.

Maryland

MD's law (HB 166) states in its preamble that, "The Exchange must be transparent, accountable and able to perform inherently governmental functions such as determining income eligibility and citizenship status, coordinating with other State agencies and programs, and adopting rules and regulations governing health insurance plan participation." Further, "The Exchange must at the same time be nimble and flexible, able to respond quickly to changing insurance market conditions, be sensitive and responsive to consumer demands, and remain insulated from changes in the political environment." For these reasons, MD chose to establish its Exchange as "a public entity, independent of other units of State government, which shall be subject to certain State laws and regulations to ensure transparency, accountability, and coordination with State agencies and programs, but which shall be exempt from other State administrative laws and

regulations affecting government operations to ensure sufficient flexibility to operate effectively, efficiently, and in coordination with the private sector." However, the law requires that by December 1, 2015 the Exchange shall conduct a study and report its findings and recommendations to the Governor "on whether the Exchange should remain an independent public body or should become a non-governmental, non-profit entity."

The Exchange is governed by a nine member Board. In addition to specifying the make-up of the Board related to appointments and knowledge base, the Board must also reflect a diversity of expertise; reflect the gender, racial, and ethnic diversity of the State and represent the geographic areas of the State. The Board shall also "create and consult with advisory committees" and appoint their members. The advisory committees shall include members from various types of health plans, provider groups, consumers (including employers, public employee unions and consumers), public health researchers and other stakeholders.

Washington State

The Washington (WA) Exchange is established as "a public-private partnership separate and distinct from the State."

The Exchange is governed by a nine member Board (including a chair who is non-voting, except in the case of a tie), composed of persons with expertise in the WA State health care system and private and public health care coverage. In addition, there are two non-voting ex officio members. The Board is to "establish an advisory committee to allow for the views of the health care industry and other stakeholders to be heard in the operation of the Health Benefit Exchange." In addition, the Board may establish technical advisory committees or seek the advice of technical experts when necessary.

West Virginia

West Virginia's (WV's) Exchange is established within the Offices of the Insurance Commissioner. This is a governmental entity of the State. The exchange is governed by a 10 person Board.

Conflict of Interest Provisions

When selecting Board members, it is important to get members with considerable knowledge of the affected health insurance markets. Many of those with the most knowledge may, however, have conflicts of interest that would compromise their ability to serve on the board. In this section we present conflict of interest provisions written into various state exchange laws.

California

"A member of the Board or of the Staff of the Exchange shall not be employed by, a consultant to, a member of the board of directors of, affiliated with, or otherwise a representative of, a carrier or other insurer, an agent or broker, a health care provider, or a health care facility or health clinic while serving on the Board or on the Staff of the Exchange. A member of the Board

or of the Staff of the Exchange shall not be a member, a board member, or an employee of a trade association of carriers, health facilities, health clinics, or health care providers while serving on the Board or on the Staff of the Exchange. A member of the Board or of the Staff of the Exchange shall not be a health care provider unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice."

Colorado

"A member of the Board shall not perform an official act that may have a direct economic benefit on a business or other undertaking in which the member has a direct or substantial financial interest."

Maryland

"A member of the Board or of the Staff of the Exchange, while serving on the Board or the Staff, may not have an affiliation with:

(I) A carrier, an insurance producer, a third-party administrator, a managed care organization, or any other person contracting directly with the Exchange;
(II) A trade association of carriers, insurance producers, third-party administrators, or managed care organizations; or
(III) Any other association of entities in a position to contract directly with the Exchange."

Washington State

"No Board member may be appointed if his or her participation in the decisions of the Board could benefit his or her own financial interests or the financial interests of an entity he or she represents. A Board member who develops such a conflict of interest shall resign or be removed from the board."

Procurement and Personnel Practices

As discussed in the Governance section, one disadvantage of having the Exchange established as a part of state government is the limitations that may apply related to procurement and personnel issues. The Exchanges will need to be able to attract and retain highly qualified individuals, both employees and contract-based work, to ensure success. In this section, we discuss language that early adopter states have included in the Exchange legislation to limit the restrictions on procurement and personnel.

California

"The executive director shall be exempt from civil service and shall serve at the pleasure of the board." The Board shall set salaries for certain exempt positions "in amounts that are reasonably necessary to attract and retain individuals of superior qualifications." These positions also "shall not be subject to otherwise applicable provisions of the Government Code or the Public Contract Code and, for those purposes, the Exchange shall not be considered a State agency or public

entity." Compensation is to be determined through the use of outside advisors, salary surveys, or other state and federal comparable exchanges, or other relevant labor pools.

The Board is directed to establish a competitive process to select carriers and other contractors. "Any contract entered into pursuant to this title shall be exempt from Chapter 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, and shall be exempt from the review or approval of any division of the Department of General Services."

Maryland

With some exceptions, "the Executive Director's appointment, retention and removal of staff of the Exchange are not subject to Division I of the State Personnel and Pensions Article." The Executive Director determines the classification, grade and compensation of staff "when possible, in accordance with the State pay plan." The Executive Director sets compensation for attorneys, financial consultants and any other professionals or consultants necessary to carry out the planning, development and operations of the Exchange and the provisions of this title.

Furthermore, "Except as otherwise provided in this title, an employee or independent contractor of the Exchange is not subject to any law, regulation, or executive order governing State compensation, including furloughs, pay cuts or any other General Fund cost savings measure."

Washington State

"The Exchange and the Board are subject only to the provisions of Chapter 42.30 RCW, the Open Public Meetings Act, and Chapter 42.56 RCW, the Public Records Act, and not to any other law or regulation generally applicable to State agencies. Consistent with the Open Public Meetings Act, the Board may hold executive sessions to consider proprietary or confidential non-published information."

West Virginia

"The executive director and all employees of the Board are exempt from the classified service and not subject to the procedures and protections provided by Article two, Chapter six-c of this code and Article six, Chapter twenty-nine of this Code."[36]

Financing

The ACA provides for grant funding for states to apply toward the planning and establishment of the Exchanges. However, by January 1, 2015, the Exchanges must be self-sustaining.[37] Federal funds are not available for running a state-established Exchange beyond 2014.

---

[36] "Article two, chapter six-c of this code" provides a procedure for the resolution of employment grievances by public employees, (see:http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=06c&art=2#02).
"Article six, chapter twenty-nine of this code" governs the civil service system, (see:http://www.legis.state.wv.us/WVCODE/Code.cfm?chap=29&art=6#06).

[37] 1311(a) and 1311(d).

The most feasible options for financing the DC HIX include assessments on health benefit plans (HBPs) inside the DC HIX, assessments on all HBPs in the individual and small group markets both inside and outside the DC HIX and appropriations from the state's general fund. As you will see later in this section, states that have passed laws establishing their exchanges are not using general funds to support Exchange administration. Financing the DC HIX through assessments on HBPs in the individual and small group markets places the expense with the markets that are to benefit from the existence of the DC HIX. Still, assessments could be levied on only those plans purchased in the DC HIX or all plans in a given market both inside and outside the DC HIX. Charging only those plans inside the DC HIX may make it more difficult to achieve revenues that meet the operational expenses in the early years when fewer people are enrolled in the DC HIX. However, given the subsidies are only available through the DC HIX, there may be sufficient enrollment to support the administrative functions, even in the early years. As we discuss later, MA currently applies surcharges only to plans purchased through the Exchange. The majority of the MA Exchange's revenue is derived from the subsidy-eligible population.

Assessing fees on all plans in a given market, both inside and outside the DC HIX, would likely allow the DC HIX to more easily achieve revenues sufficient to meet operating expenses, while also keeping the surcharge on a per member basis relatively low, since it would be spread over a larger population. However, there is also the possibility that having broad authority to levy assessments on all plans would reduce the incentive for the DC HIX to operate competitively and efficiently. The DC HIX would receive the revenue whether it was providing valuable high-quality services to its customers or not, and whether those services were provided efficiently or not. This could be perceived as a significant problem.

We would recommend that modeling be performed before deciding on a financing mechanism. Many factors can influence the expenses incurred and the revenue earned by the DC HIX including, but not limited to, enrollment levels inside and outside the DC HIX, level of integration with Medicaid and the level of interoperability with other states.

In this section, we discuss how the early adopter states have allowed for financing through their legislation.

California

CA's AB 1602 spells out financing of the Exchange. It creates the CA Health Trust Fund. The CA Health Facilities Authority may, under the law, "Charge and equitably apportion among participating health institutions, the administrative costs and expenses incurred by the authority in the exercise of the powers and duties conferred by this part." It also may, "provide a working capital loan of up to five million dollars ($5,000,000) to assist in the establishment and operation of the CA Health Benefit Exchange." The Exchange must repay any loans from the authority by June 30, 2016.

The Board shall "Assess a charge on the QHPs offered by carriers that is reasonable and necessary to support the development, operations and prudent cash management of the

Exchange." This charge will not affect the requirement that carriers charge the same premium rate for QHPs, whether offered inside or outside the Exchange.

If, at the end of any FY, the fund has unencumbered funds that exceed the approved operating budget for the next FY, the board shall reduce these charges on QHPs during the following FY "in an amount that will reduce any surplus funds of the Exchange to an amount that is equal to the agency's operating budget for the next fiscal year."

The board shall, "Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue in the fund, and if sufficient revenue is not available to pay estimated expenditures, institute appropriate measures to ensure fiscal solvency."

No General Fund money is to be used for the Exchange.

Colorado

CO's law does not establish the financing mechanism that will be used to support the Exchange. The law does, however, indicate that "Moneys from the General Fund shall not be used for the implementation of this article," except for amounts for committee members for attendance at certain meetings and for "Legislative Staff agency services."

Maryland

MD's law establishes the MD Health Benefit Exchange Fund. The Exchange may "impose user fees, licensing or other regulatory fees, or other assessments" provided they do not exceed reasonable projections of the amount needed to support the operations of the Exchange. These funds "may not be used for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory actions." In addition, the fees assessed may not provide a competitive disadvantage to HBPs operating outside the Exchange.

Washington State

By January 1, 2012, the WA State Health Care Authority (the State agency that purchases health care coverage for eligible State employees, officials and their dependents) is to produce a report containing analysis and recommendations on several items including, "Development of sustainable funding for administration of the exchange as of January 1, 2015," as well as "The staff, resources, and revenues necessary to operate and administer an Exchange for the first two years of operation."

West Virginia

"On or after July 1, 2011, the Board is authorized to assess fees on health carriers selling qualified dental plans or HBPs in this State, including HBPs sold outside the Exchange, and shall establish the amount of such fees and the manner of the remittance and collection of such fees in legislative rules. Fees shall be based on premium volume of the qualified dental plans or

HBPs sold in this State and shall be for the purpose of operation of the Exchange." This language is notable since the funding can begin well before the Exchange is operational, and may apply to HBPs outside of the Exchange.

The Exchange may not "use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications." Furthermore, monies in the WV Health Benefits Exchange Fund do not revert to the General Fund.

Integration with Medicaid

There appears to be a lack of information publicly available regarding the processes states are planning to use to integrate their Exchanges with Medicaid. We believe all states are in preliminary stages of such integration efforts. There will also be issues that are unique to a state's current processes. In addition, further guidance is needed from the Federal Government related to Modified Adjusted Gross Income, third-party verification of income and identification of "newly eligible" Medicaid beneficiaries, for which states will receive enhanced federal matching dollars.[38] In this section we discuss information that is available from states' Exchange legislation.

California

The board of the Exchange is required to "Inform individuals of eligibility requirements for the Medi-Cal program, the Healthy Families Program or any applicable state or local public program and, if, through screening of the application by the Exchange, the Exchange determines that an individual is eligible for any such program, enroll that individual in the program." The Board shall also "Develop processes to coordinate with the county entities that administer eligibility for the Medi-Cal program and the entity that determines eligibility for the Healthy Families Program, including, but not limited to, processes for case transfer, referral and enrollment in the Exchange of individuals applying for assistance to those entities, if allowed or required by federal law."

The Board is further required to "Collaborate with the State Department of Health Care Services and the Managed Risk Medical Insurance Board, to the extent possible, to allow an individual the option to remain enrolled with his or her carrier and provider network in the event the individual experiences a loss of eligibility of premium tax credits and becomes eligible for the Medi-Cal program or the Healthy Families Program, or loses eligibility for the Medi-Cal program or the Healthy Families Program and becomes eligible for premium tax credits through the Exchange."

[38] http://www.maxenroll.org/files/maxenroll/file/maxenroll%20Bachrach%20033011.pdf.

Colorado
CO's legislation does not explicitly address Medicaid; however, it allows the Board to "enter into information-sharing agreements with federal and State agencies and other state Exchanges to carry out its responsibilities."

Maryland
The Board is permitted to "contract or enter into memoranda of understanding with eligible entities, including the MD Medical Assistance Program." The Exchange is required to make determinations regarding eligibility for State and local public health insurance programs, and to "facilitate the enrollment of any individual who the Exchange determines is eligible for" another public health insurance program.

Washington State
The WA State health care authority must analyze and make recommendations including whether to adopt and implement a federal BHP option including "Coordination of the exchange with other state programs" and "whether the federal BHP option should merge risk pools for rating with any portion of the state's Medicaid program." In addition, the legislation allows the authority to enter into "Information sharing agreements with federal and State agencies and other state exchanges" as well as "interdepartmental agreements with the Office of the Insurance Commissioner, the Department of Social and Health Services, the Department of Health, and any other State agencies necessary to implement this Act."

West Virginia
WV's legislation allows the Exchange to "enter into memoranda of understanding with other governmental agencies" presumably to allow for integration with other public health insurance programs. Information-sharing agreements are also permitted, provided confidential information is protected.

Merging of Individual and Small Group Markets
The ACA allows a state to merge its individual and SHOP Exchanges, and to merge the individual and small group markets into a single risk pool.[39] It is not clear how a state would merge the Exchanges without merging the risk pools. If the markets remain separate, it is possible that product offerings could be significantly different in the markets, and premium levels for similar benefits could be significantly different as well. Even with the essential health benefits and the minimum actuarial values being specified, material differences could remain.

Merging of the risk pools first requires detailed analysis to understand the likely impact on enrollment, product choice and premium levels. Merging of risk pools could have very different impacts in different states, depending upon the current characteristics of each market. This is

[39] 1311 and 1312.

likely the reason that the states that have adopted exchange legislation generally require the Exchange Board to perform analysis and report on recommendations related to the merging of the markets.

California

CA's legislation (AB 1602) establishes a SHOP Exchange that is "separate from the activities of the Board related to the individual market." However, it also requires the Board of the Exchange to, "Report, or contract with an independent entity to report, to the Legislature by December 1, 2018, on whether to adopt the option in paragraph (3) of subdivision (c) of Section 1312 of the federal Act to merge the individual and small employer markets."

Colorado

The Board of the Exchange is to "consider the desirability of structuring the Exchange as one entity that includes two underlying entities to operate in the individual and the small employer market, respectively."

Maryland

MD's law requires establishment of a SHOP Exchange. It appears that, at least initially, this will be a separate Exchange. However, the law also requires the Exchange to study "whether the current individual and small group markets should be merged."

Washington State

The authority is required to develop a report, including analysis and recommendations on "Individual and small group market impacts, including whether to…merge the risk pools for rating the individual and small group markets in the Exchange and the private health insurance markets."

Geographic Considerations

The District is in a unique position given its small geographic size and relatively large concentration of people that work in the District, but reside in another jurisdiction or vice versa. There may be opportunities to work with neighboring states, or other states, to integrate some aspects of the DC HIX operations. For example, perhaps joint purchasing of administrative functions such as website development could be done. This might create economies for the participating jurisdictions, which do not necessarily need to be in the same geographic area. In addition, if neighboring states have similar websites it may make movement of members between the individual and small group markets more seamless where changing markets also includes a change of jurisdiction (i.e., if the place of residence is in a different jurisdiction than the place of employment, as is the case for many residents and employees in the District.)

"Early Innovator" grants were awarded to six states (Kansas, MD, New York, Oklahoma, Oregon and Wisconsin) and a consortium of New England states. The New England Consortium, New England States Collaborative Insurance Exchange Systems (NESCIES), is led by MA, which is

already operating an Exchange and has a goal to "create Health Insurance Exchange information technology components in MA that are consumer-focused, cost-effective, reusable and sustainable, and that can be leveraged by New England and other states to operate Health Insurance Exchanges."[40] In awarding the grants, HHS indicated "All Early Innovator states have committed to assuring that the technology they develop is reusable and transferable."[41] The District may be able to leverage the technology developed by Early Innovator states to reduce administrative redundancies.

Colorado

As mentioned previously, the Board may enter into information-sharing agreements with other state exchanges. No further information is contained in the law related to partnering with other states or considering a multi-state Exchange.

Maryland

MD's law requires the Exchange to study and make recommendations regarding "multi-state or regional contracting." No additional detail is provided in the legislation. However, since MD is one of the jurisdictions that shares a border with the District and is further along in its Exchange planning, it may be beneficial to begin discussions regarding some level of integration.

MD is also a recipient of an Early Innovator grant. Below is a summary of MD's proposal.[42]

> *MD proposes to build off a prototype it has already developed that models the point of access for the Exchange, integration with MD legacy systems and the federal portal systems, and MD's consumption of planned federal web services (e.g. verification and rules). The technology foundation used by MD in its Healthy Maryland initiative is currently being used by several other states. This "point" solution will extend the existing Healthy Maryland platform, which was recently implemented.*

Washington State

WA's legislation calls for creation of a single State-administered Exchange for both the individual and small employer markets. However, the authority is required to develop a report, including analysis and recommendations on "Whether and under what circumstances the State should consider establishment of, or participation in, a regionally administered multi-state Exchange." As previously noted, the State may enter into information sharing agreements with other state Exchanges.

---

[40] http://nescies.org/index.htm.

[41] http://www.hhs.gov/news/press/2011pres/02/20110216a.html.

[42] http://www.healthcare.gov/news/factsheets/exchanges02162011a.html.

West Virginia

WV's law specifically permits the Exchange to enter into memoranda of understanding with other governmental agencies "including agreements with other states to perform joint administrative functions." Information-sharing agreements are also permitted, provided confidential information is protected.

Other States

In this section we discuss relevant actions taken by other states, or information available from other research efforts.

Governance

Appendix E shows how each state has established or proposed to establish its Exchange in legislation. However, since most states have not passed the legislation cited, the data shown is preliminary and subject to change. In addition, the wording in the legislation is not always clear as to which type of governing structure the Exchange will use. In these cases, we used our best judgment to assign a structure. Based on our judgment, we estimate that roughly one quarter of states that have proposed or enacted legislation to create an Exchange are using the non-profit structure, while the remaining three quarters use one of the governmental forms.

Other State Exchanges

In this sub-section we discuss experience from Exchanges already operating in other states. While these Exchanges will need to be modified to comply with the provisions of the ACA, they may provide some useful insight.

Structure of the Exchange

In MA, the Connector is required to "be an independent public entity not subject to the supervision and control of any other executive office, department, commission, board, bureau, agency or political subdivision" of the State.[43] There is a Board that governs the Connector, and consists of 10 members representing various interests.[44] The Connector has a staff of roughly 50 people.[45]

---

[43] http://www.mass.gov/legis/laws/mgl/176q-2.htm.

[44] The 10 member board consists of the secretary for administration and finance, ex officio, who shall serve as chairperson; the director of Medicaid, ex officio; the commissioner of insurance, ex officio; the executive director of the group insurance commission; three members appointed by the governor, one of whom shall be a member in good standing of the American Academy of Actuaries, one of whom shall be a health economist, and one of whom shall represent the interests of small businesses; and three members appointed by the attorney general, one of whom shall be an employee health benefits plan specialist, one of whom shall be a representative of a health consumer organization, and one of whom shall be a representative of organized labor.

[45] http://www.maxenroll.org/files/maxenroll/file/Connector%20presentation_3-10-2011.pdf.

UT has an Exchange that was established to provide a defined contribution coverage model to businesses, whereby the employer sets a fixed contribution toward coverage and its employees may choose among several plan options with the cost to the employee varying depending on the coverage selected.[46, 47] The Exchange was initially rolled out to small employers, those with two to 50 employees. Large employers were to be able to participate in 2011; however, legislation passed in 2011 eliminated the large group market from the Exchange.[48] UT's Exchange is a State-run entity. It has a small number of employees and the operational work is contracted to private vendors. The Exchange is governed by an Advisory Board, consisting of two producers, two consumers and two insurers participating in the Exchange, the Insurance Department and the Department of Health. In addition, there is a Board that governs the risk adjuster. Revenues for plans within the Exchange are risk adjusted so that insurers that receive a disproportionate share of less healthy individuals are not disadvantaged financially. The risk adjuster board is comprised primarily of the participating insurers, allowing the insurers to determine the most appropriate and equitable formula for the risk adjustment.

Financing of the Exchange

To fund the initial start up of the Connector, $25 million was appropriated by the State.[49] The Connector applies a surcharge to the HBPs it administers to pay for its expenses.[50] For the Commonwealth Choice program (unsubsidized coverage), the surcharge was 4.5% of premium, until FY 2011 when the surcharge was reduced to 3.5% of premium.[51] Plans sold outside of the Connector are not subject to this surcharge. Carriers that sell in the Connector must charge the same premium to similarly situated individuals who purchase coverage outside the Connector for the same benefit plan.

The Commonwealth Care (subsidized coverage) surcharge percentage has also decreased over time and is at 3.2% for FY 2011. In FY 2012, it is estimated that the Connector will collect over $33 million in revenue, with about 77% of it from the Commonwealth Care program.[52] Slightly over $1 million is anticipated to come from federal grant funding. In FY 2011, it is estimated that

---

[46] http://s3.amazonaws.com/thf_media/2009/pdf/wm2569.pdf.

[47] http://s3.amazonaws.com/thf_media/2010/pdf/bg_2399.pdf.

[48] http://le.utah.gov/~2011/bills/hbillenr/hb0128.pdf.

[49] http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2009/May/Issue %20Brief.pdf.

[50] http://www.mass.gov/legis/laws/mgl/176q-12.htm.

[51] https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2010/2010-06-10/FY10%2520FY11%2520Budget%2520BOD%2520Mtg%25206_10_10%2520FINAL.ppt.

[52] https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/About%2520Us/Publications%2520and%2520Reports/2011/2011-6-9/4%2520-%2520FY11%2520FY12%2520Admin%2520Budget%2520BOD%25202011_06_09%2520v1%25209.pdf.

about 80% of the final revenue will have come from the Commonwealth Care subsidized insurance program. Commonwealth Care plans are only available through the Connector.

UT's Exchange, on the other hand, has a budget of only $600,000.[53] We expect that UT is currently able to operate on a much lower budget than MA for several reasons: it is not currently administering government subsidies; it is targeting small groups, which are typically less expensive to market to than individuals; and perhaps producer commissions are not paid through the Exchange or included in the budget.

Coordination with Other State Agencies

In 2006, when MA' reforms were implemented, the Exchange used existing Medicaid systems and program standards as the foundation for the Commonwealth Care subsidized insurance program.[54] The Medicaid program in MA performs the following functions on behalf of the exchange for the subsidy-eligible population:[55]

- Application processing
- Eligibility determination and verification
- Appeal adjudication
- Analytics and reporting
- Customer service
- Provider interface

Two of the lessons learned in MA, according to the Blue Cross Blue Shield of MA Foundation are:[56]

- Strong, centralized coordination among government agencies helps to overcome the fragmentation often inherent in the health care system and in government functions
- Close coordination between Medicaid and new public insurance programs is needed to maximize enrollment and retention, while also reducing redundancy and administrative costs

The Secretary of the MA Health and Human Services Agency held weekly meetings where members across State government shared information. A Health Care Reform Outreach and Education Unit was created within the Office of Medicaid to coordinate the State's reform activities. Joint training sessions were held by the Medicaid Agency and the Exchange for outreach and enrollment workers.

---

[53] http://www.governing.com/topics/health-human-services/closer-look-utah-health-insurance-exchange.html.

[54] http://www.maxenroll.org/files/maxenroll/file/Connector%20presentation_3-10-2011.pdf.

[55] Ibid.

[56] http://bluecrossfoundation.org/~/media/Files/Publications/Policy%20Publications/Lessons%20from%20the%20Implementation%20of%20MA%20Health%20Reform.pdf.

Merging of Individual and Small Group Markets

MA' 2006 reforms merged the individual and small group markets effective July 1, 2007. Product choice, base rates and rating factors are identical. Premiums may vary by group size, but the highest group size factor may not exceed the lowest factor by more than 15.8%. Individuals are currently subject to the "group size" factor.

It is important to note that prior to the merger MA' individual market was a guaranteed issue without medical underwriting. Premiums in the individual market were significantly higher than small group premiums for similar benefits and member age as a result. Because of the nature and relative size of the markets prior to the reforms, individual premiums post-merger were significantly less than pre-merger premium levels, all else equal. Small group premiums would have had to increase by about 2% to 3% to achieve the same loss ratio as that of the small group market alone.[57]

In jurisdictions that currently permit carriers to deny coverage to individuals that do not pass medical underwriting or vary rates based on health status in the individual market, the results of merging the individual and small group markets could be significantly different than the results in MA. It could even have the opposite effect, with premiums for individuals increasing significantly.

Other Lessons Learned

Patty Conner, the director of the UT Exchange was asked what has been learned by rolling out the Exchange. She said "First, being able to get all of the stakeholders to buy in on what the Exchange is trying to accomplish and aligning that with their values has been beneficial for everybody. For example, the brokers are really critical to the success of the UT Health Exchange. Second, [you need to make] sure you have a rating methodology that provides parity with the traditional market for a level playing field. Finally, it's important to beta-test your Exchange before opening it up to a large-scale enrollment."[58]

This lesson was also expressed in MA. The Blue Cross Blue Shield Foundation found that "Ongoing stakeholder engagement in health reform facilitates implementation and helps overcome inevitable obstacles."[59] Examples of stakeholders that helped in implementing MA' health care reform are:

- Community coalitions
- Faith-based coalitions

---

[57] http://www.mass.gov/Eeohhs2/docs/dhcfp/r/cost_trends_files/part2_premium_levels_and_trends.pdf.

[58] http://www.governing.com/topics/health-human-services/closer-look-utah-health-insurance-exchange.html.

[59] http://bluecrossfoundation.org/Health-Reform/~/media/Files/Health%20Reform/Lessons%20for%20National%20Reform%20from%20the%20Massachusetts%20Experience%20Lessons%20Learned.pdf.

- Business groups
- Health plans
- Provider associations

Summary Comparison of State Exchange Progress

Appendix F contains a summary table that compares the progress made to date by each of the states discussed in this chapter.

APPENDIX A

Estimate of Undocumented Medicaid Lapse Rate

The DHCF informed us that enrollees are identified in the Eligibility Span Document, which is summarized in the table below.

Enrollment Spans from DCHF (Fixed)

Date	First	Span	Last
Oct 2009	11,843	196,436	11,280
Nov 2009	10,669	198,271	10,828
Dec 2009	10,483	198,520	11,354
Jan 2010	10,873	199,374	10,382
Feb 2010	9,492	200,082	10,877
Mar 2010	11,260	198,155	12,291
Apr 2010	12,154	199,532	10,890
May 2010	11,218	201,558	10,913
Jun 2010	9,549	171,701	43,544
Jul 2010	42,660	171,251	12,998
Aug 2010	13,222	202,065	12,834
Sep 2010*	12,975**	204,216	11,994
Oct 2010	11,853	205,479	12,749
Nov 2010	12,429	202,991	15,513
Dec 2010	15,185	203,333	13,242
Jan 2011	12,718	207,957	11,595
Feb 2011	11,779	209,447	11,977

Calculated with Theoretical Lapse (Renewed)

Lapse Rate	Persistence	Revised First
0.02	0.78	9,293
0.02	0.80	8,543
0.02	0.82	8,565
0.02	0.83	9,065
0.02	0.85	8,075
0.02	0.87	9,775
0.02	0.89	10,767
0.02	0.90	10,140
0.02	0.92	8,808
0.02	0.94	40,151
0.02	0.96	12,698
0.02	0.98	12,716
	Total Renewed	148,597
	Total Fixed***	62,787
	Total	**211,384**
	Total Span	229,185
	Difference	**17,801**

** Total Sep 2010 spans = 229,185*
*** Cap of new enrollees from Oct 2009-Sep 2010 = 166,398*
**** Total Fixed Enrollees is calculated by subtracting Cap of new enrollees from Total Sep 2010 spans.*

The DHCF also informed us that enrollees are not removed from the report unless they have acquired coverage from a private source and attempt to have services paid for the public coverage. The managed care plans participating in Medicaid and the Alliance program would identify the enrollees and reclassify them as not covered. Otherwise, an enrollee could obtain coverage from a private source and they would not come off the enrollment report until 12 months after their initial enrollment.

The DHCF also informed us that most enrollees are treated as new enrollees when they re-enroll. The table also shows our estimate that there are approximately 62,000 enrollees that did not re-enroll as a new enrollee. If we assume that enrollees have undocumented lapses at approximately 2% per month (or about 22% per year), we find that the total eligibility estimates drops from 229,000 to 211,000. This is a difference of about 18,000 enrollees. If the DHCF spans show that enrollment in January 2010 was 220,000, it is reasonable to assume (if the lapse assumptions are appropriate) that the actual enrollment could have been closer to 202,000.

APPENDIX B

Estimate of Individuals Covered by Public Coverage in the District

In the following table, we identify the public coverage enrollment implied by the DHCF's Medicaid and Alliance program enrollment report. The table shows the raw estimate of enrollment in different insurance modes under ACS. It shows the estimates of enrollment after we have revised the status of many direct purchase enrollees. We implemented this revision to more closely match the direct purchase enrollment identified by the District's insurance carriers.

	ACS Data					
	Without Medicaid Edits		**With Medicaid Edits**		**Urban Institute**	**DHCF/CMS**
	Persons	**Dist**	**Persons**	**Dist**		
Employer (Active)	298	49.7%	295	49.2%		
Employer (Retired)	27	4.5%	27	4.5%		
Military (Active)	8	1.3%	8	1.3%		
Military (Retired)	2	0.3%	2	0.3%		
Direct Purchase	41	6.8%	22	3.7%		
Medicare	21	3.5%	21	3.5%		57
Medicaid	134	22.3%	156	26.0%		200
Dual	27	4.5%	27	4.5%		20
No Coverage	42	7.0%	42	7.0%		
Total	600	100.0%	600	100.0%		600
ESI	306		303			
Percent of Total	51%		51%		55%	
Public Coverage	211		233			
Percent of Total	35%		39%		33%	46%
Uninsured	42		42			
Percent of Total	7%		7%		6%	

Finally, the table shows that the District's reports, when coupled with CMS's Medicare enrollment estimates, produce public coverage estimates of about 46% of the population. The District identifies 220,000 enrollees in Medicaid and the Alliance program; it identifies 20,000 dual eligible enrollees (for 200,000 non-duals). If we assume that CMS's 77,000 Medicare enrollees are reflected in the 20,000 duals, we have 57,000 enrollees in Medicare that are not in the DHCF's report. This brings the total individuals with public coverage to approximately 277,000, which is about 46% of the population.

APPENDIX C

Hierarchy for Assigning ACS Respondents to a Payer Mode

The following table shows the hierarchy that we used to classify enrollees in the ACS data.

District of Columbia — ACS Category map

Employer	Direct Purchase	Medicare	Medicaid	Tricare	VA	Indian Health	Category
1	1	1	1	1	1	2	DUAL
1	1	1	1	1	2	2	DUAL
1	1	1	1	2	1	2	DUAL
1	1	1	1	2	2	1	DUAL
1	1	1	1	2	2	2	DUAL
1	1	1	2	1	2	2	MIL_R
1	1	1	2	2	1	2	ESI_R
1	1	1	2	2	2	2	ESI_R
1	1	2	1	1	1	2	MCA ID
1	1	2	1	1	2	2	MCA ID
1	1	2	1	2	2	2	MCA ID
1	1	2	2	1	1	2	MIL_A
1	1	2	2	1	2	2	MIL_A
1	1	2	2	2	1	2	ESI_A
1	1	2	2	2	2	1	ESI_A
1	1	2	2	2	2	2	ESI_A
1	2	1	1	1	2	2	DUAL
1	2	1	1	2	1	2	DUAL
1	2	1	1	2	2	2	DUAL
1	2	1	2	1	1	2	MIL_R
1	2	1	2	1	2	1	MIL_R
1	2	1	2	1	2	2	MIL_R
1	2	1	2	2	1	2	ESI_R
1	2	1	2	2	2	2	ESI_R
1	2	2	1	1	2	2	MCA ID

Employer	Direct Purchase	Medicare	Medicaid	Tricare	VA	Indian Health	Category
1	2	2	1	2	1	2	MCA ID
1	2	2	1	2	2	2	MCA ID
1	2	2	2	1	1	1	MIL_A
1	2	2	2	1	1	2	MIL_A
1	2	2	2	1	2	2	MIL_A
1	2	2	2	2	1	2	ESI_A
1	2	2	2	2	2	1	ESI_A
1	2	2	2	2	2	2	ESI_A
2	1	1	1	2	1	2	DUAL
2	1	1	1	2	2	2	DUAL
2	1	1	2	1	1	2	MIL_R
2	1	1	2	2	1	2	MCARE
2	1	1	2	2	2	1	MCARE
2	1	1	2	2	2	2	MCARE
2	1	2	1	2	2	2	MCA ID
2	1	2	2	2	1	2	MIL_A
2	1	2	2	2	2	2	DP
2	2	1	1	1	1	2	DUAL
2	2	1	1	1	2	2	DUAL
2	2	1	1	2	1	2	DUAL
2	2	1	1	2	2	2	DUAL
2	2	1	2	1	1	2	MIL_R
2	2	1	2	1	2	2	MIL_R
2	2	1	2	2	1	2	MCARE
2	2	1	2	2	2	2	MCARE
2	2	2	1	1	2	2	MCA ID
2	2	2	1	2	1	2	MCA ID
2	2	2	1	2	2	2	MCA ID
2	2	2	2	1	1	2	MIL_A
2	2	2	2	1	2	2	MIL_A
2	2	2	2	2	1	2	MIL_A
2	2	2	2	2	2	2	NOCOV

APPENDIX D

Early Innovators — Board Make-up

	California	Colorado	Maryland	West Virginia	Washington
1	Governor appointee	Governor appointee	Secretary of Health and Mental Hygiene	Commissioner of Insurance (ex officio*)	Governor appointee and employee benefits specialist
2	Governor appointee	Governor appointee	Commissioner of Insurance	Commissioner of the WV Bureau for Medical Service (ex officio*)	Governor appointee and health economist or actuary
3	Senate Committee on Rules appointee	Governor appointee	Executive Director of the MD Health Care Commission	Director of the WV Children's Health Insurance Program (ex officio*)	Governor appointee, representing small business
4	Speaker of the Assembly appointee	Governor appointee	Governor appointee, representing consumers	Chair of the WV Health Care Authority (ex officio*)	Governor appointee, representing health consumer advocates
5	Speaker of the CA Health and Human Services or designee (ex officio*)	Governor appointee	Governor appointee, representing consumers	Governor appointee, representing individual consumers	Governor appointee**
6		President of the Senate appointee	Governor appointee, representing consumers	Governor appointee, representing small employers	Governor appointee**
7		Minority Leader of the Senate appointee	Member with knowledge of at least two of the various public or private health coverage areas	Governor appointee, representing organized labor	Governor appointee**
8		Speaker of the House of Representatives appointee	Member with knowledge of at least two of the various public or private health coverage areas	Governor appointee, representing insurance providers	Governor appointee**
9		Minority Leader of the House or Representatives appointee	Member with knowledge of at least two of the various public or private health coverage areas	Representative of the interests of payors (selected by majority vote of an advisory group)	Governor appointed chair (non-voting, except in the case of a tie)

	California	Colorado	Maryland	West Virginia	Washington
10		Executive Director of the Department of Health Care Policy and Financing (ex officio* and non-voting)		Representative of the interests of payors (selected by majority vote of an advisory group)	Insurance commissioner (ex officio* and non-voting)
11		Commissioner of Insurance (ex officio* and non-voting)			Administrator of the health care authority (ex officio* and non-voting)
12		Director of the Office of Economic Development and International Trade (ex officio* and non-voting)			

** Ex officio members may designate a representative to serve in his or her place*

*** Must have a demonstrated and acknowledged expertise in individual health care coverage, small employer health care coverage, HBP administration, health care finance and economics, actuarial science, or administering a public or private health care delivery system*

APPENDIX E

Exchange Legislation — Governance

State	Non-Profit	State	Quasi-State	Reference
Alabama	x			http://e-lobbyist.com/gaits/text/243204/243204.pdf
Alaska			x	http://www.legis.state.ak.us/basis/get_bill_text.asp?hsid=SB0070A&session=27
Arizona		x		http://www.azleg.gov/legtext/50leg/1r/bills/hb2666p.pdf
Arkansas	x			http://www.arkleg.state.ar.us/assembly/2011/2011R/Bills/HB2138.pdf
California			x	http://www.healthexchange.ca.gov/Documents/SB%20900,%20Elaine%20Alquist.%20California%20Health%20Benefit%20Exchange.pdf
Colorado	x			http://www.leg.state.co.us/clics/clics2011a/csl.nsf/fsbillcont/7233327000DC9A078725780100604CC4?Open&file=200_enr.pdf
Connecticut		x		http://www.cga.ct.gov/2011/TOB/S/2011SB-01204-R00-SB.htm
Delaware				
Florida				
Georgia		x		http://www.legis.ga.gov/Legislation/20112012/112689.pdf
Hawaii	x			http://www.capitol.hawaii.gov/session2011/bills/SB1348_CD1_.pdf
Idaho				
Illinois				
Indiana				
Iowa				
Kansas				
Kentucky				
Louisiana				
Maine				
Maryland		x		http://mlis.state.md.us/2011rs/chapters_noln/Ch_2_hb0166T.pdf
Massachusetts			x	http://www.malegislature.gov/Laws/SessionLaws/Acts/2006/Chapter58
Michigan				

State	Non-Profit	State	Quasi-State	Reference
Minnesota	x			http://wdoc.house.leg.state.mn.us/leg/LS87/HF0497.0.pdf
Mississippi		x		http://billstatus.ls.state.ms.us/documents/2011/pdf/HB/1200-1299/HB1220PS.pdf
Missouri			x	http://house.mo.gov/billtracking/bills111/biltxt/intro/HB0609I.htm
Montana			x	http://data.opi.mt.gov/bills/2011/billpdf/HB0124.pdf
Nebraska				
Nevada			x	http://www.leg.state.nv.us/Session/76th2011/Bills/SB/SB440.pdf
New Hampshire		x		http://e-lobbyist.com/gaits/text/147064
New Jersey			x	http://www.njleg.state.nj.us/2010/Bills/A4000/3561_I1.PDF
New Mexico	x			http://www.nmlegis.gov/Sessions/11%20Regular/bills/senate/SB0038.pdf
New York				
North Carolina	x			http://www.ncga.state.nc.us/Sessions/2011/Bills/House/PDF/H115v1.pdf
North Dakota				
Ohio				
Oklahoma			x	http://webserver1.lsb.state.ok.us/cf/2011-12%20INT/hB/HB2130%20INT.DOC
Oregon			x	http://www.leg.state.or.us/11reg/measpdf/sb0001.dir/sb0099.intro.pdf
Pennsylvania			x	http://www.legis.state.pa.us/cfdocs/legis/PN/Public/btCheck.cfm?txtType=HTM&sessYr=2011&sessInd=0&billBody=H&billTyp=B&billNbr=0627&pn=0628
Rhode Island			x	http://www.rilin.state.ri.us/BillText/BillText11/SenateText11/S0087.htm
South Carolina		x		http://www.scstatehouse.gov/sess119_2011-2012/bills/3738.htm
South Dakota				
Tennessee				
Texas			x	http://www.capitol.state.tx.us/tlodocs/82R/billtext/pdf/HB00636I.pdf#navpanes=0
Utah		x		http://www.exchange.utah.gov/about-the-exchange/overview

State	Non-Profit	State	Quasi-State	Reference
Vermont		x		http://www.leg.state.vt.us/docs/2012/Acts/ACT048.pdf
Virginia				
Washington			x	http://apps.leg.wa.gov/documents/billdocs/2011-12/Pdf/Bills/Senate%20Passed%20Legislature/5445-S.PL.pdf
West Virginia		x		http://www.legis.state.wv.us/bill_status/bills_text.cfm?billdoc=sb408%20intr.htm&yr=2011&sesstype=RS&i=408
Wisconsin				
Wyoming				
Count	**7**	**10**	**13**	

The wording in the legislation is not always clear as to which type of governing structure the Exchange will use. In these cases we used our best judgment to assign a structure

APPENDIX F

Comparison of States' Exchange Progress

	California	Colorado	Maryland	Washington State	West Virginia	Massachusetts	Utah
Governance	SB 900 established CA's Exchange as “an independent public entity not affiliated with an agency or department." Governed by a five member Board, made up of residents of CA.	The Exchange is created as a "non-profit unincorporated public entity" and as "an instrumentality of the State." Neither the Board nor the Exchange is an agency of the State. The Governing Board is comprised of 12 members, of which nine have voting rights. The Board shall create technical and advisory groups as needed, and the legislation establishes the legislative health benefit Exchange implementation review committee.	The Exchange is an independent public entity, but shall conduct a study and report on whether the Exchange should remain independent or become a non-governmental, non-profit entity. The Exchange is “a public entity, independent of other units of State government, which shall be subject to certain State laws and regulations to ensure transparency, accountability, and coordination with State agencies and programs, but which shall be exempt from other State administrative laws and regulations. The Exchange is governed by a nine member Board that must reflect a diversity of expertise; reflect the gender, racial, and ethnic diversity of the State; and represent the geographic areas of the State.”	The WA Exchange is established as “a public-private partnership separate and distinct from the State.” The Exchange is governed by a nine member Board, including a chair who is non-voting, except in the case of a tie. There are also two non-voting, ex officio members. The Board is to “establish an advisory committee to allow for the views of the health care industry and other stakeholders to be heard in the operation of the health benefit Exchange.” The Board may establish technical advisory committees or seek the advice of technical experts.	WV’s Exchange is established within the Offices of the Insurance Commissioner, which is a governmental entity of the State. The Exchange is governed by a 10 person Board.	The Connector is an independent public entity that is not subject to control or supervision of any other executive office, department, commission, board, bureau, agency, or political subdivision. The Board governing the Connector consists of 10 members representing various interests.	The Exchange is a State-run entity with operational work contracted to private vendors. The Board governing the Connector consists of two producers, two consumers and two insurers participating in the Exchange, the Insurance Department, and the Department of Health. A separate Board, comprised primarily of the participating insurers, governs the risk adjustor process.

	California	Colorado	Maryland	Washington State	West Virginia	Massachusetts	Utah
Conflict of Interest	A member of the Board or of the Staff of the Exchange shall not be: • Employed by, a consultant to, a member of the board of directors of, affiliated with, a carrier or other insurer, an agent or broker, health care provider or a health care facility or health clinic. • A member, a board member, or an employee of a trade association of carriers, health facilities, health clinics, or health care providers • A health care provider, unless he or she receives no compensation for rendering services as a health care provider and does not have an ownership interest in a professional health care practice.	Members of the Board shall not perform any official acts that may have a direct economic benefit on a business or other undertaking in which the member has a direct or substantial financial interest.	A member of the Board or of the Staff of the Exchange may not have an affiliation with a carrier, trade association of carriers, insurance producer, third-party administrator, managed care organization, or any other party contracting directly with the Exchange.	No Board member may be appointed if his or her participation in the decisions of the board could benefit his or her own financial interests or the financial interests of an entity he or she represents.			

	California	Colorado	Maryland	Washington State	West Virginia	Massachusetts	Utah
Procurement and Personnel Practices	The Executive Director shall be exempt from civil service and shall serve at the pleasure of the Board. These positions shall not be subject to otherwise applicable provisions of the Government Code or the Public Contract. Salaries should be set in amounts that are reasonably necessary to attract and retain individuals of superior qualifications. The Board is directed to establish a competitive process to select carriers and other contractors.		The Executive Director determines the classification, grade and compensation of staff in accordance with the State pay plan. The Executive Director sets compensation of attorneys, financial consultants and any other professionals or consultants necessary to carry out the planning, development, and operation of the Exchange. An employee or independent contractor of the Exchange is not subject to any law, regulation or executive order governing State compensation including furlough, pay cuts or any other General Fund cost savings measure.	The Exchange and the Board are subject only to the Open Public Meetings Act and the Public Records Act, and not to any other law or regulation generally applicable to state agencies. Consistent with the Open Public Meetings Act, the Board may hold executive sessions to consider proprietary or confidential non-published information.	"The Executive Director and all employees of the Board are exempt from the classified service and not subject to the procedures and protections provided by Article two, Chapter six-c of this Code and Article six, Chapter twenty-nine of the Code.		

	California	Colorado	Maryland	Washington State	West Virginia	Massachusetts	Utah
Financing	CA Health Facilities Authority may: • Charge and equitably apportion among participating health institutions the administrative costs and expenses incurred by the authority. • Provide a working capital loan of up to $5 million to assist in the establishment and operation of the Exchange that must be repaid by June 30, 2016. The Board shall: • Assess a charge on QHPs that is reasonable and necessary to support the development, operations and cash management of the Exchange. • Maintain enrollment and expenditures to ensure that expenditures do not exceed the amount of revenue in the fund and institute measures to ensure financial solvency.	The financing mechanism that will be used to support the Exchange is not established in law. Money from the General Fund shall not be used for the implementation of the Exchange, except for amounts for committee members for attendance at certain meetings and for legislative staff agency services.	MD law establishes the MD Health Benefit Exchange Fund ,which may impose user fees, licensing or other regulatory fees or other assessments, provided the do not exceed the reasonable projections of the amount needed to support the operations of the Exchange. Funds may not be used for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory actions. Fees may not provide a competitive disadvantage to HBPs operating outside the Exchange.	By January 1, 2012, the WA State Health Care Authority is to produce a report containing analysis and recommendations on the development of sustainable funding for administration of the Exchange, as well as the staff, resources and revenues necessary to operate and administer an Exchange for the first two years of operation.	The Board is authorized to assess fees on health carriers selling qualified dental plans or HBPs in the State, including HBPs sold outside the Exchange. Fees shall be based on premium volume of the qualified dental plans or HBPs sold in the State and shall be for the purpose of operation of the Exchange. The Exchange may not “use any funds intended for the administrative and operational expenses of the Exchange for staff retreats, promotional giveaways, excessive executive compensation or promotion of federal or State legislative and regulatory modifications.” Monies in the WV Health Benefits Exchange Fund do not revert to the General Fund.	To fund the initial start-up of the Connector, $25 million was appropriated by the State. The Connector applies a surcharge to the HBPs it administers to pay for its expenses. The Commonwealth Choice program (unsubsidized coverage), charges a surcharge of 3.5% of premium. Plans sold outside of the Connector are not subject to this surcharge. The Commonwealth Care (subsidized coverage) surcharge percentage has decreased over time and is at 3.2% for FY 2011.	UT’s Exchange has a budget of only $600,000. UT is currently able to operate on a low budget for several reasons: it is not currently administering government subsidies; it is targeting small groups, which are typically less expensive to market to than individuals; and perhaps producer commissions are not paid through the Exchange or included in the budget.

	California	Colorado	Maryland	Washington State	West Virginia	Massachusetts	Utah
Integration with Medicaid	The Board is required to: • Inform individuals of eligibility requirements of the Medi-Cal program, the Healthy Families Program, or any other applicable public program and enroll eligible individuals in such programs. • Coordinate with the eligibility administrators for the Medi-Cal and Health Families programs to develop processes for case transfer, referral, and enrollment in the Exchange. • Coordinate with the Dept. of Health Care Services and the Managed Risk Medical Insurance Board to allow an individual the option to remain enrolled with his/her carrier and provider network in the event the individual loses eligibility for premium tax credits and becomes eligible for	CO's legislation does not explicitly address Medicaid; however, it allows the Board to "enter into information-sharing agreements with federal and State agencies and other state Exchanges to carry out its responsibilities."	The Board is permitted to "contract or enter into memoranda of understanding with eligible entities, including the MD Medical Assistance Program." The Exchange is required to make determinations regarding eligibility for State and local public health insurance programs, and to "facilitate the enrollment of any individual who the Exchange determines is eligible for" another public health insurance program.	The WA State Health Care Authority must: • Analyze and make recommendations, including whether to adopt and implement a federal basic health plan option including "coordination of the Exchange with other state programs" and "whether the federal BHP option should merge risk pools for rating with any portion of the state's Medicaid program." • Enter into information sharing agreements with federal and State agencies and other state Exchanges, as well as interdepartmental agreements with the Office of the Insurance Commissioner, the Department of Social and Health Services, the Department of Health, and other State agencies.	WV's legislation allows the Exchange to "enter into memoranda of understanding with other governmental agencies" presumably to allow for integration with other public health insurance programs. Information-sharing agreements are permitted, provided confidential information is protected.		

	California	Colorado	Maryland	Washington State	West Virginia	Massachusetts	Utah
	the Medi-Cal or Health Families program, or loses eligibility for Medi-Cal or Healthy Families program and becomes eligible for premium tax credits through the Exchange.						
Merging of Individual and Small Group Markets	The SHOP Exchange is separate from the activities of the individual market. However, the Board of the Exchange is required to report to the Legislature by December 1, 2018, on whether to merge the individual and small employer markets.	The board of the Exchange is to "consider the desirability of structuring the Exchange as one entity that includes two underlying entities to operate in the individual and the small employer market."	MD law requires the establishment of a SHOP Exchange. The law requires the Exchange to study whether the current individual and small group markets should be merged.	The authority is required to develop a report, including analysis and recommendations on "Individual and small group market impacts, including whether to merge the risk pools for rating the individual and small group markets in the Exchange and the private health insurance markets."		MA' 2006 reforms merged the individual and small group markets. Product choice, base rates and rating factors are identical in the individual and small group markets. Premiums may vary by group size, but the highest group size factor may not exceed the lowest factor by more than 15.8%. Individuals are currently subject to the "group size" factor.	

	California	Colorado	Maryland	Washington State	West Virginia	Massachusetts	Utah
Geographic Considerations	The law does not address multi-state or regional contracting.	The Board may enter into information-sharing agreements with other state Exchanges. No further information is contained in the law related to partnering with other states or considering a multi-state Exchange.	The Exchange must study and make recommendations regarding multi-state or regional contracting. MD is a recipient of an Early Innovator grant. MD proposes to build off a prototype it has already developed that models the point of access for the Exchange, integration with MD legacy systems and the federal portal systems, and MD's consumption of planned federal web services (e.g., verification and rules).	WA's legislation calls for creation of a single State-administered Exchange for both the individual and small employer markets. However, the authority is required to develop a report, including analysis and recommendations on "Whether and under what circumstances the state should consider establishment of, or participation in, a regionally administered multi-state Exchange."	WV's law specifically permits the Exchange to enter into memoranda of understanding with other governmental agencies "including agreements with other states to perform joint administrative functions." Information sharing agreements are also permitted, provided confidential information is protected.		

Government Human Services Consulting
Mercer Health & Benefits LLC
333 South 7th Street, Suite 1600
Minneapolis, MN 55402-2427
+1 612 642 8600