District of Columbia Mayor's Health Reform Implementation Committee
Insurance Subcommittee

Report and Recommendations on the Health Insurance Market Structure of the District of Columbia

April 12, 2012

Report Summary

The following report presents the formal recommendations of the Mayor's Health Reform Implementation Committee's (HRIC) Insurance Subcommittee on the health insurance market structure of the District of Columbia upon full implementation of the Affordable Care Act (ACA) and launch of the District of Columbia Health Benefits Exchange (DC HBX) insurance marketplace.

These recommendations are based on a number of sources, including the work completed by Mercer under the federal Exchange Planning grant awarded to the District, the work of other states implementing ACA including Maryland, Oregon, Washington, and Massachusetts among others, and the input and feedback of District stakeholders.

The primary sources used to support the recommendations in this report are within the appendix, including stakeholder feedback.

Above all else, the Department of Insurance, Securities, and Banking (DISB) as well as all other HRIC member agencies approach ACA and DC HBX policy questions guided by the following principles;

1. Affordability for consumers and reasonable administrative costs for administering the DC HBX Authority (Authority),
2. Transparency,
3. Administrative efficiency,
4. Consistent regulations and non-duplicative administrative functions, and
5. Ease of enrollment and access for District residents and employers seeking health insurance.

The Insurance Subcommittee acknowledges the difficulty in reaching unanimity in DC HBX insurance marketplace policy decisions. While there are some instances in which there is broad stakeholder consensus, there are many in which opinions span a wide spectrum. This report makes every effort possible to identify these areas of disagreement and urges policy makers, especially the Authority, to take these into consideration when promulgating any future policies.

The following report offers the following two recommendations on market structure and plan selection within the DC HBX insurance marketplace.

1. **Plans offered in the DC HBX insurance marketplace must meet minimum requirements set forth by the ACA for qualified health plans (QHPs) as well as any additional requirements set forth by the HRIC and/or the DC HBX Authority (Authority).**

2. **The DC HBX insurance marketplace should be the sole marketplace in the District of Columbia for the purchase of individual and small group health insurance plans ("Option 2").**

In addition to these broad market recommendations, this report also recommends the following;

3. **The risk pools of the small group market and individual markets in the DC HBX insurance marketplace should be merged into one single risk pool.**

4. **Small group size in the District of Columbia should be defined as 2-100 as opposed to the current practice of 2-50.**

5. **The District of Columbia should opt into the federally administered risk adjustment and reinsurance programs for the DC HBX insurance marketplace.**

Although these additional recommendations were not laid out in the original request for comment to stakeholders, many stakeholders responded with specifics in this area and the Insurance Subcommittee offered stakeholders an additional week of time to respond to these additional policy areas.

Ease of use is one of our guiding principles in building a successful DC HBX insurance marketplace and user portal. This is especially important when it comes to small business owners as we see the successes of the Small Business Health Options (SHOP) marketplace being key to long-term sustainability. All recommendations in this report are made with the assumption that insurance brokers will and must continue their work with employers in the small group market not only to ease the transition to the DC HBX insurance marketplace but to continue the ability to offer the value added services so many small business owners view as vital.

The specific role of brokers in the DC HBX insurance marketplace is being studied by DHCF contractor The Crider Group as part of their larger analysis of the ACA-mandated Navigator program. As with all areas of ACA implementation, innovation is necessary and we are looking for ways in which brokers could serve a role for the DC HBX insurance marketplace similar to the role they currently serve for their clients. This includes potential contracting between licensed brokers and the Authority to carry out specific functions, especially in the small group market.

The Insurance Subcommittee and the greater HRIC will continue its engagement with brokers as our policies are finalized. This will include focus groups and working group meetings over the next weeks and months.

All recommendations in this report are subject to approval by the HRIC Executive Board.

Recommendation #1- Plans offered in the DC HBX insurance marketplace must meet the minimum requirements set forth by the Affordable Care Act (ACA) for qualified health plans (QHPs) as well as any additional requirements set forth by the HRIC and/or the DC HBX Authority (Authority).

This recommendation addresses the issue of whether or not the Authority should engage in selective contracting with insurance carriers for plans to be offered in the DC HBX insurance marketplace ("active"), or operate the DC HBX insurance marketplace as open clearinghouse for any and all plans that meet at least the minimum QHP requirements of ACA ("passive").

Some states and consumer advocates argue that an active purchaser model allows Exchanges to better control the quality and cost of offered plans. This approach is similar to the Massachusetts Connector model and is endorsed by other ACA implementers such as California and Oregon. However, the District must address some unique factors in establishing an Exchange that these other states do not, including[1];

- Relatively small number of uninsured residents (approximately 42,000 or 7%)
- Small population (approximately 610,000)
- Daily transience of population (large number of workers who live in Maryland or Virginia who work in the District and vice versa)

These three examples suggest that achieving a large, diverse, and sustainable risk pool for the DC HBX insurance marketplace requires innovation and a distinctively District approach to implementation.

Implementing a more passive model that allows all plans meeting certain requirements to participate allows the Authority to control standards while still encouraging broader carrier participation than an entirely active purchaser model. At least initially, this policy decision will help the DC HBX insurance marketplace attract more carriers to offer products in the DC HBX insurance marketplace and minimize potential market disruptions in the early stages of operation.

The Exchange Authorizing law grants the Authority power to enter into selective contracting with carriers for plans to be offered in the DC HBX marketplace upon further study. The Insurance Subcommittee supports this legal requirement of the Authority and as such, recommends that upon launch, any plan meeting Federal and District QHP requirements (to be made available to carriers months prior to the opening of the DC HBX portal) is eligible to be offered in the DC HBX insurance marketplace.

In their Insurance Marketplace report, Exchange Establishment grant contractors Mercer highlight the benefits of a hybrid approach to plan availability in the DC HBX insurance marketplace, especially given the unique demographic composition of the District. These benefits are summarized below:

- A hybrid model allows broader participation in the Exchange market place initially, which will allow the Exchange Authority to identify the best standards once the new market structure is in place.

- Standards can be changed or added depending on employer and carrier actions, impacts of neighboring state Exchange decisions, and actions needed to balance network and quality

[1] See "District of Columbia Health Insurance Demographics" in Appendix for detail.

standards. The Exchange can use any early lessons learned to adjust standards or negotiate better options for the insurance marketplace.

- The potential size of the Individual Exchange and the SHOP Exchanges are much smaller than those in most other states. This issue of scale would impact financial sustainability parameters and therefore insurance standards.

- A hybrid model would provide opportunities for change in the future as needed and a degree of active purchasing that can be adjusted and phased in over time as necessary. The application of this model will give the Exchange opportunities to balance the needs of carriers and consumers, which will help establish a healthy insurance marketplace in the District.

The Insurance Subcommittee will continue to work on developing recommendations for District specific standards for QHPs, including consideration of:

- Requiring carriers to offer more medal levels than just gold and silver.

- Requiring carriers to participate in both the individual and small group markets.

- Requiring elements that lead to more standardization of plans such as limits on cost sharing features.

- Requiring carriers to allow premium payments to be made through the DC HBX Authority.

Stakeholder Comment

The Insurance Subcommittee acknowledges the tenuous support that stakeholders who largely identify as "consumer advocates" have for a passive plan selection process. We encourage the Authority and the HRIC to continue engaging with consumer advocates as policies are formalized for QHP requirements and the EHB.

These recommendations are not a rebuke of selective contracting. Instead, we simply recommend that the Authority, per the authorizing legislation, study market activity closely upon launch of the DC HBX insurance marketplace on January 1, 2014 and make a decision on selectively contracting based on the real world experience of the marketplace.

- The D.C. Coalition on Long-Term Care (DCLTC) "recommends initially a 'passive exchange' because the limited experience of exchanges to date has shown that it is difficult to attract insurers and consumers through this market"

- Kaiser Foundation Health Plans of the Mid-Atlantic States (Kaiser) supports a passive model that allows the sale of any plan as long as it meets District and Federal QHP standards, but notes that "the description of this model as being 'passive' may wrongly suggest (the Authority) would have little or nothing to do once it is established. On the contrary…we believe the DC HBX (or any Exchange) should have a clear set of rules for both its own market and the outside market, and make certain those rules are followed by all carriers. This is not a 'passive' role, but an active one in managing a new kind of health insurance market."

- AARP DC favors a more active exchange, but suggests that "active and passive are (not) two antipodes. We (see) a sliding scale between the passive clearing house and exclusive active models, and see the District enabling a structure somewhere within this zone…(but) we would encourage the Exchange to engage in a more active role…to ensure that the plans (carriers) offer meet Federal and District requirements in terms of QHP standards." They add that if the District proceeds with passive model, we should;

    - Put in place an effective cost sharing structure

    - Ensure a limited number of plans

    - Allow the Board to provide quality ratings of plans

    - Build out a timetable for evaluation, so that the passive structure can be revisited by the Executive Board at a point in the not too distant future

- Families USA acknowledges the challenges of initially entering into selective contracting with plans but encourages the District to set QHP requirements that go beyond the minimum federal requirements for and Exchange; "These requirements should assure that plans provide value; address the District population's prevalent health problems; standardize cost-sharing with particular attention to needs of low- and middle-income consumers (for instance, ensure that deductibles are not so high that they pose a barrier to care); and facilitate transitions for people leaving Medicaid.

- United Healthcare (United) believes that "exchanges should be set up in a manner that develops fair and efficient markets, creates a positive consumer experience, advances consumer choice and innovation, promotes consumer responsibility, and balances national standards with (District) flexibility." United endorses a more passive approach in that "all qualified health plans should be permitted to participate in the Exchange."

Recommendation #2- The DC HBX insurance marketplace should be the sole marketplace in the District for the purchase of individual and small group health insurance plans ("Option 2").

DISB presented stakeholders with three options for the overall health insurance market structure upon full implementation of ACA. These three options and a brief description of each follow;

1. Maintain current insurance market structure and implement only required QHP/ACA mandates,
    - Under this option, Essential Health Benefit (EHB) requirements would be extended to all plans inside and outside the DC HBX insurance marketplace, carriers would have to make plans available on at least the silver and gold precious metal levels inside of the DC HBX insurance marketplace, and no additional requirements would be placed on carriers in the District.
    - There are several provisions within ACA that are intended to mitigate adverse selection under this scenario, including the "3 R's" (risk adjustment, risk corridors, and reinsurance), the requirement that carriers offering QHPs make plans available on at least the gold and silver coverage levels, and market-wide implementation of the eventual District EHB package

2. Consolidate all individual and small group insurance plans in to the DC HBX insurance marketplace,
    - A consolidated health insurance marketplace would grant the District the most robust tools in preventing adverse selection in the DC HBX insurance marketplace. Consolidating health insurance plans for the individual and small group markets would help to ensure that the DC HBX insurance marketplace achieves a sustainable and diverse risk pool which will lead to long-term viability.
    - The District faces a great challenge in guaranteeing the long-term viability of the DC HBX insurance marketplace. Consolidating small group and individual health insurance markets into the DC HBX insurance marketplace virtually assures a robust and diverse risk pool in addition to the critical mass needed to sustain the Authority financially. In addition, this option would also potentially allow carriers to shift more administrative costs to the Authority where economies of scale might produce overall administrative cost reductions.
    - The DC Healthcare Alliance (Alliance) would still be offered in addition to the DC HBX insurance marketplace and alternatives for addressing the population that would not be eligible for the DC HBX insurance marketplace or the Alliance are being considered, including asking for a waiver as Vermont has proposed or allowing buy-in to the Alliance.

3. Extend all QHP requirements to plans both inside and outside of the DC HBX insurance marketplace; require all carriers offering health insurance in the District to participate in the DC HBX insurance marketplace and offer "Bronze" level plans.
    - The outside market would remain open, but all carriers who want to continue to offer health insurance in the District must also offer QHPs in the DC HBX insurance marketplace while plans sold in the external market would be required to adhere to all DC HBX insurance marketplace QHP requirements. This policy would extend the concept of the "level playing field" further than the existing ACA provisions do. In

addition, this policy would help to protect against individuals with healthy risk being steered outside the DC HBX insurance marketplace by the availability of leaner "young invincible" plans and/or bronze level coverage.

- In addition to the ACA requirement for carriers to offer plans at least silver and gold plans in the DC HBX insurance marketplace, the District would require carriers to offer bronze plans on the HBX insurance marketplace as well. This would eliminate a major area of potential adverse selection in that carriers would have to offer leaner plans, more appealing to healthy individuals, in the HBX insurance marketplace instead of incentivizing those individuals to purchase coverage outside the HBX insurance marketplace. This increases the stability and overall rating of the risk pool by maintaining a potentially healthier risk pool.

As referenced throughout this paper, the District is faced with unique demographic challenges in implementing an Exchange. We have a relatively small population and a low level of uninsured residents. Of the approximately 42,000 uninsured District residents, 10,416 of them have incomes above 401% FPL[2] and nearly half of them are "Young Invincibles" (ages 18-34)[3]. One of the vital elements of establishing a sustainable and successful Exchange insurance marketplace is a sizable and diverse pool of participants. With such a small initial market of subsidy eligible uninsureds, it is vital for the DC HBX insurance marketplace to capture this low risk population for the sustainability of the risk pool. This guides our thinking when evaluating all options in determining rules and regulations for a post-ACA insurance market.

Option 2, consolidating the District health insurance market in the Exchange, ensures that the DC HBX has the best chance of success. This model supports the largest risk pool to mitigate adverse selection, ensures a consistent consumer experience for both individuals and employers, and provides more opportunity for revenue collection to sustain ongoing operations of the DC HBX. Although stakeholders were generally divided on this issue, all acknowledge the necessity of consistency between products offered inside and outside of the DC HBX insurance marketplace and/or making the consumer experience simpler. The consistency requirement, along with the need for a large pool of participants to spread the cost and avoid adverse selection and provide for a uniform consumer experience (for both individuals and businesses) argues for a single marketplace for the purchase of individual and small group health insurance plans.

The National Association of Insurance Commissioners (NAIC) notes in their Adverse Selection white paper the challenges that some states are more susceptible to than others in crafting the market structure and mitigating adverse selection;

- "The existence of two markets, the Exchange and a traditional health insurance market outside the Exchanges, must be crafted carefully to avoid one from becoming the equivalent of a state high risk pool. This would likely happen if one market is able to offer stripped down plan designs while the other is required to offer more robust options. Ultimately, the more healthy population will select a lower priced plan option while the less healthy will choose the more comprehensive plan. The ACA includes some provisions to address the adverse selection issues between these markets, however the ACA also allows insurers to offer less comprehensive plans—provided they meet the essential health benefit package in the external market."

[2] See Appendix A for FPL dollar amounts.
[3] Mercer, *Current Status of Insurance Coverage in the District of Columbia*, pp. 59-62.

In the Insurance Marketplace Report, Mercer notes both the benefits and potential challenges that would come from our recommended market structure;

- "Under this option, all products available all products available to individuals and/or small groups would be required to be offered through the Exchange and meet the standards for QHPs. This policy option would eliminate the opportunity for adverse selection against the Exchange in a particular market, because the Exchange would be the only source of coverage available for that market. It would also potentially allow carriers to shift more administrative costs to the Exchange where economies of scale might produce overall administrative cost reductions and lower premiums. Despite its effectiveness as a solution to the adverse selection issue, there are a number of disadvantages to this option."

In order to carry out a consolidation of the health insurance market upon launch of the DC HBX insurance marketplace in 2014, legislative action will need to be taken to effectively and legally move all small group and individual health insurance products into the DC HBX insurance marketplace. DISB's Office of General Counsel (OGC) continues to analyze any potential legal issues and report to the Insurance Subcommittee on their findings.

Stakeholder Comments

The Insurance Subcommittee acknowledges the clear opposition that health insurance carriers have towards consolidating individual and small group health insurance coverage through the DC HBX insurance marketplace. As the insurance carrier umbrella association District of Columbia Association of Health Plans (DCAHP) articulated, "it is critical that the establishment of an Exchange does not give an unfair competitive advantage to Exchange products over options made available outside the Exchange."

Choice and completion are important for consumers when it comes to selecting a health insurance policy for themselves or their family. In the District today, the four largest insurance carriers account for approximately 90% of plans purchased. Should our recommendation on a more passive approach to plan selection (coupled with a consolidated small group and individual health insurance marketplace)be adopted by the HRIC, no plan that meets the minimum essential health benefits (EHB) adopted by the District and approved by the federal government and any other minimum QHP requirements mandated by ACA and the District will be prevented from sale in the DC HBX marketplace.

We encourage stakeholders opposing this recommendation to review the attached Mercer reports on the Current Status of Insurance Coverage in the District of Columbia and on the Insurance Marketplace in a post-ACA world. DISB and DHCF staff worked with Mercer to establish modeling assumptions that were extremely conservative so that we could view the future District health insurance market place through skeptical lenses. HRIC staff will continue to work with District carriers to ensure that the transition to the DC HBX insurance marketplace causes minimal disruption to not only the market as a whole, but also newly anticipated administrative processes.

- United does not support consolidation of the small group and individual markets through the Exchange because it would eliminate consumer choice and competition.
    - However they do argue that rules for open enrollment should be applied equally inside and outside the HBX insurance marketplace.

- AARP supports consolidation of the markets because "given the population size of the District and those who will be affected within the individual and small group markets, it seems reasonable to consider consolidating both markets into one on the Exchange. We support Market Option 2 for this reason, but continue to have a few questions."

- Kaiser supports the hybrid option 3 which would extend all QHP requirements to plans offered both inside and outside of the HBX and require all carriers offering health insurance in the District to participate in the HBX. This option also requires all carriers in the HBX to offer bronze plans. In addition, Kaiser supports;
    - Requiring carriers to participate in both the individual and small group markets in the Exchange, and
    - Carriers should be prohibited from offering the ACA's specified catastrophic plan outside the Exchange, unless they offer it inside the Exchange as well.

- Carefirst supports the creation of a Basic Health Plan (BHP) - currently under analysis at DHCF- and suggests that the HRIC should not make any recommendation on the market structure until a final decision on BHP is made.

- DC Association of Health Plans (DCAHP) "supports the preservation of the insurance market outside the Exchange…(because) it is critical…an Exchange does not eliminate the current health insurance marketplace or give an unfair advantage to Exchange products over options made available outside the Exchange."
    - The DCAHP advocates for "mak[ing] our health care system simpler for consumers and should not add bureaucratic complexity that can add to the cost of insurance."

- Families USA supports option 3, offering additional modifications based on Maryland's exchange law: "we would suggest modifying this to require that IF a carrier offers a bronze plan outside the exchange, it must also offer a silver and gold plan outside of the exchange and seek to offer the bronze plan inside the exchange. That way, the District will not necessarily be encouraging the offer of bronze plans which provide minimal protection, but will be preventing bronze plans from existing only on the outside market and will be requiring carriers that offer this low level of coverage to also offer coverage that is more likely to attract people with higher health needs. Maryland's Exchange Act requires plans in its exchange to offer a bronze plan inside the exchange but also to offer one silver and one gold plan outside of the exchange, which is another way of ensuring that more comprehensive coverage be balanced in both markets"

- DCCLTC opts "for consolidating the individual and small group market under one super structure while keeping the individual and the small group insurance plans separate. This would allow for the most efficient and robust use of resources of the Health insurance Exchange while not merging the risk pools."

Recommendation #3: The risk pools of the small group market and individual markets in the DC HBX insurance marketplace should be merged into one single risk pool.

Recommendation #4: Define small group size in the District as 2-100 as opposed to the current practice of 2-50.

These recommendations are viewed as pragmatic policy decisions to further guarantee the success and sustainability of the DC HBX insurance marketplace. This decision is based on research (see below) and the flexibility granted to the District through ACA to craft an Exchange that is uniquely suited to the District. We acknowledge the opposition to these policy recommendations from carriers and interpret it to be largely based on the scope of IT system and business process changes that must occur to adhere to these policies. The HRIC and the eventual members and employees of the Authority are ready to work with District carriers in any capacity to ensure that these transitions- not these recommendations but all aspects of ACA implementation- are as smooth and non-disruptive as possible.

While we have relied on several external resources for our recommendations, these recommendations are based largely on the work performed and reported by Mercer under the District's Exchange Establishment grant. Mercer looked at District specific demographic information as well as information gained from an insurance carrier data call to craft various scenarios of how certain policy decisions and ACA mandates would impact the health insurance market in 2014.

It should be noted that our neighbor Maryland recently formalized their policy decision that small groups remain defined as 2-50 (our other neighbor Virginia is not actively implementing ACA). The HRIC will continue its engagement with Maryland on HBX IT coordination and will work to ensure that these different definitions of small group do not cause any undue technical or administrative burden.

Mercer evaluated two scenarios related to the merging of the small group and individual markets: the first looked at what would happen if the markets were merged and the definition of small group remained 2-50, and the second maintains the merged market with small group being redefined as 2-100 (*the assumptions used for these models, including predicted actuarial values in the individual and small group markets, are on pages 44-59 in Mercer's Marketplace Report*).

Key observations from the merged scenario where small groups remain 2-50 include;

- Premium levels do differ as a result of the market merger; however, the variance is not so extreme that take-up patterns are markedly different.
- Premiums in the individual market are 3.5% lower while premiums in the small group market are 3.6% higher in 2014 in a merged market.
- The average enrollment in this merged scenario is not significantly different than under the baseline scenario (markets remain separate under existing definition of small group).

Key observations from the above scenario where small groups are redefined as 2-100 include;

- Premiums in the individual market are expected to be 4.2% lower than under the baseline scenario.
- Premiums in the expanded small group market are expected to be 2.8% higher than under the baseline scenarios compared to a 3.6% increase when the definition of small group remains 2-50.

The Insurance Subcommittee acknowledges that these policy recommendations are not necessarily consistent with those of other ACA implementers. The most often cited issue is that of "rate shock" in the small group market, especially when it is merged with the individual market. However, as the above numbers reveal, this is not necessarily the case in the District of Columbia. We also acknowledge that there will be technical and administrative challenges for carriers in implementing these new policies. HRIC will continue to work with carriers through individual meetings and working groups to refine processes and transition to the DC HBX insurance marketplace.

Stakeholder Comments

Feedback on the above recommendations was more varied then other policy areas. In general, consumer advocates support the expansion of the definition of small group as well as the merging of the individual and small group risk pools as an effective means of mitigating adverse selection. Carriers generally support maintaining the current definition of small group as well as keeping the individual and small group risk pools separate in the DC HBX insurance marketplace, but one carrier was supportive of both the merging of the risk pools and the redefining of small group.

- United "believe(s) that Exchanges should select 50 employees as the initial size limit for the small group market… (To) minimize market disruption and (to) avoid overtaxing the Exchanges' administrative systems as they get up and running."
- Also supports keeping individual and small group risk pools separate in the Exchange over concerns that "combining the two markets would be to increase the rates for small groups, which could destabilize the small group market."

- Kaiser makes several recommendations intended to ensure that the DC HBX insurance marketplace has "a risk pool that is of an actuarially sound size."
- Should the District continue to administer the DC HBX as a state-based Exchange (as is currently defined in law), they ask us to "consider expanding the size of the small group market to 100…and the risk mix in the 50-100 small group population should be examined to determine if it would provide a pool that has a risk-mix that will allow the Exchange to be sustainable."

- Carefirst supports maintaining the definition of small employer as 2-50, stating that "larger employers that fall into the 51 to 100 employee definition but have low claims costs would be motivated to explore other coverage options, such as minimizing their risks with stop-loss insurance with a low attachment point or, for those with multiple worksites, purchase group health insurance outside of the District of Columbia."

Recommendation #5: The District intends for the DC HBX to opt into Federal programs for risk adjustment and reinsurance.

The federal government (CCIIO) has offered to states and the District the opportunity to "opt-in" to federally administered risk adjustment and reinsurance programs. Unlike many other "partnership" models offered by CCIIO, this choice does not have any impact on the statutory designation of the DC HBX as a "state-based" exchange. In addition, the compressed timelines of ACA implementation have created a huge burden on states working to fully implement ACA by January 1, 2014. The ability to defer the time, money, and other resources needed to successfully implement these complex programs while maintaining control over the policies and operations of the DC HBX makes this one of the more simple decisions the District will make during implementation.

Appendix A

District of Columbia Health Insurance Demographic Summary

District of Columbia Health Insurance Demographics
From Mercer Report "Current Status of Insurance Coverage in the District of Columbia"

**Based on information from the American Community Survey (ACS), 2009 Urban Institute Report for DHCF, carrier data call, DISB rate filing information, CMS reports, the Medical Expenditure Panel Survey (MEPS), U.S. Census Bureau, and various other sources.*

Health Insurance in the District of Columbia

	Persons (approximate)	**Distribution (percentage)**
Employer (active)	295,000	49.2%
Employer (retired)	27,000	4.5%
Military (active)	8,000	1.3%
Military (retired)	2,000	0.3%
Direct Purchase (individual market)	22,000	3.7%
Medicare	21,000	3.5%
Medicaid	156,000	26%
Dual Medicare/Medicaid Coverage	27,000	4.5%
No Insurance Coverage	42,000	7%
Total	600,000	100%

Health Insurance in the United States

	Persons (approximate)	**Distribution (percentage)**
Employer (active)	150,097,000	49%
Employer (retired)	12,878,000	4.2%
Military (active)	7,144,000	2.3%
Military (retired)	1,926,000	0.6%
Direct Purchase (individual market)	16,722,000	5.5%
Medicare	20,499,000	6.7%
Medicaid	40,687,000	13.3%
Dual Medicare/Medicaid Coverage	9,902,000	3.2%
No Insurance Coverage	46,660,000	15.2%
Total	306,515,000	100%

Health Insurance Coverage and Employment in the District of Columbia

Private Employees by Income and Residence

Federal Poverty Level (FPL)	District of Columbia Residents	Percent	Non-District of Columbia Residents	Percent
0-100%[1]	10,000	6%	8,000	2%
101%-138%[2]	7,000	4%	5,000	2%
139%-200%[3]	12,000	8%	14,000	4%
201%-300%[4]	20,000	13%	30,000	9%
301%-400%[5]	16,000	10%	35,000	11%
401% +	89,000	57%	235,000	72%
N/A	2,000	1%	-	0%
Total	**156,000**		**327,000**	

Employer Sponsored Health Insurance Coverage by Group Size among Private Sector Employees in the District

Group Size	Distribution of Employees	Percent Covered by Employer
0-9	7%	71%
10-24	6%	81%
25-99	13%	61%
100-999	29%	60%
1000 +	45%	66%

2012 Federal Poverty Guidelines[6]

Persons in Household	100% FPL	133% FPL	200% FPL	300% FPL	400% FPL
1	$11,170	$14,856	$22,340	$33,510	$44,680
2	$15,130	$20,122	$30,260	$45,390	$60,520
3	$19,090	$25,389	$38,180	$57,270	$76,360
4	$23,050	$30,656	$46,100	$69,150	$92,200

[1] ACA mandated Medicaid population
[2] Ibid.
[3] Presumptively eligible for Basic Health Option (BHP)
[4] Eligible for Premium and Cost-Sharing subsidies
[5] Ibid.
[6] U.S. Department of Health and Human Services (http://aspe.hhs.gov/poverty/12poverty.shtml#thresholds)

Appendix B

Stakeholder Feedback

TO: HRIC Insurance Subcommittee

FROM: James McSpadden, AARP DC

RE: District of Columbia Insurance Market Structure Under the ACA

DATE: March 27, 2012

This memo provides some commentary from AARP DC in response to the report by the HRIC Insurance Subcommittee that outlined the current proposed recommendations regarding the market structure of the District's health insurance exchange (Exchange).

Active Exchange vs. Passive Exchange

The mission of the Exchange is to create a well-functioning health insurance marketplace providing an array of affordable, high-quality health insurance plans to individuals and small businesses and to provide access to Medicaid and federal subsidies. Desirable outcomes of a District-operated Exchange include increased efficiency and effectiveness, with firms competing on the basis of price and quality rather than on risk selection. AARP believes that District residents will be best served by creation of an Exchange large enough to alter the health insurance marketplace and strong enough to foster active negotiation with the plans that wish to be included in the Exchange to drive high value. We recognize the unique challenges that the District faces, especially when we consider the size of our population and the likely participants in the Exchange.

In prior comments, we have expressed our position regarding an active versus passive exchange. We believe that an active exchange, which is able to limit the number of plans available, is in the best interest of the District and consumers. Limiting the number of plans participating in the Exchange can help reinforce several policy imperatives: it allows the setting of high standards, rather than a "least common denominator" approach that all can meet; it provides a strong basis for negotiation; it rewards with greater market share those plans that meet the highest standards; and it provides real choice for consumers rather than a confusing array of options for which "apples-to-apples" comparisons are difficult, if not impossible, to make. The Massachusetts Connector has completed focus groups on this issue and found a strong consumer preference for a small, "manageable" number of plans. Information on the focus group findings can be found on page 21 of the full report, which can be accessed here.

We do not believe, however, that active and passive are two antipodes. We a sliding scale between the passive clearing house and the exclusive active models, and see the District enabling a structure somewhere within this zone. Given the recent legislation that grants the District's Health Benefits Exchange the ability to enter into selective contracting, we would encourage the Exchange to engage in a more active role. As carriers will need to ensure that the plans they offer meet federal and District requirements in terms of qualified health plan (QHP) standards, it does not seem likely that an active exchange would place an additional or undue burden on either the insurers or the Exchange itself. By reviewing the plan proposals, the District will ensure that those who offer coverage through the Exchange are offering products that meet the needs of the consumers. It will also provide a baseline for the Exchange, helping to provide a clear understanding of what the

market currently offers and afford an appropriate starting place for quality reporting and the integration of quality measures for future QHP analysis.

Even so, the recruitment of carriers and plans will be a challenge given the size of DC's enrollment pool. Therefore, if the District decides to pursue a more passive model, we recommend the following:

- Put in place an effective cost sharing structure
- Ensure a limited number of plans
- Allow the Board to provide quality ratings of plans
- Build out a timetable for evaluation, so that the passive structure can be revisited by the Executive Board at a point in the not too distant future

Individual and Small Group Market Structure

We appreciate the careful consideration and thought that has been made in the analysis that developed the three proposed market structures. AARP echoes your concern for balancing affordability with access, transparency, efficiency, and consistency. With the unique population and governing structure within the District, the need to ensure that administrative efficiencies are preserved while ensuring appropriate and effective insurance coverage for the individual and small group markets is particularly challenging.

For purchasing pools to be sustainable and to avoid adverse selection, the Exchange will need to operate on a level playing field with the market outside the pools. If selection undermines the Exchange and raises its costs, it will harm everyone – directly affecting those buying in the Exchange and indirectly affecting those who help underwrite the cost of coverage for those in the Exchange through our tax dollars.

The requirements for risk adjustment, and the temporary reinsurance and risk corridor programs, as well as the requirement that plans pool risk inside and outside the Exchange, are critical tools to limit adverse selection and encourage participation in the Exchange. However, these tools will not be sufficient if the District does not apply the same rules to plans inside and outside the Exchange.

Given the population size of the District and those who will be affected within the individual and small group markets, it seems reasonable to consider consolidating both markets into one on the Exchange. We support Market Option 2 for this reason, but continue to have a few questions. We are concerned with differences that exist between these markets. There are many pieces to reconcile in order to achieve efficiencies of governance, and it is unclear how consolidating the markets would impact the costs of small group plans and the overall risk pool. We encourage DISB to continue seeking answers to these questions.

Because the Exchange should establish the same rules for insurance offered inside and outside the Exchange to prevent unfair competition and discourage cherry picking, it may be in the District's best interest to purse consolidating the inside and outside markets. Market Option 3, which would require all carriers who seek to offer coverage within the District meet all Exchange regulatory requirements, as well as require that all Exchange participating plans offer a bronze-level choice, begins to get to this consolidation. It appears to stop short, allowing carriers to offer a plan that meets the standard inside or outside the Exchange, but this option does require that all plans that

participate in the District's marketplace adhere to federal and District requirements in terms of QHPs, which helps ensure that level playing field that is necessary. It also extends coverage options and would establish the offering of bronze plans both inside and outside the exchange, in an effort to attract the "young invincibles" who tend to be healthier and less likely to participate in more robust health coverage plans to the Exchange, therefore helping to mitigate adverse selection. We think it valuable for DISB to continue engaging with stakeholders, to have further discussions, and potentially disclose any additional analysis/research they have done, particularly as it relates to Option 3.

Role of Producers and Navigators

AARP continues to be an interested and active stakeholder in the discussions surrounding the issue of the role of producers and navigators. The role of outreach, enrollment, and education of consumers is of vital importance to the ultimate success of any Exchange. Given the options for market structure, we believe this will be particularly true of options 2 and 3. By merging the two markets, as option 2 would do, and engaging the younger population, as option 3 will do, it becomes particularly important to ensure that information is provided and all options are properly fleshed out and described prior to a consumer making their final choice.

While outreach and education was not directly addressed within this report, we would strongly encourage the Subcommittee and the Crider Group to consider this issue in their analysis. To make the market more accessible to individuals buying coverage in the Exchange, key initiatives must build ongoing education and outreach on a base of good, understandable consumer information about coverage options, plan benefits and costs. People need to be made aware of the Exchange and what it is offering, and this will require a major communications and marketing campaign. Navigator programs will be important for reaching out to diverse groups that may be harder to engage due to language and cultural differences or lack of familiarity with health insurance. AARP will play what part we can in efforts to educate our members and we look forward to working with you on this front.

With respect to the role of brokers and agents, we believe that the same requirements, including those pertaining to training, certification, continuing education and compensation should be applied inside and outside of the Exchange. The District will need to ensure that there are no inappropriate incentives by producers to steer people outside the Exchange. In addition, the District will need to develop protocols related to conflicts of interest, training and continuing education, and oversight and licensure.

We continue to support and applaud the thoughtful and engaging discussions that the HRIC Insurance Subcommittee continues to have on the issue of the District's Exchange. With the unique population and structure within the District, there are considerations that must be fully vetted in order to ensure that affordable and accessible health coverage options are provided while preserving the need for efficiencies and consistency within the administrative functions of the Exchange. We appreciate the opportunity to provide these comments and would encourage you to contact us if you have any questions or need additional clarification.

UnitedHealthcare
A UnitedHealth Group Company

800 King Farm Boulevard, Suite 600
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March 27, 2012

The Honorable William P. White
HRIC Insurance Subcommittee Chair
and Commissioner of Insurance
D.C. Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, DC 20001
Submitted via electronic mail

Dear Commissioner White:

UnitedHealthcare is pleased to provide our comments and feedback on the *District Insurance Market Structure under ACA* before the District of Columbia Health Reform Implementation Committee Insurance Subcommittee. Below, UnitedHealthcare provides some general comments on the health benefit exchange and then addresses specific issues raised by the proposed *District Insurance Market Structure under ACA*.

UnitedHealthcare is dedicated to making our nation's health care system work better. We are a part of UnitedHealth Group, whose 87,000 employees serve the health care needs of more than 75 million Americans, funding and arranging health care on behalf of individuals, employers and government, contracting with more than 5,300 hospitals and 730,000 physicians, nurses and other health professionals. Our core strengths are in care management, health information and technology. As America's most diversified health and well-being company, we not only serve many of the country's most respected employers, we are also the nation's largest Medicare health plan— serving one in five seniors nationwide— and the largest Medicaid health plan, supporting underserved communities in 24 states and the District of Columbia. Recognized as America's most innovative company in our industry by Fortune magazine, we bring innovative health care to scale to help create a modern health care system that is more accessible, affordable and personalized for all Americans.

UnitedHealthcare believes Exchanges have the potential to be valuable mechanisms to increase access to affordable health insurance. To realize this, we believe that Exchanges should be set up in a manner that develops fair and efficient markets, creates a positive consumer experience, advances consumer choice and innovation, promotes consumer responsibility, and balances national standards with state flexibility. What follows is a summary of our key principles that we believe further these goals. All of these comments and recommendations are based on our experience providing health benefits and service solutions to employers, individuals, and families.

Protect Consumer Choice To Minimize Complexity and Reduce Administrative Costs

In order to enhance competition, promote ongoing innovation, and increase consumer choice, we believe that all qualified health plans should be permitted to participate in the Exchange. Participating health plans should be encouraged to differentiate their plan offerings to appeal to a wide variety of consumers with different needs and preferences, while remaining consistent with federal standards regarding specified actuarial values. For example, at a particular actuarial plan value (e.g., Silver), some consumers might wish to purchase a high deductible health plan that would be compatible with a health savings account, while others may prefer a plan that offers more first-dollar coverage of pharmacy benefits and lower deductibles.

A District-based Exchange will ensure that the Exchange is responsive to unique District characteristics, including the specific dynamics of the individual and small group markets and the structure of public programs. Since insurance is regulated on a state or District level, an Exchange will generally be more flexible if it operates under the laws of a single state or District instead of a multiple states. Conflicting state regulations and statutes may make any kind of regional regulatory harmonization difficult to implement and maintain. A regional structure could include administrative economies of scale, but potentially, the same scale economies could be found by using a single administrative entity regardless of whether the state-level Exchanges are affiliated.

The District-based Exchange will benefit from uniform federal standards in areas where variation at the State or District level would add unnecessary complexity, such as risk adjustment mechanisms, quality improvement measurements, and uniform data transaction standards. The District should also rely to the extent possible on existing review standards established by national accreditation agencies for use in the health plan certification process.

Preserve Existing Markets

Exchanges should supplement, but not replace, the existing small group and individual markets. Therefore, the District should preserve the existing market for health insurance outside of the Exchange, and should not force all individual health insurance products to be sold through the Exchange. Preserving a market outside the Exchange is not only beneficial for consumers, but is also supported by the express language of the PPACA. Specifically, Section 1312 of the law outlines clear Congressional intent that consumers should be empowered to enroll or select a plan outside of an Exchange, and that Exchanges should be voluntary. We believe that eliminating the external individual market would reduce competition, stifle innovation and lessen the ability of consumers to purchase insurance plans designed to fit their specific needs.

The PPACA already provides a number of mechanisms to mitigate adverse selection against an Exchange. This includes the equal application of health care reform requirements to insurers operating inside as well as outside the Exchange, including:

- Adjusted community rating rules (adjusted only by age, tobacco use, geography, and family status)
- Individual and small group plans must cover the same essential health benefits
- Limits on individual out-of-pocket cost-sharing limits
- Treating all individuals as part of one risk pool (same for small group enrollees)
- Charging the same premium rates for a plan offered inside and outside the Exchange
- The operation of the risk adjustment and reinsurance programs

Perhaps the most significant protection against adverse selection against the Exchange is the fact that federal subsidies are only available through the Exchange. Ultimately, the viability of the nongroup market will be highly dependent on the development of open enrollment rules, inside and outside the Exchange, that encourage consumers to obtain and maintain continuous coverage.

Furthermore, market rules applied inside the Exchange should not automatically be applied to plans sold outside the Exchange. Specifically, requiring that all of the same rules apply to plans sold inside and outside the Exchange or requiring that the same plans be sold inside and outside the Exchange without exception would likely serve to reduce consumer choice and competition. For example, some licensed health plans may not meet the requirements to become qualified health plans (QHPs). A rule that these plans must meet the QHP requirements to compete in the outside market could theoretically exclude them from competing in the state. However, rules related to Open Enrollment should be equally applied inside and outside the Exchange. Applying the same enrollment rules regardless of the marketplace will help encourage consumers to obtain and maintain coverage. Additionally, it will assist in lessening potential adverse risk selection. Finally, as stated in the previous section, we believe that Exchanges should promote innovation and increase consumer choice with flexibility in plan design requirements as long as plans meet federal standards regarding actuarial value.

With respect to dental coverage, we believe that the consumers in the Exchange should benefit from the same choices available in the outside market. Consumers should have the flexibility to select coverage for dental benefits either through "bundled" medical products or stand-alone dental products in the Exchange. These options are available in the current market today, and consumers benefit from this competition and choice.

We believe that bundled products provide a simplified choice, and dental benefits do not need to be priced separately to provide transparency. Price and benefit comparisons can continue as they do today in the marketplace for stand-alone products, by adding the cost of medical and dental benefits together to compare the total to bundled products. In fact, we believe that separate pricing for an embedded pediatric dental benefit (part of the PPACA Essential Health Benefits package) would be arbitrary, inconsistent across carriers, confusing to the consumer, and could perpetuate health care system silos.

It should be noted that there is a policy question as to whether certain consumer protections under the PPACA would apply to a stand-alone dental policy, as such plans are currently considered HIPAA-excepted benefits. If dental benefits are integrated with the medical product, the PPACA consumer protections would be applied, which could be considered an additional benefit to the consumer.

Navigators, Agents and Brokers

Health care coverage is a complex decision, and individuals and small employers have traditionally relied on advisors to help guide them through the process. We believe that the evolving health care system should retain the highest level of quality regarding health care purchasing assistance, and the agent/broker relationship with clients should continue.

We support requiring a Navigator to meet licensing, certification or other standards prescribed by the District or the Exchange. We believe certification standards should be similar to the current standards for agents and brokers today supplemented with specific training for Navigators on PPACA requirements, Medicaid and CHIP, in addition to individual and small group products. Additionally, any rules related to agents and brokers should promote flexible roles for them to participate in both the Exchange and traditional commercial marketplace ensuring consumers are served by knowledgeable, resourceful advisors. Such flexibility builds on their current relationships with individuals and employers, and ensures that agents and brokers are not subject to limitations in performing an Exchange eligibility assessment. In short, eligibility assessments should not be restricted to Navigators.

We recommend that over time, the Exchange become the "source of truth" for all insurance affordability programs. This will help to track and better assist individuals as they move between programs as incomes and circumstances fluctuate, advance the intent of a one-stop-shop for families with family members in more than one program, and eliminate the need and inevitable inconsistencies associated with multiple enrollment databases.

Risk Mitigation

The PPACA requires states to adopt systems of risk corridor and reinsurance for the first three years of the Exchange operation. We believe that the framework for a risk adjustment methodology for Exchanges should be established at the national level to ensure uniform standards and promote efficiency and consistency. The American Academy of Actuaries should be consulted for its recommendations on federal standards for risk adjustment, reinsurance, and risk corridor mechanisms. We believe it is important that the reinsurance, risk adjustment, and risk corridor processes are defined well in advance of the date that Exchanges become operational. They should be effectively integrated, promote stability in pricing, and not penalize efficient health plans that price responsibly to support health plans that either are inefficient or price irresponsibly.

Funding

The PPACA requires that Exchanges must be self-sustaining and we believe Exchanges should develop a funding mechanism based on a per member cost that is agnostic to the selected metallic plan designs and not based on premium amounts. This will ensure that all consumers are treated equally as they undertake their shopping and selection process. Additionally, as fees and taxes are determined we believe that only qualified individuals and or QHPs inside the

Exchange should be subject to any such fees and or assessments, and it should be clarified that any tax or assessment is user-based.

In light of a recently published report for the State of Ohio that projects the costs of operating a state based Exchange can range from $19 million to $34 million per year, we urge that any fees and taxes or assessment should be defined no less than twelve months in advance and adjusted prospectively. Using a prospective adjustment will avoid a year end true-up. Additionally, all funds collected must include a transparent plan/process as to how the funds will be attributed toward specified Exchange activities.

SHOP Exchange: Employer vs. Employee Choice

The Department of Health and Human Services (HHS) Final Rule on the Establishment of Exchanges and Qualified Health Plans allows states to determine whether the SHOP Exchange will follow an employer or an employee choice model in the selection of QHPs offered to employees. We believe that in order to minimize risk selection issues a qualified employer should be required to select a metallic level of coverage and allow qualified employees to choose any available QHP offered at that level of coverage. Alternatively, an employer can select an issuer and allow employees to purchase any product offered by that issuer inside of the Exchange. These approaches comport with the language and intent of the PPACA and promote employer and employee engagement in the shopping and enrollment process along with addressing potential risk selection issues.

Additionally, the SHOP Exchange should set minimum participation rules consistent with existing market practices in the District. By requiring the SHOP Exchange to be responsible for communicating and educating employers and consumers on the requirements of minimum participation, the SHOP Exchange helps protect against potential adverse selection, as well as promoting a stable risk pool.

Facilitation of Premiums and Enrollment

We believe that for purposes of the individual Exchange, issuers should be responsible for collecting premiums directly from the individuals and subsidy administrators. As it relates to the SHOP Exchange, we believe SHOPs must collect and distribute premium payments to issuers and issuers in the SHOP Exchange should not be permitted to accept payment directly for the employer groups. There should be firm standards for timely payment to issuers by requiring electronic funds transfers to issuers avoiding issues related to the 90-day termination provision.

Finally, we believe once the Exchange determines eligibility, QHPs should manage the enrollment process. Health plans currently understand the unique needs of consumers relative to enrollment, coverage issues, and premium payment and collection in the individual market. Exchanges should build on these existing capabilities by allowing QHPs to continue their relationships with consumers directly, thus ensuring QHPs engage consumers relative to their health care needs.

Active Exchange vs. Passive Exchange

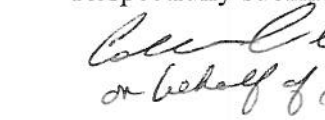
UnitedHealthcare cautions that potential active purchasing and negotiating requirements may actually reduce competition, innovation and benefit plan coverage for District consumers. Artificial limitations on pricing or non-actuarially supported negotiated rate discounts imposed by Exchanges do not address the underlying cost of health care services, and they may not be sustainable over the long-term. In a competitive Exchange environment, issuers will be competing on price, quality and service, and they will strive for innovative designs and consumer-oriented plan enhancements to differentiate their products. Competition in the Exchange is in the best interest of the District health care consumer.

Individual and Small Group Market Structure

In general, while the District may wish to share Exchange infrastructure between the individual and small group markets to achieve administrative efficiencies, we believe that maintaining separate individual and small group markets promotes long-term stability. The individual market generally has a higher risk profile than the small group market, which presents a greater potential for adverse risk selection and inherently higher administrative costs compared to small group coverage. A likely result of combining the two markets would be to increase the rates for small groups, which could destabilize the small group market. Small groups have different eligibility, enrollment and general administration needs than individuals, and employers with more than 20 employees generally require a different type of customer support service. Maintaining separate risk pools has the potential to encourage a full spectrum of participating health plans that have core competencies in dealing with the distinctly different Exchange populations.

Thank you for the opportunity to provide UnitedHealthcare's perspective on these important Exchange policy considerations. If you have any questions, please do not hesitate to contact me or Colleen Cohan on our Legal & Regulatory Affairs team.

Respectfully submitted,



John E. Fleig, Jr.
Chief Operating Officer
UnitedHealthcare Mid-Atlantic Health Plan

Respectfully submitted,

Karen M. Johnson
Unison Health Plan of Capital Area
Executive Director

cc: Brendan Rose
Exchange Project Director\Health Care Policy Analyst
DC Department of Insurance, Securities, and Banking

KAISER PERMANENTE®

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

Commissioner William White
Department of Insurance, Securities and Banking
Washington DC, 20002

March 27, 2010

Re: Comments on DISB's Proposed Market Structure Options under ACA

Dear Commissioner White:

Thank-you for seeking input on the three market structure options that are discussed in the document entitled "*District Insurance Market Structure under ACA*," that was distributed by DISB at the HRIC Insurance Subcommittee meeting held on March 13, 2012. Kaiser Permanente's comments are as follows:

1. Option 3 offers the most valuable set of market rules.

Kaiser Permanente supports Market Structure Option 3 which would extend all QHP requirements to plans offered both inside and outside of the HBX and require all carriers offering health insurance in the District to participate in the HBX. This option also requires all issuers in the HBX to offer bronze plans. As the report correctly notes, the market rules proposed in Option 3 will help to address the considerable adverse selection issues that all Exchanges will face without some management of the market.

Kaiser Permanente believes that Option 3 could be further strengthened with two additional rules. First, require issuers to participate in both the individual and small group markets in the Exchange. No issuer should be allowed to choose between the individual or the small group market. This requirement will help to alleviate the problem of stabilizing the risk pool. Under the ACA, Congress anticipated that people would shift between individual and group insurance, and we think that these transitions should be as seamless as possible. This requirement would serve to facilitate this transition for DC residents.

Second, issuers should be prohibited from offering the ACA's specified catastrophic plan outside the Exchange, unless they offer it inside the Exchange as well. Catastrophic plans, in particular, will pose one of the most significant adverse selection risks to the Exchange. While Option 3 requires issuers to offer the lowest-cost plan among the metal tiers (the Bronze plan) in the Exchange, the catastrophic plan poses the same sort of adverse selection risk, but with a more focused, and by definition, healthier population made up almost exclusively of young people. A number of states, including California, Maryland and Washington, have already crafted such a

rule to make certain "young invincibles" are not given incentives to take their business outside of the Exchange. Kaiser strongly believes such a rule is essential for the DC HBX as well.

2. The District's small market size must be addressed directly.

A theme that runs throughout DISB's market structure document is the District's small population in comparison to most other jurisdictions. This is a unique issue, common only to a few low-population states and some of the territories that will have Exchanges, but it is exacerbated in the District and is one of the biggest challenges the District faces. The District's population is comparable to that of less populated states like Wyoming and Alaska. However, unlike those states, the District's population is overwhelmingly insured by public programs, leaving an extremely small risk pool for the HBX.

The HBX will need a risk pool that is of an actuarially sound size. The ACA obviously envisions Exchanges in states where the population size is substantial, but Congress envisioned the problem of smaller risk pools, and permitted jurisdictions to enter into partnerships with one another to manage their Exchanges. The District could take advantage of this option and work with nearby states to coordinate the HBX with other Exchanges.

Alternatively, the District is ideally situated to partner with the federal government on various aspects of the Exchange. While we are aware there might be some resistance to this idea, we believe it should not be rejected without full consideration and public discussion. Although information about the federal Exchange is still being developed, we observe that this could be an excellent time to enter into discussions with HHS about the specifics of how a federal/state partnership might work. Perhaps, an established local Exchange, such as the DC HBX, will have access to certain federal Exchange services. This option could help to alleviate the problem of disproportionate administrative costs and, depending on the arrangement, could also help with the other dominant demographic issue related to the District's extremely small market size.

The Exchange's administrative costs pose a difficult problem for the HBX. The substantial start-up costs of Exchanges will be roughly similar irrespective of the size of the jurisdiction in which the Exchange is being developed. Technology costs, the extremely difficult back-office requirements of eligibility determinations for subsidies, and many other demands of the ACA will be resource-intensive for every Exchange in the early years. While we expect the ongoing administrative costs will likely stabilize over time, these up-front costs will be enormous for every Exchange irrespective of size.

The District's challenge here is enormous. Apportioning these costs across a market the size of New York's or California's will result in high but absorbable costs to all insurers. However, that apportionment to the District's issuers will be significantly higher, and that disproportionate burden will almost certainly have market consequences. We note that cooperation or partnerships with either the federal Exchange or with other state Exchanges would help to mitigate this issue.

If the District chooses to run the HBX in isolation, a third possibility is for the District to consider expanding the size of the small group market to 100, another option the ACA explicitly

mentions. While this would not be as broad-based a solution as cooperation with other Exchanges, it would at least add to the HBX market base. This would obviously require serious study, but we note it as a possibility. It must be mentioned that expanding the risk pool does not necessarily mean the pool will contain an appropriate mix of risks. The actual composition of the pool is important, and the risk mix in the 50-100 small group population should be examined to determine if it would help provide a pool that has a risk-mix that will allow the Exchange to be sustainable.

3. The HBX should manage the market rather than direct it.

The DISB document also recommends that the District establish a "passive" HBX that allows the sale of any plan as long as it meets District and federal QHP standards. Kaiser Permanente supports this model which places the HBX in the position of managing the marketplace rather than micromanaging carrier selection.

We believe the description of this model as being "passive" may wrongly suggest HBX would have little or nothing to do, once it is established. On the contrary, as we have discussed above, we believe HBX (or any Exchange) should have a clear set of rules for both its own market and the outside market, and make certain those rules are followed by all carriers. This is not a "passive" role, but an active one in managing a new kind of health insurance market. We strongly support it.

Thank-you again for the opportunity to comment on the insurance market structure in the District of Columbia. Feel free to contact me at 301-816-6480 or Laurie.Kuiper@KP.org, if you have any questions or wish to arrange further discussion.

We look forward to working with you in the future on these important issues.

Very truly yours,

Laurie G. Kuiper
Senior Director, Government Relations
Kaiser Permanente

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Rockville, Maryland 20852

Tonya Vidal Kinlow
Vice President
Government Affairs

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March 27, 2012

Mr. Brendan Rose
Exchange Project Director/Health Care Policy Analyst
D.C. Department of Insurance, Securities, and Banking
810 First St., NE, Suite 701
Washington, DC 20001

Dear Mr. Rose:

On behalf of CareFirst BlueCross BlueShield, which provides health insurance coverage to nearly 375,000 residents of the District of Columbia, I write to offer comment on the market options to support the successful implementation of the District of Columbia Health Benefits Exchange (DC HBX) presented to the D.C. Health Reform Implemention Committee (HRIC) Insurance Subcommittee on March 13, 2012. CareFirst recommends that the DC HBX create a Basic Health Plan (BHP) option. We suggest that you develop recommendations on the rules applicable to the Individual market after a final decision is made on a Basic Health Plan. For the Small Group market, CareFirst recommends that the Individual and Small Group markets not be merged. Further, we recommend that carriers offering health insurance to small employers off the Exchange be required to also offer health insurance on the Exchange.

A BHP, available to individuals and families with incomes between 133 -200 percent of FPL, would maximize continuity of care by enabling managed care organizations to continue to serve individuals and families as they transition in and out of Medicaid. It also would reduce the administrative burden for these individuals and families as they undergo these transitions. For these reasons, CareFirst strongly supports creating a BHP. If the decision is made to establish a BHP, the HRIC Insurance Subcommittee should consider the feasibility and desirability of selective contracting and limiting the Individual market in the District solely to products offered on the Exchange.

Because health care reform will cause extensive changes to the Individual and Small Group markets and the impact of these changes on premiums is not well understood at this time, it would be prudent to maintain separate markets in 2014 and reevaluate whether the markets should be merged after the District's Exchange has several years of experience.

In the Small Group market, a carrier that elects to sell products only off-Exchange may attempt to exploit that market's less-restrictive rules to offer products and services designed to attract disproportionate numbers of healthier individuals. Those carriers offering health coverage only off-Exchange can avoid the higher risk individuals expected to seek coverage on the Exchange, giving them a competitive advantage and a more attractive community rate over those carriers participating on the Exchange.

Most carriers in the Small Group Market today are a part of insurance holding companies (e.g., Aetna, CareFirst, Kaiser, UnitedHealthcare). By designating one affiliate

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carrier to offer QHPs both on and off of the Exchange while another affiliate carrier offers only non-QHPs off the Exchange, a holding company effectively protects the latter carrier from the disproportionate share of consumers with the greatest health care needs expected to purchase coverage on the Exchange. Attracting these healthier risk consumers to the off-Exchange market will result in higher premiums charged for QHPs offered on the Exchange.

Requiring all carriers, as a condition for offering Small Group health insurance products off the Exchange, to also offer QHPs to Small Groups on the Exchange (and requiring carriers also to offer QHPs off the Exchange) subjects all carriers to the same market rules while reducing the risk of adverse selection for a carrier and a QHP. Both requirements make the Exchange more viable because they reduce the risk that a QHP sold on the Exchange becomes unaffordable, attractive only to those with the greatest health care needs.

Thank you for the opportunity to provide comments on these important issues. CareFirst looks forward to continuing to work with you to ensure the successful implementation of federal health care reform in the District of Columbia.

Sincerely,

Tonya V. Kinlow
Vice President of Government Affairs – NCA

cc:

The Honorable Wayne Turnage
Director, D.C. Department of Health Care Finance
Chairman, D.C. Health Reform Implementation Committee

The Honorable William P. White
Commissioner, Department of Insurance, Securities and Banking
Co-chair, D.C. Health Reform Implementation Committee

The Honorable Mohammad N. Akhter, M.D.
Director, D.C. Department of Health.
Co-chair, D.C. Health Reform Implementation Committee

DISTRICT OF COLUMBIA ASSOCIATION OF HEALTH PLANS (DCAHP)
1455 Pennsylvania Avenue, N.W., Suite 400
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202-621-1886

March 27, 2012

Commissioner William White
District of Columbia Government
Department of Insurance, Securities and Banking
810 First Street, NE, Suite 700
Washington, DC 20002

Re: HIRC Final Market Structure Report, March 13,

Dear Commissioner White:

As you are aware, the District of Columbia Association of Health Plans (DCAHP) and its members are actively engaged in the District's efforts to implement the federal mandates of the federal Affordable Care Act (ACA). In that regard we have worked with all stakeholders including key members of the Council, Director Turnage, Policy and Legislative Affairs Director Janene Jackson and the other members of the Health Reform Implementation Committee (HRIC) in an effort to assist the District of Columbia Government and its residents with the formation and implementation of the District of Columbia Health Benefit Exchange (Exchange).

DCAHP considers the Exchange to be a critical element in the overall success of Heath Care Reform as well as an enormous potential benefit to the residents of the District if properly implemented. Our member plans also believe implementation of Exchanges should be guided by ensuring consumers have affordable products and choices that meet their needs related to family status and preference. Exchanges should also make our health care system simpler for

consumers and should not add bureaucratic complexity that can add to the cost of insurance. Our member plans subscribe to the key principles of Affordability, Competition, and Simplicity.

We are writing at this time on behalf of our member plans to provide comments on the HRIC District Insurance Market Structure under ACA (Market Structure Report) that was released on March 13, 2012. It is important to note at the outset, that our member plans are committed to working with the HRIC to ensure a viable Exchange in the District. We are therefore pleased to offer the following comments on the Market Structure Report:

1. **Outside Market Should be Preserved**

DCAHP supports the preservation of the insurance market outside the Exchange.

We believe it is critical that the establishment of an Exchange does not eliminate the current health insurance marketplace or give an unfair competitive advantage to Exchange products over options made available outside the Exchange.

Having a robust Exchange and outside health insurance market ensures choice and competition among health insurance options, which is critical to a well-functioning marketplace. We believe Exchanges should enhance, but not replace, existing markets to ensure that consumers can keep the coverage they currently have.

Exchanges should supplement, but not replace, existing markets to ensure that consumers can keep the coverage they currently have.

2. **Individual and Small Group Markets Should Remain Separate**

For rating purposes, the DCAHP believes the non-group and small-group markets should be kept as separate risk pools. Merging these markets is not a prudent step to ensure a smooth transition to the Exchange system, especially at the outset, due to the fact that the overall experience of the individual market, which is exposed to greater adverse risk selection and therefore costs, would cause small group rates to be higher in absorbing the higher risk individual population.

3. **Risk Adjustment, Transitional Reinsurance, and Risk Corridors Provisions in the ACA**

DCAHP encourages adoption of and alignment with ACA tools to limit adverse selection in the District's insurance market.

Coinciding with the 2014 market reforms, the ACA puts in place three inter-related provisions regarding: risk adjustment, reinsurance, and risk corridors. The risk adjustment and reinsurance provisions apply to health plans offered both inside and outside the exchange, and the risk corridors apply to "qualified health plans." The reinsurance and risk corridor provisions are

transitional in nature, and generally apply 2014-2016, while risk adjustment is permanent. Taken together these provisions form a risk mitigation system.

At a more granular level, each of the ACA provisions is intended to perform a different function. Below is a brief summary of the provisions:

1. ***Transitional Reinsurance***: This provision is expected to operate on a transitional basis from 2014 through 2016 (although available transitional reinsurance funds may continue to be used through 2018). The transitional reinsurance serves to help protect the individual market (and those with individual coverage) from adverse selection against the *overall market* as opposed to any individual carrier. It applies both inside and outside the exchange and is expected to apply to high-risk individuals who enroll in individual coverage, regardless of whether they are currently uninsured or enroll from group coverage markets. It is financed through $25 billion in assessments spread across both the fully insured and self-insured major medical insurance markets. It is allocated as follows: $10B 2014; $6B 2015; $4B 2016. (Note: $5B of the funding, accounting for the full $25B referenced in the statute is to be deposited in the general fund of the U.S. Treasury and is not available for the transitional reinsurance program.)

2. ***Risk Adjustment***: This provision is intended to protect the availability of health plan choices for consumers by *normalizing among carriers* risks (such as those relating to health status and other factors such as gender and age, to a limited extent) that carriers are not allowed to reflect in developing premiums.

3. ***Risk Corridors***: This provision is intended to provide a partial protection against the uncertainty in pricing coverage (either too high or too low) resulting from the breadth of changes associated with health care reform. This uncertainty is expected to be greatest in the early years of the program, reflecting the 3-year (2014-2016) limitation of the risk corridor provision. The concept of the risk corridor is that if the financial performance for a particular health plan is above or below certain defined bands or corridors, the government and health plan share unexpected losses or gains.

We thank you for your consideration on our comments on this very vital program for our community.

Sincerely,

David W. Wilmot
Executive Director, DCAHP

Cc: Beatriz Otero, Deputy Mayor for Health and Human Services
Wayne Turnage, Director, Department of Health Care Finance
William P. White, Commissioner, Department of Insurance, Securities and Banking
Janene Jackson, Director, Office of Policy and Legislative Affairs
Board of Directors, DCAHP

To: Brendan Rose, DISB

From: Cheryl Fish-Parcham, Families USA

Re: District Insurance Market Structure

Date: March 27, 2012

I write to provide brief comments on the "District Insurance Market Structure under ACA."

An "active" exchange has several advantages over a passive exchange: through a bidding process, the District could select plans that offer consumers the best value for their premium dollars; insist that plans coordinate well with Medicaid plans for people with fluctuating income by, for example, allowing them to continue using their former providers; require plans to take steps to improve quality and address the District's public health goals; and set further parameters on plans' cost-sharing structures so that, for example, low and middle-class residents would not face unaffordable deductibles.

However, for a competitive, selective contracting process to work, more carriers must be interested in bidding than the number that the District plans to select. Since neither the District's individual market nor its small group market currently includes many carriers, it may not be realistic to use this approach the first year. Could the District ask plans to submit some sort of expression of interest so that we will know in advance if the carriers now in the market intend to participate in the exchange and if any Medicaid MCOs or new commercial insurers plan to enter this market?

Even if the District decides not to enter into selective contracts for the exchange, the District should set requirements which go beyond the federal requirements for exchange plans. These requirements should assure that plans provide value; address the District population's prevalent health problems; standardize cost-sharing with particular attention to needs of low- and middle-income consumers (for instance, ensure that deductibles are not so high that they pose a barrier to care); and facilitate transitions for people leaving Medicaid. The District's Exchange board should determine whether selective contracting would be a better approach in subsequent years and should have the authority to enter into a selective process if so.

Option 3 proposes that the District require all exchange carriers to offer bronze plans in order to balance risk inside and outside of the exchange. If the purpose is to balance risk, we would suggest modifying this to require that IF a carrier offers a bronze plan outside the exchange, it must also offer a silver and gold plan outside of the exchange and seek to offer the bronze plan inside the exchange. That way, the District will not necessarily be encouraging the offer of bronze plans which provide minimal protection, but will be preventing bronze plans from existing only on the outside market and will be requiring carriers that offer this low level of coverage to also offer coverage that is more likely to attract people with higher health needs. Maryland's Exchange Act requires plans in its exchange to offer a bronze plan inside the exchange but also to offer one silver and one gold plan outside of the exchange, which is another way of ensuring that more comprehensive coverage be balanced in both markets.

It is useful to apply many of the plan requirements outside of the exchange as well as inside. This can minimize the chances that a plan would decide not to participate in the exchange just to avoid requirements that are useful to consumers. However, we recommend that this discussion be revisited once the District is clearer about what requirements it wishes to apply to exchange plans, since there could be some danger that plans would seek to weaken all District requirements if they applied universally.

March 29, 2012

William P. White, Commissioner
Department of Insurance, Securities and Banking
Chairman
The District of Columbia
Health Reform Implementation Committee
Insurance Subcommittee
1350 Pennsylvania Avenue, NW
Washington, D.C. 20004

Dear Commissioner White:

The National Association of Insurance and Financial Advisors-Greater Washington D.C. (NAIFA-GWDC) and the Greater Washington Association of Health Underwriters (GWAHU) appreciate this opportunity to comment as the District of Columbia moves forward to implement a health insurance exchange as required under the Affordable Care Act of 2010.

As you may know, NAIFA-GWDC is a local association comprised of nearly 400 insurance and other financial service professionals that live and work throughout the Washington D.C. metropolitan area. Many live and/or work in The District and many more provide a variety of professional insurance and financial services to D.C.-based companies and individuals. Many hold advanced, professional credentials in the areas of life, health and long term care insurance, as well as financial planning and other specialties.

GWAHU is a local chapter of the National Association of Health Underwriters (NAHU) which exists to improve its member's ability to meet the diverse health, financial and retirement needs through education, networking and professional development.

Many members of NAIFA-GWDC and GWAHU provide D.C. companies and individuals with expertise in the area of employee benefits, including health insurance. These licensed agents and brokers are true health insurance professionals that directly serve the needs of consumers and small businesses and are accountable to them. Specifically, brokers and agents guide their clients through the complexities of health insurance purchasing decisions and enrollment, while ensuring they get the best policy design at the most affordable cost. Agents and brokers work with clients to evaluate their need for health insurance protection. This may involve substantial research and fact-finding about the client's health care needs and coverage objectives.

The job of an agent or broker does not end with the sale—it is only the beginning of the services to be provided. Licensed agents and brokers help their clients with claims issues, service questions, and coverage enhancements and compliance matters throughout the life of each health insurance policy that is acquired by a consumer. Under many circumstances agents and brokers act as consumer advocates. Agents and brokers often

serve as ombudsmen and intermediary in helping their clients deal with insurance companies and health care providers, spending an enormous amount of time helping clients assemble the proper documentation needed to file or follow up on a claim. In addition, agents and brokers help business owners in communicating their benefit packages to employees, often assisting employees in seeing how their health insurance benefits coordinate with their personal financial plans, as well as programs provided by government entities.

In short, agents and brokers understand small business owners and their health insurance needs. We offer this expertise to you and hope you will seek our assistance as you craft a workable SHOP exchange for D.C. businesses.

NAIFA-GWDC and GWAHU strongly believe that market rules established for plans inside and outside of the exchanges should be identical. Licensed, fairly compensated insurance agents and brokers must be a part of any newly designed D.C. Exchange.

As you work to establish a role for "navigators" in the new exchange system, it is important to note that they have a very different role to play than licensed agents and brokers; these roles should be complimentary, but not overlapping. Navigators should focus on bringing people into the exchange through outreach activities, and perhaps assist with public assistance, if applicable. Then, ideally, navigators will be able to work with licensed agents and brokers to find appropriate coverage for potential clients. Agents and brokers are licensed and trained to evaluate the needs of clients and make professional recommendations as to appropriate coverage and policies. As such, they are in the best position to serve consumers in a fully informed way, while protecting their clients' interests throughout the process, both before and after the coverage is put into place.

We look forward to working with you to craft a workable, successful health insurance exchange for Washington D.C. residents and small businesses.

Sincerely,

Matthew Grace, CLTC
President
NAIFA-GWDC

Joel Pitt
President
GWAHU

Date: March 27, 2012

To: HRIC Plan Management Work Group

From: D.C. Coalition on Long Term Care

RE: District Insurance Market Structure Under ACA

1. The D.C. Coalition at this time recommends initially a "passive exchange". The limited experience of exchanges to date has shown that it is difficult to attract insurers and consumers through this market. However, we hope that the Health Exchange Governing Board will be "active" in requesting higher standards than the minimum and making the plans affordable, because otherwise we do not think that the HIX will attract a robust market. We agree with DISB that a passive exchange would attempt to mitigate additional market disruptions that are inevitable with the implementation of the ACA. We hope that the Health Exchange Governing Board would analyze the data after a suitable time period to determine what is in the best interest of the District of Columbia's residents and businesses' as to whether the exchange is active or passive. However, it is our understanding that the HIX governing board can be involved in vetting the health policies whether the exchange is active or passive. We agree that trying to emphasize balance, flexibility and reduce undue burden is essential. The D.C. Coalition also hopes that after a couple of years that there will emerge some innovations and best practices that might fit the unique features of the District of Columbia market and raise the standards of care and meet best practices.

2. The D.C. Coalition thinks that the D.C. market is too small to have an inside and an outside market. Therefore, we opt for consolidating the individual and small group market under one super structure while keeping the individual and the small group insurance plans separate. This would allow for the most efficient and robust use of resources of the Health insurance Exchange while not merging the risk pools. The Health Exchange would be the sole market place for health plans to assure the most robust risk pools in preventing adverse selection. It is to be hoped that the suppositions that DISB has put forth about long-term viability in this option will be valid.

3. We totally support the D.C. Alliance still being offered as an alternative for addressing the population that would not be eligible for the DC HBX insurance market. We are dismayed that Mayor Gray has recommended for the FY 2013 that the Alliance not pay for hospitalizations, we hope that decision can be reconsidered.

4. We applaud the DISB's guiding principles of:
    a. Affordability for consumers and reasonable administrative costs for administering the Authority,
    b. Transparency,
    c. Administrative efficiency and
    d. Consistent regulations and non-duplicative administrative functions would go a long way to attracting carriers, and

e. Ease of enrollment for DC residents and small groups seeking insurance.

Tonya Vidal Kinlow
Vice President
Government Affairs

CareFirst BlueCross BlueShield
840 First Street NE, Suite 1200
Washington, DC 20065-0001
Tel. 202-680-7444
Fax 301-470-3751

April 9, 2012

Mr. Brendan Rose
Exchange Project Director/Health Care Policy Analyst
D.C. Department of Insurance, Securities, and Banking
810 First St., NE, Suite 701
Washington, DC 20001

Dear Mr. Rose:

On behalf of CareFirst BlueCross BlueShield, which provides health insurance coverage to nearly 375,000 residents of the District of Columbia, I write to offer comment on the market options to support the successful implementation of the District of Columbia Health Benefits Exchange (DC HBX) presented to the D.C. Health Reform Implementation Committee (HRIC) Insurance Subcommittee on April 2. In addition to earlier policy recommended in our letter dated March 27, we recommend that the DC HBX define a small employer as one with 2 to 50 employees for the years 2014 through 2016.

Larger employers that fall into the 51 to 100 employee definition but have low claims costs would be motivated to explore other coverage options, such as self-insurance or minimizing their risks with stop-loss insurance with a low attachment point or, for those with multiple worksites, purchase group health insurance outside of the District of Columbia. Such actions would undermine the traditional health insurance market by removing from the community pool larger employer groups with the lowest claim costs. For this reason, the District should take the additional two years between 2014 and 2016 to explore how best to merge employers with 2 to 50 employees and those with 51 to 100 employees into the same market in ways that mitigate the risk of adverse selection.

Summarizing the market options the District of Columbia should adopt, CareFirst recommends that the District:

1. Create a Basic Health Plan (BHP) option and make decisions applicable to the Individual market after a final decision has been made on a Basic Health Plan;
2. Maintain separate Individual and Small Group markets at least until 2016 when the District has had an opportunity to understand the impact of the Exchange market environment;
3. Require carriers offering health insurance to small groups off the Exchange to also offer health insurance to the small group market on the Exchange; and
4. Maintain the current definition of a small employer as one with 2 to 50 employees until 2016.

CareFirst BlueCross BlueShield is an independent licensee of the Blue Cross and Blue Shield Association.
® Registered trademark of the Blue Cross and Blue Shield Association. ®' Registered trademark of CareFirst of Maryland, Inc.

Thank you for this opportunity to provide comments on these important issues. CareFirst looks forward to continuing to work with you to ensure the successful implementation of federal health care reform in the District of Columbia.

Sincerely,

Tonya Vidal Kinlow
Vice President of Government Affairs – NCA

cc:

The Honorable Wayne Turnage
Director, D.C. Department of Health Care Finance
Chairman, D.C. Health Reform Implementation Committee

The Honorable William P. White
Commissioner, Department of Insurance, Securities and Banking
Co-chair, D.C. Health Reform Implementation Committee

The Honorable Mohammad N. Akhter, M.D.
Director, D.C. Department of Health.
Co-chair, D.C. Health Reform Implementation Committee

KAISER PERMANENTE®

Mid-Atlantic Permanente Medical Group, P.C.
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc

Commissioner William White
Department of Insurance, Securities and Banking
Washington DC, 20002

April 9, 2012

Re: Comments on Supplemental DISB Questions related to Market Structure

Dear Commissioner White:

Kaiser Permanente appreciates the opportunity to respond to the additional questions that were distributed by Brendan Rose on April 2, 2012. Our initial comment letter dated March 27, 2012 includes comments responsive to questions 1, 2, 3 and 6. In summary, Kaiser believes the District should study the impact of expanding its small group market to employers with up to 100 employees to help mitigate the small size of the District's population; we have enumerated several market rules we think will provide appropriate guardrails for a revised marketplace that includes the Exchanges; and we think the HBX Authority should require insurers to participate in both the individual and small group Exchanges.

Question 4 asks, "Should the HBX Authority set parameters on cost sharing structures to encourage the development of comparable products or should it encourage plans to differentiate their offerings in the insurance marketplace?" Kaiser Permanente believes that this is a critical area where the Authority will need to act to avoid consumer confusion and ensure consumers can make apples-to-apples comparisons. Cost sharing, deductibles, and other strategies can be designed to obscure contractual provisions that are essential to every consumer. This would defeat one of the most central parts of the ACA, the ability of consumers to know and fully understand what they are being offered, and make a meaningful choice of what they think will be best for them. For this reason, we strongly believe the HBX Authority should set parameters related to the cost sharing structures of health plans in the Exchange.

Question 5 asks whether there can be too many options in the insurance marketplace, or too few. The ACA's emphasis on Exchanges demonstrates that Congress thought consumers were not best served by the proliferation of esoteric choices that were difficult to comprehend. For this reason, the bill attempts to standardize benefit packages. Kaiser Permanente believes standardized benefits will allow consumers to more easily compare the cost and value of the benefits offered and prevent issuers from designing benefit packages that build in strategies to avoid high-risk consumers. Too often, "innovation" is a euphemism for "risk avoidance." The ACA acknowledges the incentives in the current market to avoid covering those who need services, and tries to restructure a marketplace around those perverse motivations.

The essential health benefits in the ACA, the metal tiers, and the rules governing the actuarial value of those plans all provide limits on plan design options specifically in order to reduce the number of risk-avoiding strategies insurers can pursue. Kaiser Permanente supports that goal. The Authority should provide for sufficient flexibility in benefit design to allow issuers to effectively manage and administer the required benefits, and focus their competitive energies on quality and price, rather than risk selection. This approach may technically limit the raw number of options available, but the countervailing benefit will be an improved marketplace where the options available to consumers don't come at the cost of limited health care, or the exclusion of those who need health care the most.

Thank-you again for the opportunity to comment on the insurance market structure in the District of Columbia. Feel free to contact me at 301-816-6480 or Laurie.Kuiper@KP.org, if you have any questions or wish to arrange further discussion.

We look forward to working with you in the future on these important issues.

Sincerely,

Laurie G. Kuiper
Senior Director, Government Relations
Kaiser Permanente

2101 East Jefferson Street
Rockville, Maryland 20852

DRAFT

District of Columbia
Request for Comment
April 9, 2012

- **Small group size- 2-50 or 2-100?**

  United Concordia Dental recommends the District limit the SHOP to small groups of 2-50 for 2014-2015 for consistency with most other states. This could reduce confusion for those employers with employees located in multiple worksite locations.

- **DC HBX Insurance Marketplace risk pool- merge the small group and individual pools or keep them separate?**

  There should be two separate exchanges, one for individuals and one for small businesses. Today, there are numerous differences between the options available to individuals versus the options available to small businesses both in terms of product designs and carrier requirements. These markets demonstrate different retention and usage patterns. In 2014, all health policies are guaranteed issue. Individuals will only need to complete an enrollment form to activate coverage. The penalty for non-compliance is so minimal that it may not deter a consumer who wants to game the system by purchasing coverage, obtaining expensive services and then dropping coverage. In contrast, many small businesses have maintained coverage for themselves and employees for many years. Combining the operations and rating pools for individuals and small business into one exchange will create a hidden tax on small businesses.

- **The market structure plans for an initially passive HBX insurance marketplace, however higher standards than the minimum may be implemented (e.g., requiring issuance of bronze plan). What standards should the insurance marketplace consider?**

  United Concordia suggests that the DC HBX utilize its existing market standards to qualify dental carriers for Exchange participation wherever possible, rather than creating new, duplicative or conflicting standards. An example of what may not apply is noted in the recent Exchange Rules from HHS. To the extent that accreditation standards do not exist for stand-alone dental plans, such plans would not have to meet the accreditation timeline standards (§155.1045) of the Federal Exchange rules.

  Standards such as licensure requirements, solvency, market conduct, contract and rate requirements should be considered. A carrier that meets these standards in the District should be eligible to offer dental policies in both the AHBE and SHOP Exchanges. The District has a long history of effectively managing the insurance marketplace and we believe that use of its current market standards will ensure efficiency and continuity in the marketplace and minimize disruptions and unnecessary administrative costs that increase consumers' costs.

  Whatever the minimum standards the District considers it is important to remember that supplemental benefits like dental are unique. The ACA reinforces that dental benefits are different. Standalone dental plans are deemed "excepted benefits" because the delivery and financing systems for dental benefits differ significantly from those of medical benefits. As such, the DC HBX should establish certification standards that are specific to the unique nature of standalone dental plans and should only apply those QHP standards that are relevant to pediatric dental benefits.

With respect to requiring issuance of a bronze plan by QHPs, we recommend that standalone dental should be explicitly exempted from that requirement. Due to the construct of dental benefits, achieving a wide range of actuarial values for the "pediatric oral services" would be difficult. A benefit that mirrors national average employer-based coverage, with 100/80/50 percent coinsurance for diagnostic and preventive, basic, and major dental services respectively, would have an AV of roughly 86 percent. In order to reduce the AV to the Bronze level, significant cost-sharing on the consumer would have to be implemented, putting the benefit plan out of line with industry norms.

- **Should the HBX Authority set parameters on cost sharing structures to encourage the development of comparable products or should it encourage plans to differentiate their offerings in the insurance marketplace?**

  The DC Authority should set parameters on cost sharing structures. In today's marketplace, medical and dental claims are processed separately, most often using different claim systems, even when offered by the same carrier. Therefore, coordinating out-of-pocket limits among medical and dental carriers offering the benefits required for the EHBP for subsidized consumers in the DC HBX should be addressed carefully.

  Several potential methods to split cost-sharing limitations across medical and dental coverage include:

  - Designing "pediatric oral services" in a way that requires no cost-sharing
  - Apportioning the total out-of-pocket maximum between medical and dental
  - Developing individual carrier systems to administer a shared out-of-pocket maximum
  - Setting up the Exchange to serve the function of claims aggregator

  Cost-sharing and out-of-pocket maximum issues will apply only to the AHBE Exchange, not the SHOP Exchange. While ACA exempts dental policies from reductions in out-of-pocket cost-sharing limits, coordination between medical plans and dental plans to eliminate consumer out-of-pocket cost-sharing once consumers reach the standard out-of-pocket maximum should occur.

- **Can there be too many options in the insurance marketplace? Can there be too few?**

  Websites exist today that allow consumers to filter the selections in a user-friendly manner. So we do not believe that there can be too many options. However, limiting consumers to only a few options plans reduces choice, competition, and value in purchasing health insurance. Therefore, all carriers authorized to conduct business in the District who apply to participate should be included in the Exchange.

- **Should the HBX Authority require issuers to participate in both the individual and small group markets?**

  No. Today the individual and small group markets are very different. Many issuers do not currently offer individual plans. As such, issuers have varied degrees of experience in the individual and small group markets and should not be forced to participate in the individual Exchange during the initial years of the Exchange.

UnitedHealthcare
A UnitedHealth Group Company

800 King Farm Boulevard, Suite 600
Rockville, Maryland 20850

April 9, 2012

The Honorable William P. White
HRIC Insurance Subcommittee Chair
and Commissioner of Insurance
D.C. Department of Insurance, Securities and Banking
810 First Street, NE, Suite 701
Washington, DC 20001
Submitted via electronic mail

Dear Commissioner White:

UnitedHealth Group is pleased to provide our comments and feedback on the District Insurance Market Structure under ACA before the District of Columbia Health Reform Implementation Committee Insurance Subcommittee.

UnitedHealth Group believes Exchanges have the potential to be valuable mechanisms to increase access to affordable health insurance. To realize this, we believe that Exchanges should be set up in a manner that develops fair and efficient markets, creates a positive consumer experience, advances consumer choice and innovation, promotes consumer responsibility, and balances national standards with state flexibility. The following responses are a summary of key principles that we believe further these goals. All of these comments and recommendations are based on our experience providing health benefits and service solutions to employers, individuals, and families.

Should the small group size be 2-50 or 2-100?

Under the PPACA, states have the authority to choose to limit small groups to those with 50 or fewer employees for plan years beginning before January 1, 2016. We believe that Exchanges should select 50 employees as the initial size limit for the small group market. The 51+ employer group market is already very competitive and enjoys significant market leverage. Groups over 50 employees typically have the option to self-insure their benefits, and it is reasonable to expect that the lowest cost groups would opt to self-insure and the highest cost groups would find the community rates within the Exchange to be most attractive, making products within the Exchange increasingly more expensive for those small groups electing coverage. Limiting the small group market to groups with fewer than 50 employees will also minimize market disruption and avoid overtaxing Exchanges' administrative systems as they get up and running.

Should the DC Health Benefit Exchange (HBX) Insurance Marketplace risk pool merge the small group and individual pools or keep them separate?

We believe that maintaining separate individual and small group exchanges and markets for rating purposes is important. The individual market generally has a higher risk profile than the small group market, presenting a greater potential for adverse risk selection and inherently higher administrative costs for individual coverage compared to small group coverage. Small groups have different eligibility, enrollment, and general administration needs than individuals, and employers with more than 20 employees generally require a different type of customer support service. A likely result of combining the two markets would be to increase the rates for small groups, which could destabilize the small group market. Maintaining separate risk pools also has the potential to encourage a full spectrum of participating health plans that have core competencies in dealing with the distinctly different exchange populations. States may wish to share exchange information technology infrastructure for the individual and small group exchanges to achieve administrative efficiencies, but the exchanges and markets should remain separate.

The market structure plans for an initially passive HBX insurance marketplace, however higher standards than the minimum may be implemented (e.g., requiring issuance of bronze plan). What standards should the insurance marketplace consider?

Exchanges should enhance competition, promote ongoing innovation, and increase consumer choice, while promoting affordability and access to quality care. To best achieve these goals, we believe that all issuers that meet federal standards for qualified health plans should be permitted to participate in the Exchange. Issuers should have the flexibility to determine which metallic actuarial levels they will offer (beyond the federally required minimum) and the number of plans per metallic level within the Exchange. Burdensome Exchange contracting requirements beyond those specified by Federal law may limit innovation and discourage a broad range of issuers from participating. Additional Exchange contracting criteria will add to issuers' administrative costs and increase premiums both inside and outside the Exchange, since the Affordable Care Act requires that issuers charge the same premium rate for plans offered inside and outside the Exchange.

Should the HBX Authority set parameters on cost sharing structures to encourage the development of comparable products, or should it encourage plans to differentiate their offerings in the insurance marketplace?

Exchanges should encourage benefit flexibility within the actuarial limits, in order to avoid commoditized one-size-fits-all plan designs. Minimizing prescribed benefit plan requirements (beyond the essential health benefits package required by federal law) and levels of coverage will promote innovation and provide the flexibility for issuers to develop plan benefits that consumers both want and can afford.

Participating issuers should be encouraged to differentiate their qualified health plan offerings to appeal to a wide variety of consumers and employers with different needs and preferences, while remaining consistent with federal standards regarding essential health benefits and specified actuarial values. For example, at a particular actuarial plan value (e.g., Silver), some consumers and employers might wish to purchase a high deductible health plan that would be compatible with a health savings account, while others may prefer a plan that offers more first-dollar coverage of pharmacy benefits and lower deductibles. As long as both types of plans are certified as being actuarially equivalent, Exchanges should promote this flexibility to advance consumer choice. Factors for actuarial equivalence should focus on certification by a qualified actuary prepared in compliance with the standards of actuarial practice, state law and regulations, and an appropriate tolerance level for the size of the book of business and fluctuations in trend and utilization.

Can there be too many options in the insurance marketplace? Can there be too few?

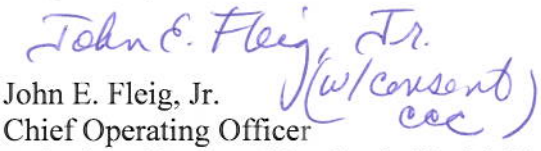
If there are a large number of plans available through the Exchange, they should not be reduced just because there are "too many." Instead, the exchange should employ web search tools that are consumer friendly and help them narrow down the options based on criteria that are important to the individual member and their family. If there are "too few" options, then the Exchange will not be as attractive to potential individual and small group participants. This could limit participation and the success of the Exchange.

Should the HBX Authority require issuers to participate in both the individual and small group markets?

Exchanges should encourage a full spectrum of participating health plans that have core competencies in dealing with the distinctly different exchange populations and not require that issuers participate in both markets.

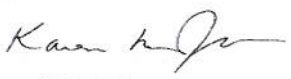
Thank you for the opportunity to provide UnitedHealth Group's perspective on these important Exchange policy considerations. If you have any questions, please do not hesitate to contact me or Colleen Cohan on our Legal & Regulatory Affairs team.

Respectfully submitted,



John E. Fleig, Jr.
Chief Operating Officer
UnitedHealthcare Mid-Atlantic Health Plan

Respectfully submitted,



Karen M. Johnson
Executive Director
UnitedHealthcare Community Plan of District of Columbia

cc: Brendan Rose
Exchange Project Director\Health Care Policy Analyst
DC Department of Insurance, Securities, and Banking

DC Primary Care Association Feedback (Howard Liebers)

DCPCA is supportive of AARP DC and Families USA comments which favor more "active" exchange requirements. The Board should, at a minimum, set standards that ensure deductibles are not so high that they pose a barrier to care and facilitate transitions for people who may move from Medicaid into an Exchange plan (such as continuity of provider networks); as well as provide quality ratings of plans. We agree with AARP DC's statement that if the District proceeds with a passive plan, "Build out a timetable for evaluation, so that the passive structure can be revisited by the Executive Board at a point in the not too distant future." DCPCA recognizes the need to have the "DC HBX insurance marketplace be the sole marketplace in the District for the purchase of individual and small group health insurance plans"; but DCPCA also supports Kaiser's and Families USA statements regarding hybrid option 3 and requirements on Bronze plans.

I would like to stress a few points related to the safety-net primary care providers, which the report and supporting documents touch upon only lightly in the report and in the NAIC content:

- NAIC Adverse Selection Issues #2 p1 { The federal Department of Health and Human Services (HHS) is required under the ACA to develop standards to ensure that there is a sufficient choice of providers and that essential community providers, such as community health centers, are included in an exchange plans' networks.}
- NAIC Section 7 Health Benefit Plan Certification p 8 { The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, etc…}

Marketplace Report Section 8 Potential Adverse Selection, p 81 stresses that the QHP requirement to "Include essential community providers in their provider networks" only applies to plans inside the exchange. However, due to the role and value of essential community providers, as demonstrated in other provisions of the Affordable Care Act, DCPCA believes that this requirement in the District should be extended also to plans outside the exchange. As mentioned earlier, it is important for there to be consistency between provider networks for folks who churn between Medicaid and Exchange plans; in the same there should be consistency of provider networks for individuals who churn between plans inside and outside of the exchange marketplace.

<u>Safety-net Provider Participation in Exchange Plans:</u>

The Affordable Care Act includes a provision that mandates full participation by safety-net providers in Exchange plans, requiring Exchange plans to contract with all safety net providers. Safety net providers are defined in the new law as those eligible to participate in the 340B drug discount program – including all FQHCs and other entities that serve predominately low-income, medically underserved individuals (*and in the District should include any entity that has received funds through the Medical Homes DC Initiative, a joint program of the DC Department of Health and the DC Primary Care Association, which has been expanded access to primary care in medically underserved areas and health professional shortage areas, particularly in communities highlighted in the RAND Corporation report "Assessing Health and Health Care in the District of Columbia"*). This requirement will ensure that as uninsured patients gain coverage through the new insurance Exchanges, the plans covering them will not exclude those low-income communities and individuals most in need of access to care.

Safety-net Provider Payment in Exchange Plans:

The Affordable Care Act aligns health center payment within private insurance plans with reimbursement under the Medicaid program to ensure that Federally Qualified Health Centers (FQHCs) do not lose revenue when they treat patients insured under the new Exchange-based plans. Bipartisan majorities in Congress have widely recognized the importance of the FQHC Medicaid Prospective Payment System (PPS) and have also created a similar payment structure under CHIP. The new health reform law requires that, starting in 2014 when insurance exchanges are operational, health centers receive no less than their Medicaid PPS rate from private insurers offering insurance plans through the new exchange. This requirement applies to all FQHCs (including grantees and non-grantees, also called Look-Alikes). *Here in the District, this should also be expanded to include any entity that has received funds through the Medical Homes DC Initiative.*

Appendix C

Mercer Research and Analysis

MERCER

Current Status of Insurance Coverage in the District of Columbia

The Government of the District of Columbia Department of Health Care Finance

July 26, 2011

Consulting. Outsourcing. Investments.

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1

Executive Summary

The Patient Protection and Affordable Care Act (the ACA) provides funding assistance for the planning and establishment of the American Health Benefit Exchanges (HBEs). 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 (the District) Department of Health Care Finance (the DHCF) to assist them in conducting planning tasks related to the development of the District's HBE. The HBE would include the Individual Exchange (generally referred to here as the 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 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 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 the 2009 calendar year. 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	Stand Dev +/-	Persons	Dist	Stand 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; first, a far larger percentage of the District's workers are employed by the government than are workers from other states, and second, 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, as well as options available to District residents. Insurers will also need to consider these dynamics when deciding whether to participate in the HBEs.

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 Healthcare 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 HealthCare Alliance program (the Alliance) 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 they would be offered it). 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 program (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 HBE will depend on the number of people that use it. In this phase of the project, we have not considered the likely enrollment in an HBE, but we have been able to identify those residents that could be eligible for incentives directing people to the Exchange. 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 Exchange. However, some employers with many low income workers may decide that it makes more sense to have their employees seek coverage through the Exchange. 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 Exchange. Several factors, including potential relationships with their agent or broker, will impact their decision to participate in the SHOP exchange.

Finally, we reviewed existing HBEs (i.e., MA and 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 HBE)
- Financing (i.e., weighing the viability of the HBE 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 HBE 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 HBE. 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 Patient Protection and Affordable Care Act (the ACA) provides funding assistance for the planning and establishment of the American Health Benefit Exchanges (HBE). Under the ACA, each state may elect to set up an HBE that will create a new marketplace for heath insurance. The HBEs will offer consumers a choice of health plan options, oversee the pricing and certification of health plans offering coverage within the HBEs, calculate premium subsidies and provide information to assist consumers in their purchasing decisions.

Mercer Government Human Services Consulting (Mercer) was engaged by the District of Columbia (the District) Department of Health Care Finance (the DHCF) to assist them in conducting planning tasks related to the development of the District's (HBE), which includes the Individual Exchange (generally referred to here as the 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 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 Basic Health Program (BHP), an optional program that the District may elect to set up for individuals with incomes between 138% and 200% of the federal poverty level (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 Exchange, the SHOP 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 HBEs 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 District's Department of Insurance, Securities and Banking (DISB), presentations of the District's estimated uninsured population, reports from the Centers for Medicare and Medicaid Services, data from the United States 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 United States 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 American Community Survey (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 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 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, 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 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 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.

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[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

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

Survey	Uninsured
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 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 the Centers for Medicare and Medicaid Services[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

[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

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 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 (i.e., TANF, SSI), they have no edits for non-traditional enrollees (e.g., those that would qualify for the District's HealthCare 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% of the 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% of 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 HealthCare 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.

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[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

Medical Expenditure Panel Survey (MEPS)

We also used the Agency for Healthcare 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 Program (FEHBP) 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.

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[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.

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 District's HealthCare 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 District's HealthCare 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 Exchange as those with individual policies.

District of Columbia's Rate Filings with the Department of Insurance, Securities, and Banking

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 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 Exchange and the SHOP Exchange 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 percentage of 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 an Exchange and a SHOP Exchange.

The HBEs are intended to provide a robust marketplace where individuals and small employers will be able to shop for health coverage. Additionally, they are expected to provide greater transparency for these purchasers by grouping plans with similar actuarial values and clearly indentified premiums. The viability of these HBEs 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 District's HealthCare Alliance (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% of 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 an Exchange.

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 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	Stand Dev +/-	Persons	Dist	Stand 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 Exchange to substantially affect the coverage for those

[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.

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

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 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 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 PPACA. The provisions on which we put particular weight are the following:

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.

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

[16] Appendix C

In general, these restrictions will have the effect of increasing rates for the young, for males in younger age ranges, 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 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 government 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). Ultimately, the penalty reflects the larger amount. For a single individual earning $25,000 per year (or approximately 225% of FPL in 2009), the penalty would be the following:

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

	2014	2015	2016
Income	$25,000	$25,000	$25,000
Flat Penalty	$95	$325	$695
Percentage	1.0%	2.0%	2.5%
Dollar Amt	$250	$500	$625
Resuling 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% of FPL toward the purchase of a qualified health insurance plan through the Exchange. The government will determine the credits based on the "Silver" plan in the Exchange 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:

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 Exchange 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% of the FPL (133% of 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 District's Healthcare 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 Exchange (if that person is found to be eligible as a result of application for coverage through the Exchange). So, if a person applies for coverage through the Exchange and is found to be Medicaid eligible, the District must have the capacity to enroll them in Medicaid through the Exchange.

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 coverage for those enrollees between 138% and 200% of FPL (or below 133% of 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.

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

5

District of Columbia 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 Exchange. 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 Exchange 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 Exchange. 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).

[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.

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%	-	0%
Total	156,000		327,000	

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% of the FPL, while the District has 57% above 400% of the 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 co-workers, 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, Maryland, 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	-	0%	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	-	0%	-	0%
Total	156,000	100%	327,000	100%

The observation noted above regarding part time and full 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 industry (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	-	0.0%	-	0.0%	-	0.0%	-	0.0%
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)s

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% of 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 District run SHOP Exchange, 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 resident 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 Establisments Offering Coverage	*Employee Contribution*	*% of Total*	*Family Contribution*	*% of Total*
Less than 10	55%	$ 650	11.9%	$ 1,933	13.8%
10 to 24	74%	449	8.6%	3,931	31.2%
25 to 99	87%	1,004	19.8%	5,006	34.2%
100 to 999	100%	886	17.2%	3,046	21.3%
1,000 or more	100%	1,013	20.4%	3,800	26.6%

Nation

	% of Establisments Offering Coverage	*Employee Contribution*	*% of Total*	*Family Contribution*	*% of Total*
Less than 10	34%	$ 752	15%	$ 2,986	24.8%
10 to 24	63%	818	18%	3,767	31.7%
25 to 99	82%	915	20%	4,124	33.4%
100 to 999	94%	988	21%	3,921	30.0%
1,000 or more	99%	1,005	22%	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 than small employers nationwide to offer coverage. 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 District run SHOP exchange than will employees of small employers in other states. However, the ultimate decision of whether to enroll in the SHOP lies with the employer. Or put differently, even if the potential market for the SHOP Exchange is relatively large, the SHOP'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% that do in the District.

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 Empoyees**	**% Cov by Employer**	**Distribution Empoyees**	**% Cov 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%
1000+	45%	66%	48%	63%
SG & LG				
0 to 49	19%	73%	27%	60%
50+	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 District's SHOP Exchange. 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%
% Employees 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 from 2005 to 2009. However, the number of employees per firm has decreased. We expect that the economic downturn has only perpetuated these trends over the period from when 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 do 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 Healthcare 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 (two 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 less 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 Hlth 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	2,403	303.88	199.89	66%
Graphic Arts Benefit Corp	2,907	N/A*	338.89	249.58	74%
Group Hospitalization & Med Srvcs	584,980	3,300	389.07	298.15	77%
Guardian Life Insurance Co	26,116	84	616.18	336.62	55%
Kaiser Fndtn Health Plan Mid Atl	317,801	272	340.03	305.24	90%
Kaiser Permanente Insurance Co	641	69	2,407.80	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				

* 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 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 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.

LARGE GROUP (Excluding FEHBP)

	Member Mo.	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 Fndtn 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 Srvcs	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 a District run exchange, at least initially, for multiple reasons. First, large groups are not eligible to enroll in the exchange. 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 exchange 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 HBEs indicate that coverage for only a sole proprietor would not constitute a group health plan under ERISA 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 Exchange.

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 health plans 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 three percent as a result of required increases in benefits.[22] Finally, 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

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

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

Carrrier A	Carrriers B, C & D	Carrriers 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 plus child or children; and a catch-all “family” category for two-adults plus 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 plus Child and Employee plus Children categories into one. Carriers E and F would need to combine Employee plus Children contracts (currently in the Family tier) with the current Employee plus 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 plus Child contracts and a decrease to rates for the Employee plus 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 Massachusetts law, and we note that in Massachusetts 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 plus Children and Family tiers. (Note, as mentioned above the Employee plus Children tier will need to be combined with the Employee plus 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 to 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 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 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 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 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 HBE. 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 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 HMO, 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 out-of-pocket 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 Carrier 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 out-of-pocket 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; out-of-pocket 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.

Carrier	Ratio Lowest Cost Plan to Highest
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

District of Columbia 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 employer sponsored insurance, 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 Exchange 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; they are 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% of FPL is better classified as a Medicaid enrollee.) As the table shows, the majority of direct purchase enrollees have incomes above 400% of FPL. These people will not have access to tax credits through the Exchange, 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 to1 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 Healthcare 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 Mo.	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 Fndtn 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 Srvcs	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 Healthcare 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 Exchange.

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 per member per month 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 UnitedHealthcare appears to indicate that those policies are sold to AARP members, which could explain the relatively high premium on a per member per month basis. The average premium in the table above is significantly lower than the average premium of $364 per member per month 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 plus child or children; and a catch-all "family" category for two-adults plus 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 to 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 to 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.

Ratio 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 qualified health plan 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 out-of-pocket 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.

Carrier	Ratio Lowest Cost Plan to Highest
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

District of Columbia Low Income Market

The District spent $1.6 billion in fiscal year 2008[23] on providing a robust healthcare 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 (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 Temporary Assistance for Needy Families (TANF) program. In addition to these enrollees, the medically needy, non-citizens, and aged or disabled individuals that receive Supplemental Security Income (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 fee-for-service. The District's programs (including the Healthcare 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 and the District's SCHIP programs 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.

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

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 healthcare 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; they are DC Chartered Health Plan and Unison Health Plan. The District's composition of enrollment across its various Medicaid programs is as follows:

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	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 fee-for-service 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 Census Bureau attempts to correct for a systematic bias of underreported Medicaid participation in the ACS data. Despite these efforts, the 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 that are not District residents that have Alliance coverage. As we understand it, a resident could potentially 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.

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 fiscal year 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% of the 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

[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% of the 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% of FPL.

expanded Medicaid coverage from 100% of FPL to 138% of FPL with a State Plan Amendment in July of 2010. As a result of that action, about 60% of the Alliance members moved into the managed Medicaid program.

Funding from the federal government will supplement the District's costs for these childless adults (under 138% of 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 of Columbia*	*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% of 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 (i.e., retail) and temporary and service firms (i.e., 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 Exchange could also help in this regard.

Approximately half of the uninsured population in D.C. below 200% of 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% of 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 Basic Health Program option. There are a few categories of members in Medicaid that could qualify for a Basic Health Program 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 state 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 Exchange 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

District of Columbia 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

[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% of the FPL.

from an earlier section, a single uninsured individual earning $25,000 per year (or approximately 225% of the FPL in 2009) would incur a penalty equal to the following:

	2014	2015	2016
Income	$25,000	$25,000	$25,000
Flat Penalty	$95	$325	$695
Percentage	1.0%	2.0%	2.5%
Dollar Amt	$250	$500	$625
Resuling Penalty	$250	$500	$695

*Assumes no wage inflation & 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% of the FPL for the purchase of a qualified health insurance plan through the Exchange. The government will ultimately determine the credits based on the premium for the second lowest cost Silver plan in the Exchange 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 is	Final Premium Percentage is
Up to 133%	2.00%	2.00%
133% up to 150%	3.00%	4.00%
150% up to 200%	4.00%	6.30%
200% up to 250%	6.30%	8.05%
250% up to 300%	8.05%	9.50%
300% up 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 per member per month, 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 DC-HIS (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 of Columbia*	*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% of FPL than the rest of the nation; correspondingly, there are a lower percentage of uninsured below 200% of FPL. There are several questions that arise from these distributions. First, what are the characteristics of these residents earning more than 400% of 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% of FPL were enrolled in Medicaid?[26]

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

[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)

Age	FPL 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% of 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 Exchange 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 (retail) as well as professional, scientific and technical industries. There are also large shares of individuals working for temporary and service firms (i.e., in management and administrative services). The following chart shows the distribution of industries for those who are both uninsured and privately employed.

District of Columbia - Uninsured

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 an Exchange, 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% of 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% of FPL. Returning to the table on the previous page, approximately 42% of those without coverage are below 200% of the FPL; these people would seem to qualify for the Alliance program. 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 DC-HIS 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 employer-sponsored health coverage.

[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 Program

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

Tax credits (through the purchase of insurance in the Exchange) are the ACA's basic approach to compel non-Medicaid eligible individuals to maintain coverage when their income is less than 200% of the FPL. There is evidence though that a significant portion of the population under 200% of the 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% of FPL for U.S citizens and below 133% 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

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

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; we identify some of those requirements here:

- 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)
- Coverage must be coordinated with Medicaid and CHIP
- The plan must provide essential 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 Exchange. 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 exchange). 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 exchange (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% of 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% of 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%. This revised cell also reflects some current Medicaid fee-for-service 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% of the 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 District sponsored Exchange 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 an Exchange, but we have been able to identify those residents that could be eligible for incentives designed to direct people to the Exchange.

The following table shows the individuals that could be eligible for subsidies through the Exchange by coverage mode. From the group with ESI, we have removed anyone that is employed by the government; we 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 an Exchange 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% of FPL, assuming that they would receive coverage through Medicaid, the Basic Health Program, or the Healthcare Alliance program. Please note that some people that are not eligible for credits through the exchange 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		
Between 201% and 400%	12,800	820
Greater than 400%	10,500	810
Direct Purchase		
Between 201% and 400%	6,300	570
Greater than 400%	15,700	1,060
ESI		
Between 201% and 400%	48,000	1,240
Greater than 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 Exchange. 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 Exchange. It is important to note that not all of these employees losing coverage would be eligible to enroll in the District's Exchange; 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% of FPL might purchase insurance through the Exchange. If the Exchange provides a more accessible or transparent view of available products, those individuals may decide that the Exchange 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 Exchange. 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 Massachusetts and the District, the Massachusetts' 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 (Massachusetts' equivalent of the SHOP).

In addition, employees with work coverage (who are also eligible for subsidies through the Exchange) will have to decide if coverage through the Exchange is a more affordable option than their employer coverage. These people will base their decision to acquire coverage through the Exchange 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 Exchange.

[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 Exchange. 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 District's Exchange is going to explicitly recognize the effect of a potential presence from the District's largest carrier. Plans considering participation in the Exchange will also consider the size of the potential Exchange market. As the number of subsidy eligible people participating in the market increases, so will the attractiveness of offering plans in the Exchange. 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 Exchange 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 Exchange alongside the larger carriers. Any marketing advantage the larger carriers have would likely be mitigated on the Exchange 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 Exchange.

Some plans may choose not to participate in the Exchange 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 Exchange, not reveal their disadvantages, and compete for enrollees outside of the Exchange. This is particularly true under the scenario where the benefit designs inside the Exchange are standardized. (Requirements around benefit offerings is one of many decisions the District would need to make in designing its Exchange.)

Lastly, carriers may decide not to participate in the Exchange if they are concerned that other costs do not justify the market's potential. For example, if the government requires that benefit designs in the Exchange 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 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 Exchange are only levied against market participants, it raises another barrier to participation in the Exchange.

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 Massachusetts and Utah 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.

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[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)

Early Adopters

Governance

The ACA states, "An Exchange shall be a governmental agency or nonprofit 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.

Nonprofits 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.

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.

[35] 1311(d)(1)

California

California's SB 900 established the California 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 California.

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

Colorado

Colorado's exchange is created as a "nonprofit 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 nonprofit entity to the State.

Maryland

Maryland'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, Maryland 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 nongovernmental, nonprofit 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 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 nonvoting except in the case of a tie), composed of persons with expertise in the Washington State health care system and private and public health care coverage. In addition, there are two nonvoting 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 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 nonpublished 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.

The most feasible options for financing the exchange include assessments on health benefit plans inside the exchange, assessments on all health benefit plans in the individual and small group markets both inside and outside the exchange, 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 exchange through assessments on health benefit plans in the individual and small group markets places the expense with the markets that are to benefit from the existence of the exchange. Still, assessments could be levied on only those plans purchased in the exchange or all plans in a given market both inside and outside the exchange. Charging only those plans inside the exchange may make it more difficult to achieve revenues that meet the operational expenses in the early years when fewer people are enrolled in the exchange. However, given the subsidies are only available through the exchange there may be sufficient

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[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)

enrollment to support the administrative functions, even in the early years. As we discuss later, Massachusetts currently applies surcharges only to plans purchased through the exchange. The majority of the Massachusetts exchange's revenue is derived from the subsidy-eligible population.

Assessing fees on all plans in a given market, both inside and outside the exchange, would likely allow the exchange 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 exchange to operate competitively and efficiently. The exchange 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 exchange, including but not limited to enrollment levels inside and outside the exchange, 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

California's AB 1602 spells out financing of the Exchange. It creates the California Health Trust Fund. The California 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 California Health Benefit Exchange." The Exchange must repay any loans from the authority by June 30, 2016.

The board shall "Assess a charge on the qualified health plans 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 qualified health plans whether offered inside or outside the Exchange.

If, at the end of any fiscal year, the fund has unencumbered funds that exceed the approved operating budget for the next fiscal year, the board shall reduce these charges on qualified health plans during the following fiscal year "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

Colorado'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

Maryland's law establishes the Maryland 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 health benefit plans operating outside the Exchange.

Washington State

By January 1, 2012, the Washington 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 health benefit plans in this state, including health benefit plans 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 health benefit plans 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 health benefit plans 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 West Virginia 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."

Colorado

Colorado'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."

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

Maryland

The Board is permitted to "contract or enter into memoranda of understanding with eligible entities, including the Maryland 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 Washington 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 basic health plan 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

West Virginia'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 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 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.

[39] 1311 and 1312

California

California'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

Maryland's law requires establishment of a SHOP Exchange. It appears at least initially that this will therefore 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 exchange 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, Maryland, 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 Massachusetts which is already operating an exchange and has a

goal to "create health insurance exchange information technology components in Massachusetts 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

Maryland's law requires the Exchange to study and make recommendations regarding "multistate or regional contracting." No additional detail is provided in the legislation. However, since Maryland 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.

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

> Maryland proposes to build off a prototype it has already developed that models the point of access for the Exchange, integration with Maryland legacy systems and the federal portal systems, and Maryland's consumption of planned federal web services (e.g. verification and rules). The technology foundation used by Maryland 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

Washington'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 multistate exchange." As previously noted, the state may enter into information sharing agreements with other state exchanges.

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[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

West Virginia'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 nonprofit 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 Massachusetts, 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]

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[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.

Utah 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] Utah'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 health benefit plans it administers to pay for its expenses.[50] For the Commonwealth Choice program (unsubsidized coverage), the surcharge was 4.5% of premium, until fiscal year 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 fiscal year 2011. In fiscal year 2012, it is estimated that the Connector will collect over $33 million in revenue, with about 77% of

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

[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

it from the Commonwealth Care program.[52] Slightly over $1 million is anticipated to come from federal grant funding. In fiscal year 2011, it is estimated that 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.

Utah's exchange, on the other hand, has a budget of only $600,000.[53] We expect that Utah is currently able to operate on a much lower budget than Massachusetts 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 Massachusetts' 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 Massachusetts 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 Massachusetts, according to the Blue Cross Blue Shield of Massachusetts 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

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[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

[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

- 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 Massachusetts 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.

Merging of Individual and Small Group Markets

Massachusetts' 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 Massachusetts' 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 Massachusetts. It could even have the opposite effect, with premiums for individuals increasing significantly.

Other Lessons Learned

Patty Conner, the director of the Utah 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 Utah 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]

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[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

This lesson was also expressed in Massachusetts. 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 Massachusetts' health care form are:

- Community coalitions
- Faith-based coalitions
- 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.

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

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 DHCF

Date	*First*	*Span*	*Last*			**Calculated with Theoretical Lapse**		
						Lapse Rate	*Persistence*	*Revised First*
Oct-09	11,843	196,436	11,280			0.02	0.78	9,293
Nov-09	10,669	198,271	10,828			0.02	0.80	8,543
Dec-09	10,483	198,520	11,354			0.02	0.82	8,565
Jan-10	10,873	199,374	10,382			0.02	0.83	9,065
Feb-10	9,492	200,082	10,877			0.02	0.85	8,075
Mar-10	11,260	198,155	12,291			0.02	0.87	9,775
Apr-10	12,154	199,532	10,890			0.02	0.89	10,767
May-10	11,218	201,558	10,913			0.02	0.90	10,140
Jun-10	9,549	171,701	43,544			0.02	0.92	8,808
Jul-10	42,660	171,251	12,998			0.02	0.94	40,151
Aug-10	13,222	202,065	12,834			0.02	0.96	12,698
Sep-10	12,975	204,216	11,994	166,398	Cap of new enrollees	0.02	0.98	12,716
Oct-10	11,853	205,479	12,749	229,185	Total Sep-10 spans			
Nov-10	12,429	202,991	15,513	62,787	Fixed enrollees		Total Renew	148,597
Dec-10	15,185	203,333	13,242				Total Fixed	62,787
Jan-11	12,718	207,957	11,595				Total	211,384
Feb-11	11,779	209,447	11,977					
							Total Span	229,185
							Difference	17,801

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 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 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.

District of Columbia

	ACS Data						
	W/out Medicaid Edits		With Medicaid Edits		Urban		
	Persons	Dist	Persons	Dist	Institute*		DHCF/CMS
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%		**Medicare**	57
Medicaid	134	22.3%	156	26.0%		**Medicaid**	200
Dual	27	4.5%	27	4.5%		**Dual**	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; 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	MCAID
1	1	2	1	1	2	2	MCAID
1	1	2	1	2	2	2	MCAID
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	MCAID
1	2	2	1	2	1	2	MCAID
1	2	2	1	2	2	2	MCAID
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	MCAID
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	MCAID
2	2	2	1	2	1	2	MCAID
2	2	2	1	2	2	2	MCAID
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

Board make-up

	California	Colorado	Maryland	West Virginia	Washington
1	Governor appointee	Governor appointee	Secretary of Helath 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 West Virginia 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 Maryland Health Care Commission	Director of the West Virginia 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 West Virginia Health Care Authority (ex officio)*	Governor appointee, representing health consumer advocates
5	Secretary of California Health and Human Services or designee (ex	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 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 various public or private health coverage areas	Governor appointee, representing insurance producers	Governor appointee**
9		Minority Leader of the House of Representatives appointee	Member with knowledge of at least two of various public or private health coverage areas	Representative of the interests of payors (selected by majority vote of an advisory group)	Governor appointed chair, nonvoting except in the case of a tie
10		Executive Director of the Department of Health Care Policy and Financing (ex officio and nonvoting)*		Representative of the interests of providers (selected by majority vote of an advisory group)	Insurance commissioner (ex officio and nonvoting)*
11		Commissioner of Insurance (ex officio and nonvoting)*			Administrator of the health care authority (ex officio and nonvoting)*
12		Director of the Office of Economic Development and International Trade (ex officio and nonvoting)*			

* 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, health benefits plan 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				
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

State	Non-Profit	State	Quasi-State	Reference
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
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 "nonprofit 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 9 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 Washington 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 nonvoting except in the case of a tie. There are also two nonvoting 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.	• West Virginia'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.
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, a 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	• 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 nonpublished 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.		
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 qualified health plans 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 establish 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.	• Maryland law establishes the Maryland 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 health benefit plans operating outside the Exchange.	• By January 1, 2012, the Washington 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 health benefit plans in the state, including health benefit plans sold outside the Exchange. • Fees shall be based on premium volume of the qualified dental plans or health benefit plans 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 West Virginia 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 health benefit plans 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 fiscal year 2011.	• Utah's Exchange has a budget of only $600,000. • Utah 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 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.	• Colorado'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 Maryland 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 Washington 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 basic health plan 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.	• West Virginia'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.		
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."	• Maryland 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."		• Massachusetts' 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.	
Geographic Considerations	• The law does not address multistate 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 multistate or regional contracting. • Maryland is a recipient of an Early Innovator grant. Maryland proposes to build off a prototype it has already developed that models the point of access for the Exchange, integration with Maryland legacy systems and the federal portal systems, and Maryland's consumption of planned federal web services (e.g., verification and rules).	• Washington'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 multistate 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.		

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DISTRICT OF COLUMBIA HEALTH INSURANCE EXCHANGE

MARKETPLACE REPORT

DEPARTMENT OF HEALTH CARE FINANCE

NOVEMBER 23, 2011

Government Human Services Consulting

MARSH & McLENNAN COMPANIES

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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), along with its sister company Oliver Wyman Actuarial Consulting, Inc. (Oliver Wyman) as a subcontractor, 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 Exchanges 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. The results of our work in this area were presented in a report titled "Current Status of Insurance Coverage in the District of Columbia". We provided the final copy of this report to the District on September 28, 2011. The goal of that work was to develop a current picture of the District's population by insurance mode, prior to the impact of major reforms scheduled to begin in 2014. This report focuses on changes that will occur in the District's insurance marketplace in 2014 and later.

For this report, we have relied on many of the same data sources that provided the foundation for our Background Research Report, as well as regulations issued by The United States (US) Department of Health and Human Services (HHS) as of October 26, 2011, the date this report was initially released in draft format. In this report, we relied on information from the US Census Bureau, the American Community Survey, the Medical Expenditure Panel Survey (MEPS), Dun & Bradstreet (D&B), annual statutory financial statements of insurers issuing policies in the District and other sources. Most critically, we also relied on data provided by insurance carriers that participate in the District's current insurance marketplace. This allowed us to calibrate our actuarial models at a granular level, using very detailed, District-specific information on premium rates, benefits, demographics and group composition.

Oliver Wyman's Healthcare Reform Micro-simulation Model (Oliver Wyman's HRM Model) was used to project potential enrollment in a District-run Exchange under four scenarios. The model is comprised of three primary modules. The first module generates a synthetic population made up of individuals, families, employer groups and government programs using the data described above. In addition, a synthetic insurance market is developed. The second module uses the synthetic population to calibrate the model by solving for various model parameters such that the model reproduces the District's current insurance marketplace. The calibration occurs at eight different sub-population levels. Using the simulated population, the solved-for model parameters

and many other economic variables, the third module introduces the changes to the marketplace that will come about as a result of the ACA. In particular, the third module projects the migration of individuals among the various coverage statuses that will be available to them in the post-reform insurance marketplace.

Similar to the Congressional Budget Office's (CBO's) Health Insurance Simulation model, a key underlying assumption of Oliver Wyman's HRM Model is that it assumes decisions related to the purchase of health insurance are made at the Health Insurance Unit (HIU)[1] level, and that the decisions made by these HIUs follow rational choice theory.[2] All options available to the HIU for obtaining health insurance are evaluated (i.e., they select among various insurance options with various premiums and out-of-pocket (OOP) cost sharing, public programs, or chose to remain uninsured), and the option with the highest economic utility is selected. For the group purchasing decision, the model uses a demand elasticity curve. In selecting the elasticity curve, we relied on a review of existing research into price elasticity of the demand for health insurance as published by Mathematica[3] and the CBO's assumptions employed in its own micro-simulation model. Employers are assumed to respond to subsequent increases in premiums by reducing benefits until a Bronze level benefit plan has been reached. Once coverage has been reduced to Bronze level, the model assumes that additional decreases in benefits the employer would like to make are instead shifted to the employee through higher premium contributions. We have assumed that employers drop coverage once they have shifted an additional 10% of the contribution requirements to their employees.

There are several key underlying assumptions of the model that are important for the reader to understand. These include:

- A steady state population is assumed. While the population ages and grows, and incomes increase over time, the underlying mix of the population does not change with respect to most other variables. The distribution of the District's overall population by income, gender, health status, occupation, family size and other variables is assumed to remain relatively constant over the projection period.
- All major carriers participating in the District's individual and small group markets during the base period continue to participate in 2014 and beyond.
- No new carriers enter the market and obtain significant market share.
- All carriers participate in both the inside and outside Exchange markets.

---

[1] A Health Insurance Unit (HIU) is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy.

[2] Rational choice theory is based on the assumption that individuals act as if comparing the costs against the benefits of various choices to arrive at the action that maximizes their personal satisfaction.

[3] "Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature." Mathematica. http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf

- Products offered inside the Individual and SHOP Exchanges are similar to products offered outside the Individual and SHOP Exchanges, and premium rates are the same inside and outside the Exchanges for the same benefit package.
- Individuals currently enrolled in Medicaid, Children's Health Insurance Program (CHIP) and the DC Health Care Alliance Program (Alliance) will remain in those programs.
- Large employers with 101 or more employees are assumed to continue to offer coverage at the same rate they did in 2010.
- Small employers not offering coverage in 2010 will not begin offering coverage in 2014.
- Individuals and families receiving employer sponsored insurance (ESI) coverage through a government employer will not enroll in the Exchange, with the exception of members of Congress and their staff.
- The will be no individuals or small groups with grandfathered policies in 2014.
- Small groups will not self insure. (We note that with the rate shock that will occur in 2014, some groups are likely to self insure.)
- The model does not consider the impact that private exchanges may have on enrollment in the District's Individual and SHOP Exchanges.
- The model assumes undocumented workers are not included in the underlying American Community Survey (AC Survey)[4] data.
- Based on discussion with the District, 50% of all non-subsidy residents enrolling in individual coverage will do so through the Individual Exchange.
- 10% of all District small employers offering coverage will do so through the SHOP Exchange.
- The District will extend its 138% up to 200% of the Federal Poverty Level (FPL) Waiver program (if approved) or establish a Basic Health Program (BHP). As a result, individuals with incomes between 138% up to 200% FPL were not modeled as being eligible to enroll in the Individual Exchange.

Baseline Reform Scenario

To understand how certain design scenarios could impact enrollment and premiums in the District's Individual and SHOP Exchanges, four scenarios identified by the District were modeled. The focus of the modeling is on exchange design scenarios and the sensitivity of results to those scenarios. Our Baseline Reform Scenario assumes separate individual and small group markets are maintained; it also assumes the definition of small group remains at 50 until 2016, at which point it increases to 100. The following table summarizes the modeled enrollment and premium in the Exchange in this Baseline Scenario.

[4] In the Background Research Report, we referred to the American Community Survey as the ACS data. In order to avoid potential confusion with Information Technology vendors with the same acronym that were also reviewed in this project, we are referring to the American Community Survey as the AC Survey going forward.

	Baseline Scenario								
	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	14,500	$4,710	$68,341,000	37,500	$5,440	$204,143,000	52,000	$5,240	$272,484,000
2015	14,000	$4,900	$68,559,000	38,000	$5,620	$213,457,000	52,000	$5,420	$282,016,000
2016	17,500	$5,320	$93,117,000	39,000	$5,980	$233,135,000	56,500	$5,770	$326,252,000
2017	17,000	$5,620	$95,540,000	41,000	$6,470	$265,429,000	58,000	$6,220	$360,969,000
2018	16,750	$5,870	$98,301,000	42,500	$6,880	$292,508,000	59,250	$6,600	$390,809,000

** Covered Lives are rounded to the nearest 250; Annual Average Premium are rounded to the nearest $10; Total Premium are rounded to the nearest $10,000.*

Key observations for calendar year 2014 (as compared to 2010) when employing the assumptions previously described include:

- Enrollment in the District's total individual market is projected to more than triple, from roughly 20,000 members in 2010 to 61,250 members in 2014 (not shown), with 61% of covered individuals enrolled in the Individual Exchange.
- Of the individuals that enroll in the Individual Exchange, 22% will receive premium subsidies.
- Average premium on a per capita basis in the individual market, prior to application of premium subsidies, are projected to increase by 45% from 2013 to 2014. The Essential Health Benefits (EHB) package (i.e., required coverage for EHB and the required increase to an actuarial value of at least 0.60) accounts for roughly 25% of the increase.
- Individual premiums are projected to be 15% higher than small group premiums in 2014. This compares to premiums in the individual market today that are 25% lower than in the small group market.
- Enrollment in the District's small group market is projected to decline by approximately 13% in 2014, with roughly 18% of individuals receiving coverage through their small group employer enrolled in the SHOP Exchange.
- Enrollment in the SHOP Exchange increases by roughly 3,500 members in 2016 when the definition of small group expands to include businesses with up to 100 employees.
- Average premiums on a per capita basis in the small group market are projected to increase by only 6% from 2010 to 2014. This reflects significant rate decreases (averaging 12.2%), which results from carriers' efforts to comply with minimum loss ratio requirements starting in 2011. It also reflects a recent significant rate decrease by one major carrier.
- Enrollment in Medicaid/CHIP (based on coverage up to 200% FPL) is projected to increase by roughly 9,500 lives from 2010 to 2014.
- The uninsured population in 2014 is projected to be roughly half of the 2009 level,[5] decreasing to roughly 21,000 individuals, or approximately 3.5% of the District's population.

[5] The current uninsured rate is based on the 2009 American Community Survey data that was used for the background research. As of the time this analysis was completed, 2010 American Community Survey data was not available to update this statistic.

Underlying this estimate is an underlying assumption that 20% of those currently eligible for Medicaid, but uninsured would enroll by 2014.[6]

Alternate Reform Scenario 1

This scenario assumes that the District elects to define a small group as employers with 50 or fewer eligible employees until 2016, but decides to merge the individual and small group pools into one. Merging these markets would mean that the rates for the individual and small group markets would be based on the combined morbidity of the two pools, which would have the effect of spreading risk across a wider pool of participants and potentially provide greater rate stability for all. Based on information from the Census Bureau, the average morbidity of the two pools is not assumed to be significantly different today (the average morbidity of the current individual pool is roughly 2% lower than the average morbidity of the current small group pool).

	Alternate Reform Scenario 1								
	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	13,750	$4,760	$65,447,000	38,500	$5,210	$200,690,000	52,250	$5,090	$266,137,000
2015	12,750	$5,100	$64,981,000	39,500	$5,410	$213,686,000	52,250	$5,330	$278,667,000
2016	17,250	$5,250	$90,548,000	39,750	$5,780	$229,676,000	57,000	$5,620	$320,224,000
2017	16,750	$5,550	$92,907,000	41,750	$6,250	$260,863,000	58,500	$6,050	$353,770,000
2018	16,250	$5,910	$96,040,000	43,250	$6,650	$287,798,000	59,500	$6,450	$383,838,000

** Covered Lives are rounded to the nearest 250; Annual Average Premium are rounded to the nearest $10; Total Premium are rounded to the nearest $10,000.*

Without a merger, the average morbidity of the individual pool would be roughly 7.3% higher than the average morbidity of the small group pool, after the influx of uninsured into the individual market. Therefore, a merger would provide moderate premium relief to the individual market at a small cost to the small group market. Other key observations from this scenario, relative to the Baseline Scenario, include:

- Premium levels do differ as a result of the market merger; however, the variance is not so extreme that take-up patterns are markedly different.
- Premiums in the individual market are 3.5% lower in 2014 in a merged market, relative to the Baseline Scenario.
- Premiums in the small group markets are 3.6% higher in 2014 in a merged market, relative to the Baseline Scenario.
- Individual market consumers react to the somewhat lower premiums with slightly higher take-up rates than in the Baseline Scenario. Small employers and their employees react to higher premiums with somewhat lower take-up rates.

[6] Note, not all individuals eligible for Medicaid but not currently enrolled are uninsured; many of these individuals currently have ESI coverage.

- The average enrollment in the combined Individual and SHOP Exchanges is not significantly different than under the Baseline Scenario.
- Most of the difference in the results in this scenario relative to the Baseline Scenario is migration from the small group market to the individual market, such that the size of the overall insurance market in the District is relatively the same.

In addition to the direct financial impact that merging the individual and small group pools may have on the rates for each market, there are other considerations when making the decision of whether or not to merge the pools, which are discussed in the report.

Alternate Reform Scenario 2

This scenario assumes that the District elects to define a small group as employers with 100 or fewer eligible employees immediately in 2014, but decides not to merge the individual and small group pools into one. Groups with 51-100 employees are less likely to participate in the SHOP Exchange unless significant administrative savings exist. Without concerted effort to provide either value-added services for larger small employers or significantly lower premiums, the Exchange may not be able to attract those consumers.

Defining small group in the District to include employers with up to 100 employees in 2014 and 2015 may enlarge and strengthen the small group risk pool in the near term, but it does not produce significantly higher levels of Exchange enrollment in the long term. This is because the current 51-100 market is roughly half the size of the current small group market and groups size 51-100 will not be eligible for small business tax credits, which are projected to attract a fair number of small groups.

Projected enrollment and premium in the Exchange under this scenario are presented in the following table. We have assumed that carriers with under 100 employees would not self insure. This is a key assumption that could have a significant impact on the results.

Alternate Reform Scenario 2

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,750	$4,810	$90,095,000	37,500	$5,450	$204,550,000	56,250	$5,240	$294,645,000
2015	18,250	$5,000	$91,309,000	38,000	$5,630	$213,883,000	56,250	$5,430	$305,192,000
2016	18,000	$5,260	$94,769,000	38,500	$6,010	$231,453,000	56,500	$5,770	$326,222,000
2017	17,500	$5,600	$98,018,000	40,500	$6,480	$262,436,000	58,000	$6,210	$360,454,000
2018	17,250	$5,870	$101,316,000	42,000	$6,900	$289,919,000	59,250	$6,600	$391,235,000

** Covered Lives are rounded to the nearest 250; Annual Average Premium are rounded to the nearest $10; Total Premium are rounded to the nearest $10,000.*

Key observations for this scenario, relative to the Baseline Scenario, include:

- An additional 4,250 members are projected to enroll in the SHOP Exchange in 2014 due to inclusion of the 51-100 population in the small group pool.
- The early entrance of the 51-100 life groups into the small group pool slightly increases premiums in the expanded small group market. This increase is due to differences in demographics and benefits of these two sub-populations (the under 50 population and the 51-100 population).
- The early expansion of the small group market has almost no impact on either premiums or enrollment in the individual market.

Given the fact that the District will be required to ultimately change its current definition of small group to 1-100, it may be easier to make the change along with the host of other changes that will occur in 2014. On the other hand, if carriers are allowed to continue rating groups size 51-100 using current methods until 2016, postponing the market merger may limit the number of groups that decide to self insure or drop coverage.

Alternate Reform Scenario 3

This final scenario assumes that the District elects to define a small group as employers with 100 or fewer eligible employees immediately in 2014 and also decides to merge the individual and small group pools into one. Projected enrollment and premiums in the Exchange under this scenario are as follows:

	Alternate Reform Scenario 3								
	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,250	$4,840	$88,313,000	38,500	$5,200	$200,288,500	56,750	$5,090	$288,601,500
2015	17,250	$5,160	$88,941,000	39,500	$5,390	$212,748,500	56,750	$5,320	$301,689,500
2016	17,250	$5,380	$92,728,000	39,750	$5,790	$230,197,500	57,000	$5,670	$322,925,500
2017	16,750	$5,680	$95,205,500	41,750	$6,260	$261,517,000	58,500	$6,100	$356,722,500
2018	16,250	$6,060	$98,467,500	43,250	$6,660	$287,971,500	59,500	$6,490	$386,439,000

** Covered Lives are rounded to the nearest 250; Annual Average Premium are rounded to the nearest $10; Total Premium are rounded to the nearest $10,000.*

The results for this scenario are similar to those of Alternate Scenario 1, because the early expansion of the definition of small group to 100 had little impact on the projected results. However, given the merger in Alternate Scenario 1 had the effect of lowering premiums for the individual market in 2014, merging with a larger small group pool will result in larger decreases for the individual market. Other key observations for this scenario include:

- Premiums in the individual market are expected to be 4.2% lower than under the Baseline Scenario. This compares with only a 3.5% reduction when the individual market is merged with a small group market defined as 2-50 employees.

- Premiums in the expanded small market are expected to be 2.8% higher than for the small group market under the Baseline Scenario or Alternate Scenario 2. This compares with a 3.6% increase when the individual market is merged with a small group market defined as 2-50 employees.
- Total enrollment in the Exchange is relatively the same as under the Baseline Scenario.

Increased Participation in the Exchange

In order to ensure a viable Exchange, sufficient enrollment must be obtained. It will be important that an adequate mix of affordable plan choices be made available within the Exchange in order to incentivize individuals and small groups who are not eligible for subsidies to participate. If broad choices at affordable rates cannot be found, these individuals and small groups will look to additional options made available in the outside market. Premium and cost sharing subsidies will draw many into the Individual Exchange; however, there are no comparable financial incentives to draw small groups into the SHOP Exchange with the exception of small business tax credits, which are temporary and only apply to a small number of groups.

There are several key items we recommend the District consider in planning its Exchange to try to maximize enrollment. These items, which are discussed further in the report, include:

- Attract a sufficient number of carriers
- Ensure a broad selection of product choices
- Ensure easy access to Information
- Engage brokers and agents
- Consider offering value-added services and benefits inside the Exchange

Benefit Levels Permissible Under the ACA

Starting in 2010, all plans sold in the individual and small group markets must meet prescribed actuarial values. The higher the actuarial value, generally the lower point-of-service cost sharing required of the enrollee. There are four levels at which coverage will be permissible. These levels and their corresponding actuarial values are: Platinum (0.90), Gold (0.80), Silver (0.70) and Bronze (0.60). The ACA requires the HHS develop guidelines that provide for a de minimis variation in the actuarial values used in determining the level of coverage of a plan.[7] In addition, carriers will be able to offer a catastrophic plan to individuals under age 30; however, the details of that plan have not yet been released.

Starting with the underlying 2010 cost of coverage in the District, we projected these costs forward to 2014. We then calibrated Oliver Wyman's Benefit Rating Model to this cost and developed benefit design and cost sharing options that would meet each of the actuarial levels permissible under the ACA. A wide range of deductibles, coinsurance, copayments and OOP limit combinations are offered in the market today leading to almost an endless number of

[7] Section 1302(d)(3) of the ACA.

possible benefit combinations. Even with the restricted actuarial values in the future, we anticipate variation in benefit design within each metallic level.

For simplicity and ease of comparison, we developed plans where all services are subject to an overall deductible, coinsurance and OOP maximum. In reality, plans offered will likely include copayment for various services as they do in many cases today. We restricted the deductible and OOP maximum to meet the requirements of the EHB package. The following table presents various benefit offerings anticipated at each metallic level in 2014:

Coverage Level	Deductible	Coinsurance	OOP Max
Platinum	$200	90%	$1,000
	$50	100%	$1,000
Gold	$250	70%	$2,500
	$500	80%	$2,500
	$750	90%	$2,500
Silver	$500	65%	$5,500
	$750	70%	$5,000
	$1,000	80%	$5,950
	$1,500	85%	$3,500
Bronze	$1,500	60%	$6,000
	$2,000	70%	$6,000
	$2,500*	80%	$5,000
	$3,000*	90%	$5,000

*Not available in the Small Group market

Services Beyond Federally Mandated Benefits

According to the ACA, states will be required to cover the cost of any benefits provided by a qualified health plan (QHP) inside the Individual and SHOP Exchanges that are not included in the EHB package. So, for those policies sold inside the Exchange, the District will bear the cost for those benefits mandated by the District that are not included in the EHB package.

The long awaited (and recently released) report from the Institute of Medicine (IOM) did not include recommendations for specific services in the EHB package. Further, the report suggests that HHS should establish its initial draft of the EHB package by May 2012. With this uncertainty around the EHB package, it is not clear which services mandated by the District will be excluded from the EHB. Ultimately, we cannot perform a complete analysis of the potential cost to the District to cover these benefits.

However, we did perform a high level analysis, relying on information from the IOM Report, services explicitly included through the ACA and the frequency of certain mandated benefits

from a report published by the Council for Affordable Health Insurance. Based on this information, there are four current District mandates that have a reasonable chance of not being included in the EHB package. Those mandates, and our estimate of the costs, are:

- Autism: $0.70 per member per month (PMPM) to $1.00 PMPM
- Habilitative services for congenital/genetic defects: $0.20 PMPM
- Hormone replacement therapy: $0.14 PMPM
- Speech and hearing therapy: $0.03 PMPM

These costs total $1.07 PMPM to $1.37 PMPM. In total, these estimates suggest that under the Baseline Scenario the District would have to pay approximately $650,000 to $850,000 in 2014, increasing to $750,000 to $950,000 in 2018, to cover these benefits. This range assumes that the District's other mandated benefits are included in the EHB package. It also assumes that the scope of the District's coverage (e.g., age limits, annual visits, etc.) is consistent between the District and those states for which the estimates were prepared.

Adverse Selection and Options for Mitigation

There are three primary types of adverse selection that have the potential to influence the District's individual and small group health insurance marketplace in the reformed environment that will exist beginning in 2014:

- Adverse selection against the market — If healthier individuals and groups choose not to participate in the fully insured market, either by going uninsured or self insuring.
- Adverse selection against the Exchange — If its design causes the Exchange to be more attractive to higher risk populations while healthier populations stay in the outside market.
- Selection among carriers and products offered inside the Exchange.

Adverse selection against the market is likely to occur as a result of guarantee issue and adjusted community rating (ACR) rules. This could cause groups and individuals to delay purchase of insurance until they need it. Without enough healthy individuals in the risk pool, premiums will be higher. Another potential source of selection against the small group market is self insurance.

Adverse selection against the Exchange could result if the Exchange disproportionately attracts less healthy enrollees than the outside market. This type of environment could discourage carriers from offering coverage through the Exchange, which would reduce consumer choice and threaten the ongoing viability of the Exchange. There are a number of ACA provisions designed to discourage this type of selection, but there remain a number of areas that could contribute to it. Adverse selection against the Exchange can occur as a result of:

- Product offerings designed to attract healthy individuals and offered only outside the Exchanges
- Narrow networks designed to attract healthy individuals outside the Exchanges

- Grandfathered plans outside the Exchanges, which will typically be comprised of healthier individuals, as they will benefit most from pre-ACA rating rules
- Self funded Multiple Employer Welfare Arrangements (MEWAs) outside the Exchange enrolling health groups willing to self insure
- Exchange fees assessed only inside the Exchange
- Employee contributions set at levels such that they will be deemed unaffordable for low-income employees in poor health

Adverse selection can also occur within the Exchange. Greater choice afforded to employees of small groups and individuals will likely result in healthy individuals selecting low-cost Bronze plans and less healthy individuals selecting higher cost Gold and Platinum plans. Given that plans must be priced based on the entire pool of individual or small group business, this type of selection will lead to Bronze plans being over priced for the healthy individuals, but by less than the Gold and Platinum plans are underpriced for the less health individuals.

As noted earlier, the ACA includes a number of provisions designed to discourage adverse selection, but many sources of selection remain. Possible actions the District could take to mitigate these sources of adverse selection include:

- Eliminate the outside market
- Extend some or all QHP requirements to the outside market
- Require carriers to participate in the Exchange
- Require carriers participating only in the outside market to offer Gold and Silver products
- Require carriers participating in the Exchange to offer Bronze products
- Prohibit carriers from establishing affiliates which offer lean plans only outside the Exchange
- Restrict products with narrow networks from being offered only outside the Exchange
- Control the minimum level for specific and aggregate stop-loss
- Take actions to increase enrollment in the Exchange
- Place restrictions on plan designs offered outside the Exchange
- Do not allow employees in the SHOP Exchange to select from all products

The District must decide whether its Exchange will follow an active purchaser model, a passive model of a market organizer/aggregator or a hybrid model, combining some features of each model. An active purchaser model would allow the Exchange to selectively contract with QHPs and potentially impact health care costs, access and quality. As an active purchaser the Exchange may be in a better position to control adverse selection by limiting the products offered and standardizing cost sharing. However, this type of model is very resource intensive and additional costs would be incurred. A passive market organizer model would function more like a clearing house, setting minimum standards for the Exchange. This type of model would likely provide for more consumer choice and less market disruption than the active purchaser model; however, it would not leverage the purchasing power of the Exchange. A hybrid model would allow the Exchange to impose stricter requirements in areas most effective for controlling adverse selection while allowing flexibility and product innovation that could be attractive to new

carriers considering the market, which would be beneficial in markets such as the District which are dominated by only a few carriers.

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, along with its sister company Oliver Wyman as a subcontractor, were engaged by the the DHCF to assist them in conducting planning tasks related to the development of the District's Exchange, which includes the Individual Exchange and the 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. The results of that research, which were presented in a report dated July 26, 2011, serve as the basis for many of the inputs into our actuarial modeling that is the focus of this report.

Oliver Wyman's HRM Model was used to project potential enrollment in a District-run Exchange under four scenarios. A considerable amount of data from various sources was gathered and synthesized to populate the model, which was then calibrated to reproduce the 2010 District population and insurance marketplace, prior to projecting estimated enrollment and premium from 2014 through 2018.

In the remaining sections of this report, we first describe the various data sources that were used in our analysis. We then provide a discussion of key aspects of the ACA that will cause individual and employer behavior changes in the post-2014 market, which are reflected in our modeling. These changes are the result of many aspects of the ACA which will impact access to coverage, benefits covered, and the associated premiums. Next, we describe the methodology upon which our model is based. We describe how the various data sources were synthesized and discuss key underlying assumptions of the model. In the next section we present our results for each of the following four scenarios:

- Baseline Scenario: Small group up to 50 until 2016; separate individual and small group pools
- Alternate Scenario 1: Small group up to 50 until 2016; merged individual and small group pool
- Alternate Scenario 2: Small group up to 100 in 2014; separate individual and small group pools
- Alternate Scenario 3: Small group up to 100 in 2014; merged individual and small group pool

After the presentation of our model, modeling methodology and modeling results, we include two additional sections. The first of these is a discussion of the financial impact to the District of maintaining mandated benefits beyond the EHB. Since the list of EHB has not yet been defined, a detailed analysis of the financial impact of mandated benefits cannot be completed at this time. In our discussions with the District, it was agreed that our analysis would include high level estimates based on assumptions as to which of the current District mandates might be considered EHB. Next, we provide a discussion of potential sources of adverse selection and discuss methods for mitigating these risks. Finally, we discuss various Exchange models and various insurance standards that could be applied to the market outside of the Exchange.

Mercer has prepared these projections exclusively for the District, to estimate the range of the impact of federal Health Care Reform. These estimates were based on draft regulations issued by HHS as of October 26, 2011. Our work 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.

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.) 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 commentary on legal issues and regulations, does not constitute, nor is it, 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 of the attachments is not intended by Mercer to be used, nor can it 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 relied on many of the same data sources that provided the foundation for our Background Research Report, "Current Status of Insurance Coverage in the District of Columbia." We provided the final copy of this report to the District on September 28, 2011. In this report, we relied on information from the Census Bureau, the MEPS, D&B, annual statutory financial statements of insurers issuing policies in the District and other sources. Most critically, we also relied on data provided by insurance carriers that participate in the District's current insurance marketplace. We discuss these data sources below.

Population Data

We relied on various data sources from the United States 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 AC Survey.

Consistent with the Background Research Report, we felt it important that we have one primary data source to provide a demographic characterization of the District's population. 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.

Ultimately, we chose to rely on the AC Survey data (e.g., instead of the Current Population Survey) for several reasons. First, there is a documented bias in most survey data where Medicaid enrollment is substantially lower than administrative counts. The AC Survey applies logical edits to the data to adjust for this 'Medicaid undercount.'[8] Second, the AC Survey questionnaire includes the question: "Is this person CURRENTLY covered by any…health insurance or health coverage plans?"[9] (Emphasis is from the survey). In contrast, the Current Population Survey assesses insured status over an entire year. The first presentation of the question is more consistent with our approach to the model we present in this report, as it examines a population at a point in time. Third, enrollees are legally obligated to respond to the AC Survey, so the response rate is quite high (i.e., 98% in 2009).[10] Fourth, and finally, the AC Survey includes measures that permit the calculation of standard errors from the sample.

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

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

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

As discussed in the Background Research Report, there were inconsistencies between the AC Survey and two external sources. First, the DHCF identified Medicaid enrollment that was higher than the AC Survey. Second, statutory financial statements filed by insurers in the District's market suggest that the AC Survey overstated those residents with individual coverage by approximately 20,000. In the Background Research Report, we identify a number of possible reasons for these inconsistencies.

Although we were unable to fully reconcile these Medicaid enrollment inconsistencies, we did reclassify a number of people in the AC Survey data into Medicaid. Specifically, we moved approximately 19,000 persons identified with individual coverage and household earnings below 200% FPL (or whose income was not identified) into Medicaid.

Medical Expenditure Panel Survey and Dun & Bradstreet

We also used the Agency for Health Care Research and Quality's MEPS Insurance/Employer Component data from 2009 and 2010 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 were available by various employer group sizes. We used the average of the 2009 and 2010 survey results to enhance the credibility.

We also used the D&B employer data to establish distributions of group sizes by major industry classification. These distributions were critical for accurately classifying employees in the District in appropriate pools of groups. In preparing the D&B data, we removed any groups that reflected government employers (either domestic or foreign).

Carrier Data Call

The primary data source for calibrating premium, benefits and other rating factors was provided by carriers, as part of the carrier data call.

With the assistance of the Department of Insurance, Securities and Banking (DISB), we submitted a request for data and received responses from four small group carriers and five individual carriers. Together these carriers provide coverage to approximately 83% of the small group market and 95% of the individual market.

Our request for data focused on those rating elements that the ACA was most likely to affect. Specifically, we requested that carriers provide distributions by enrollment, premium, and claims by the following factors from the 2009 and 2010 experience periods:

- Age/gender/family composition
- Morbidity load
- Group size factor (for small group carriers)
- Industry load (for small group carriers)

Of the carriers that responded, we ultimately received enough information to reconcile the responses to their corresponding financial statements. (We were provided the full collection of information necessary for our reconciliation on September 15, 2011.)

The information provided by the carriers suggested a general consistency of rating practices, with some exceptions. For example, some carriers apply age/gender factors based on the average age of the group, while others calculate a rate for each contract, which they then composite for each group. Similarly, some carriers charge different rates to small groups based on the group's size, while others do not vary their rates by group size.

Finally, some carriers currently apply industry loads based on Standard Industrial Classification factors. In preparing the AC Survey data, we relied on North American Industry Classification System identifiers. In assessing the rate shock from the elimination of industry as a rating factor, we employed a weighted average factor based on the D&B data.

The reader can find additional discussion of adjustments we made to the carrier data in the technical appendix to this report.

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 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.[11] The Supplemental 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 ACA to define small groups up to 50 employees until 2016.[12] The large group employer category includes the Federal Employees Health Benefit Program (FEHBP) and state and local fully insured government programs. Access to the Annual Statutory Financial Statement data was obtained through a subscription service.

[11] Experience for individual plans sold through an association or trust is allocated to the issue state of 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.

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

In comparing various sources of data and following up with insurers regarding discrepancies, it was determined appropriate to make one significant adjustment to the financially reported data for use in this project, relative to that which was reported in the Background Research Report. Roughly 30,000 small group members for Kaiser which were reported in the financial statement as small group reflected a block of trust business that should have been reported as large group, and as a result was not included in the small group modeling.

Carrier Rate Filing Data

In addition to the annual financial statements, we also relied on rate filings to validate the information from the carrier data call. As part of the Background Research, we obtained copies of the most recent rate filings for individual and small group products filed with DISB for the six carriers with the largest market share in the District. These rate filings provided an independent source for the product offerings, premiums and rating structures employed by carriers offering coverage in the individual and small group markets.

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 these data.

4

Key Reform Issues

With the passage of the ACA, there are many changes scheduled to occur within the insurance marketplace in 2014 and beyond, including changes that will impact eligibility criteria, covered benefits, patient cost sharing, premium rates and more. At any point in time, there will be individuals moving in and out of the Exchange and between various coverage statuses (e.g., between small group and uninsured) for a variety of different reasons. This movement will be driven not only by changes in individuals' characteristics (e.g., health status or employment status) and eligibility status for various types of coverage (e.g., Medicaid, Medicare), but also changes in employers' behavior regarding their decision to offer coverage to their employees.

In addition to these traditional drivers, there are many new provisions in the ACA that will impact the demand for health insurance. These include the expansion of Medicaid eligibility, federal premium and cost sharing subsidies inside the Individual Exchange, individual penalties for not taking coverage, employer penalties for not offering coverage, and guarantee issue of coverage in the individual and small group markets, among other things. It is worth noting that the impact of the expansion of Medicaid eligibility will have minimal impact on enrollment in the District given that it has already expanded Medicaid eligibility to 138% FPL through a state plan amendment. In addition, it is important to keep in mind that the employer penalty for not offering coverage does not apply to groups with fewer than 50 employees.

The option for states to establish a BHP for individuals with incomes between 138% and 200% FPL also impacts the potential enrollment in the Individual Exchange. If a BHP is established, individuals in this income range would not be eligible to enroll in the Individual Exchange and receive subsidized insurance coverage. The District currently has in place a 138%-200% FPL Waiver program that will be effective through 2013. We have been directed by the District to assume in our modeling that individuals in this income range would continue to receive this highly subsidized level of coverage in 2014 and beyond, either through a continuation of the Waiver program or through the establishment of a BHP. Therefore, regardless of which of these two options are ultimately elected by the District, in our modeling we have not allowed these individuals to enter the subsidized Exchange population.

Key ACA Provisions

New provisions under the ACA will redesign the landscape of the individual and small group insurance markets in the District. Requirements regarding minimum covered benefits and the standardization of coverage and rating rules will mean significant changes for insurance purchasers and companies issuing health insurance coverage. This section will describe key

provisions of the ACA, almost all of which are directly incorporated into the Oliver Wyman HRM Model, that are likely to impact the District's insurance market, including:

- Rating and issue rules
- Essential benefits package
- Individual mandate
- Employer mandate
- Premium and cost sharing subsidies
- Temporary small business tax credits
- Minimum medical loss ratio (MLR)
- Grandfathering of plans
- Inclusion of high risk pool insureds in the individual market
- Mandated benefits
- Risk adjustment, reinsurance and risk corridors
- New taxes and assessments impacting premiums
- Other key benefit changes required prior to 2014
  - Guarantee issue without pre-existing condition exclusions for children
  - Other changes that were effective September 23, 2010
  - Coverage of women's preventive benefits without cost sharing

Rating and Issue Rules

Currently, each state establishes its own rules regarding how insurance products are issued and rated within the state, subject to some broad federal requirements, such as the guarantee issuance of coverage in the small group market. Beginning in 2014, the ACA establishes a consistent framework of minimum standards for rating and issue rules throughout the country for the individual and small group markets. The ACA defines a "small group employer" as one with up to 100 employees, but provides an option for states to maintain their current definition of a small employer until 2016.

In general, the ACA issue and rating requirements that apply to these markets are designed to encourage access to health insurance for all Americans by removing barriers associated with poor health status. These changes are paired with an individual coverage mandate, which is hoped to prevent healthy risks from fleeing the market in response to the changes, with the intent of ensuring a balanced risk pool. An employer penalty for not offering coverage is also designed to maintain this channel for providing access to coverage.

To start, the ACA requires individual and small group markets to issue insurance products on a "guarantee issue and renewal" basis, which means that applicants cannot be denied coverage due to their health status. For example, individuals without access to ESI coverage, and who currently are unable to purchase insurance in the private market due to their health status, will be able to purchase coverage in 2014 under the new rules. The premiums they will be charged will not reflect the relative level of their own risk, but the overall pool risk. Although small group coverage already meets this standard in all 50 states, as mandated by the Health Insurance

Portability and Accountability Act of 1996 (HIPAA), many states (including the District) currently allow insurers to deny coverage in the individual market. In addition, small groups may be denied coverage today if they do not meet minimum participation or employer contribution requirements.

Second, under the ACA, premium costs may only be determined using ACR rules. ACR limits the number of factors that can be used to set the premium to recognize the expected cost of providing coverage for a particular individual or group. This process, as outlined in the ACA, allows premiums to be adjusted based only on the following risk factors:

- Geographic rating area (based on state requirements)
- Age (no more than a 3:1 ratio across adult age bands within a coverage tier)
- Family composition (single, couple, single parent, family)
- Tobacco use (no more than a 1.5:1 ratio)

The experience of all individual policies, both inside and outside the Individual Exchange, must be pooled together for the purpose of determining premium rates. Likewise, the experience of all small groups inside and outside the SHOP Exchange must be pooled. Premiums will no longer be allowed to vary based on health status or gender. Further, in the small group market premiums will no longer be allowed to vary based on group size or industry. The effect of these changes will be more cross-subsidization in premium levels — younger insureds and those in better health will pay relatively more, so that older insureds, and those in poor health, can pay less. 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 may 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.

These changes to rating and issue rules under the ACA will occur in conjunction with many other reform-related marketplace changes that will occur in 2014, including a shift to minimum required benefits, benefit packages with standardized actuarial values, an individual coverage mandate, and significant premium subsidies for low-income populations. It is possible that new market entrants will introduce fundamental changes in the covered population demographics and risk levels on which premiums are based. Any particular consumer's change in premium will likely reflect the interaction of a host of changes, and will depend on his or her current product choice, age and health status, among other things.

All else being equal, healthier market participants will pay higher premiums than they do today with medical underwriting. Older purchasers in the individual market will continue to pay higher premiums than younger people, but the difference will not be as great as it is today. In the small employer market, the smallest employers will no longer be levied extra charges related to their

size. Marked premium changes such as those expected in 2014 have a high potential to produce short-term churn in the marketplace.

Essential Health Benefits Package

Effective January 1, 2014, all individual and small group policies sold both inside and outside the exchanges must include the EHB package. According to §1302 of the ACA the EHB package is defined to include three components:

- Coverage for all EHB, as defined by the Secretary
- Limits placed on certain cost sharing amounts
- Defined actuarial coverage values

Coverage for Essential Benefits

All policies must include a minimum set of covered services, referred to as EHB. The Secretary of HHS has yet to specify the benefits that will be considered EHB that insurers will be required to cover beginning in 2014. Per federal law, this package must be based on offerings in a "typical employer plan" and include at least the following service categories:

- Ambulatory patient services
- Emergency services
- Hospitalizations
- Laboratory services
- Maternity and newborn care
- Mental health and substance abuse (MHSA) services, including behavioral health treatment
- Pediatric services, including oral and vision care
- Prescription drugs
- Preventive and wellness services and chronic disease management
- Rehabilitative and habilitative services and devices

On October 6, 2011 the IOM released its report on EHB.[13] The report does not define the EHB, but rather recommends a process to help HHS select the benefits that would be included. The report indicates that the package of benefits ultimately selected must strike a balance between enabling access to essential services while at the same time allowing coverage to remain affordable.

Since several of the services included in the list above are not included in many individual policies today (e.g., maternity coverage or prescription drug coverage), the impact of the requirement to include the essential benefits in all individual policies starting in 2014 will be greater to premiums in the individual market than it will be in the small group market.

[13] "Essential Health Benefits: Balancing Coverage and Cost." Institute of Medicine. October 6, 2011.

Cost Sharing Limits

Annual maximums for OOP cost sharing will be subject to thresholds applicable for qualified high deductible health plans (HDHPs).[14] In 2014, small group plans will be prohibited from imposing a deductible greater than $2,000 for self only coverage and $4,000 for any other coverage; this amount will be adjusted annually thereafter. This requirement will likely require some employers to change their plans. Employers that maintain their grandfathered plan status will not be subject to these ACA deductible thresholds.

Actuarial Values

The ACA establishes various "tiers" of health insurance coverage, labeled as Bronze, Silver, Gold and Platinum. These coverage tiers will apply to all products offered in the individual and small group insured markets starting in 2014.[15] They allow for a level of standardization and comparison across products, without imposing a particular cost sharing structure.

The ACA's levels of coverage are defined using the concept of actuarial value. The higher the actuarial value, generally the lower point-of-service cost sharing required of the enrollee. For example, a Gold plan with an actuarial value of 80% would be expected to pay approximately 80% of covered benefits for a standard population. In a Platinum product, the insurer would be expected to pay 90% of covered benefits for that population. Silver and Bronze coverage levels correspond to actuarial values of 70% and 60%, respectively. The actual cost sharing paid by any particular individual enrolled in one of those plans will differ based on his or her specific service usage. Insurers may design a variety of cost sharing structures that produce a particular actuarial value. The ACA requires HHS to develop guidelines that provide for a de minimis variation in the actuarial values used in determining the level of coverage of a plan.[16]

The Congressional Research Service (CRS) characterizes actuarial value as a summary measure of a health plan's benefit generosity.[17] All else being equal, a higher actuarial value is associated with a higher premium, and a lower actuarial value is associated with a lower premium. Given a choice, healthier individuals may choose a lower actuarial value plan with higher OOP cost sharing, reasoning that this choice is cost effective for them and provides the greatest economic utility. Conversely, individuals with greater health needs may be willing to pay a higher monthly premium to have lower direct service costs when they receive care.

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[14] The 2011 levels are $5,950 for single coverage and $11,900 for family coverage.

[15] The ACA also allows insurers to sell catastrophic plans with a lower actuarial value to persons in the individual market who are under the age of 30 or would otherwise be exempt from maintaining coverage because the coverage is unaffordable or enrollment in the available coverage would be a financial hardship.

[16] Section 1302(d)(3) of the ACA.

[17] Hinda Chaiking, Bernadette Fernandez, Mark Newsome, and Chris Peterson. Congressional Research Service. "Private Health Insurance Provisions in the Patient Protection and Affordable Care Act (PPACA)." May 4, 2010.

At this time, there is no federal guidance on the technical details for how the actuarial value should be determined. There are outstanding questions, such as:

- If plans offer benefits beyond the essential benefits, does the extra coverage get reflected in the actuarial value?
- Should network pricing variation factor into the actuarial value calculation?

In addition, as noted in the recent Kaiser Family Foundation report on ACA actuarial values, the results of an actuarial value calculation are quite sensitive to underlying assumptions regarding health care trends, individual claims distribution and enrollee utilization changes associated with cost sharing levels.[18]

Currently, carriers are not yet generally marketing products targeted to these specific actuarial values, as they will in the reformed market. Therefore, in 2014 when only products with these actuarial values will be allowed to be sold in the individual and small group markets, those with non-grandfathered plans will be required to change their benefits. This will mean, for example, that individuals and small groups with a plan having an actuarial value of 0.75 (i.e., 75%) in 2013 will need to, at a minimum, chose between increasing their benefits to a Gold plan with an actuarial value of 0.80 or decreasing their benefits to a Silver plan with an actuarial value of 0.70. As a result, additional premium shock will be introduced into the market. We note again that a de minimis variation around these actuarial values will likely be allowed so the required benefit change may be slightly less than implied by this example.

Individual Mandate

The ACA imposes an individual mandate to encourage healthy populations to stay in the market and balance the risk pool. If the individual mandate is successful in achieving its goal, the impact of the new rating and issue rules will be to further cross-subsidize risk between lower cost and higher cost populations. Beginning in 2014, all non-incarcerated US citizens must maintain minimum essential coverage.[19] Minimum essential coverage is defined as coverage that meets one of the following:

- Coverage under a government sponsored program (e.g., Medicaid, Medicare)
- Coverage under an ESI plan offered in the small or large group market
- Coverage under a plan offered in the individual market
- Coverage under a grandfathered plan
- Coverage under a state risk pool as recognized by HHS

[18] The Henry J. Kaiser Family Foundation, Focus on Health Reform. "*What the Actuarial Values in the Affordable Care Act Mean*." April 2011.

[19] Section 5000A of the ACA.

The ACA imposes a penalty for those individuals who do not maintain minimum essential coverage. The mandate is not universal and provides a penalty exemption for certain low-income individuals who cannot afford coverage (those where the cost of coverage is more than 8% of their income), individuals with a tribal affiliation or exemption due to religious beliefs. Among those who are not exempt, individuals not maintaining coverage will be subject to the following penalties, as outlined in the ACA:

Year	Flat Annual Penalty	Percent of Income Penalty
2014	$95	1.0%
2015	$325	2.0%
2016	$695	2.5%

The penalty is the larger of the flat annual penalty or the percent of income penalty shown in the table above. Children are assessed one half of the annual penalty shown in the table and the flat annual penalty for a family is capped at 300% of the amount shown in the table.

The presence of the mandate is expected to bring more individuals into the market, particularly young, healthy individuals who have not found great economic utility in purchasing health insurance coverage up to this point. The addition of healthier individuals to the risk pool would have a favorable effect on rates and reduce adverse selection. The individual mandate penalty is low in 2014 and will increase until fully implemented in 2016. This may cause take-up rates to be lower during the first few years after 2014.

Employer Mandate

The ACA does not directly require that employers offer health insurance coverage to their employees. However, if they do not offer minimum essential coverage, they will be subject to annual penalties.[20] Employers with less than 50 employees are exempt from the penalty. Employers with 50 or more full-time employees that do not offer minimum essential coverage will pay an annual penalty of $2,000 for every employee, beyond the first thirty, given at least one employee is eligible for and enrolls in subsidized coverage within the Individual Exchange.

Employers with 50 or more full-time employees that do offer coverage will pay a penalty equal to the lesser of $3,000 a year for each employee who is offered coverage but instead enrolls in the Individual Exchange and receives a premium subsidy, and $2,000 per full-time employee. Employees offered coverage by their employer will not be eligible to enroll in the Individual Exchange and receive subsidies as long as coverage offered by the employer has at least a 0.60 actuarial value and the employee is not required to pay more than 9.5% of household income for single coverage.

[20] Section 1513 of the ACA.

Premium and Cost Sharing Subsidies

Beginning in 2014, premium subsidies in the form of advance tax credits will be available to individuals and families with household incomes between 138% and 400% FPL[21, 22] who are eligible to enroll in the Individual Exchange. Those with incomes below 250% FPL will also be eligible for cost sharing subsidies. Individuals with incomes between 138% and 200% will not be eligible for subsidized coverage in the Individual Exchange if the District establishes a BHP. Individual premium and cost sharing subsidies will only be available to individuals that enroll for coverage within the Individual Exchange.

The amount of the premium subsidy will be tied to both the household income and the premium associated with the second lowest cost Silver plan available within the Individual Exchange. The following table shows the maximum premium that an individual or family will be required to pay.

Household Income as a % of FPL	Maximum Premium as a % of Household Income
138% up to 150%	3.00%-4.00%
150% up to 200%	4.00%-6.30%
200% up to 250%	6.30%-8.05%
250% up to 300%	8.05%-9.50%
300% up to 400%	9.50%

After the maximum premium is calculated from the table above, it will be subtracted from the cost of the second lowest Silver plan to determine the subsidy the individual or family is eligible to receive. The individual or family may then “go shopping” with this subsidy and select from any plan available within the Individual Exchange, with the exception of those who are also eligible for cost sharing subsidies and must enroll in a Silver plan to receive them. The net premium paid will be equal to the premium for the plan selected, less the subsidy amount.

Individuals who do not have qualified ESI coverage available to them may enter the Individual Exchange. In order for an employer’s plan to meet the definition of qualified coverage for a given individual it must:

- Provide coverage that has an actuarial value of at least 0.60
- Require employee contributions for single coverage that are not more than 9.5% of household income

[21] The lower FPL limit is 133% in the ACA, however after application of a 5% disregard, this limit essentially becomes 138%.

[22] Modified Adjusted Gross Income (MAGI) will be used to determine the percentage of FPL that a household’s income represents.

If either of the two conditions outlined above are not met, and the employee's household income is less than 400% FPL, the employee may opt out of the employer's plan and is eligible for premium subsidies within the Exchange.

Cost sharing subsidies will also be made available to individuals and families with household incomes below 250% FPL.[23] The purpose of the cost sharing subsidies is to protect lower-income individuals by reducing the total OOP costs required at the point of service. To receive cost sharing subsidies, individuals must enroll in the second lowest cost Silver plan. The reduction in OOP costs essentially increases the actuarial value of the benefits they receive to levels above a Silver plan. The following table shows the enhanced actuarial value of benefits these individual will receive, after the impact of cost sharing subsidies:

Household Income as a % of FPL	Enhanced Actuarial Value of Benefits
138% up to 150%	0.94
150% up to 200%	0.87
200% up to 250%	0.73

The table above shows that after application of the cost sharing subsidies, individuals with incomes between 138% and 150% FPL would essentially receive coverage greater than that provided by a Platinum plan. Those with incomes between 150% and 200% FPL will receive coverage slightly below Platinum benefits, while those with incomes between 200% and 250% will receive coverage that is only slightly enhanced over the standard Silver level. The lower cost sharing levels at the lowest income levels will help smooth the transition as individuals move between Medicaid eligibility and subsidized coverage in the Individual Exchange.

How these cost sharing subsidy reductions would actually filter through the system is complex and somewhat unclear. The ACA entitles low-income exchange enrollees to coverage with the enhanced actuarial values shown above, and it requires QHPs to provide that coverage. The Federal Government will pay insurers directly for the difference between cost sharing under a Silver plan and the lower cost sharing eligible individuals will pay. It is anticipated that an advance payment may be made to insurers based on the population enrolled in their plans that are receiving cost sharing subsidies, with an end of year reconciliation, similar to the process used with the Medicare Part D program. Therefore, these low-income individuals will see the effects of the lower cost sharing up front at the time services are received.

The CBO estimates that 57% of people purchasing coverage in the individual market in 2016 will receive subsidized coverage through the Individual Exchange, and that the average subsidy would result in premiums for these individuals that are 56% to 59% lower than premiums they

[23] Section 1401 of the ACA.

would have paid in the absence of the ACA.[24] This assumption is based on individuals 138% up to 200% FPL enrolling in the Exchange.

Temporary Small Business Tax Credits

The ACA made temporary tax credits available to small employers beginning in 2010. These credits will continue through 2013 at the current levels. The amount of the credit will increase in 2014; however, they may only be claimed for two years after 2014. The credits are designed to encourage small employers to offer coverage for the first time or maintain coverage already in place. In general, the credit is available to small employers that offer qualified coverage and pay at least 50% of the cost for single premiums for their employees.

In order to receive the credit today, an employer must have fewer than 25 full-time workers and an average annual payroll below $50,000. The maximum credit is equal to 35% of the small employer's premium costs (25% for tax-exempt organizations) and available to employers with 10 or fewer full-time employees and an average payroll of $25,000 or less. The amount of the credit phases out gradually as the number of full-time employees increases to 25 and the average annual payroll increases to $50,000.

In 2014, the amount of the credit increases to 50% of the small employer's premium costs (35% for tax-exempt employers). Small employers must enroll in the SHOP Exchange in order to receive these tax credits.

While these credits will undoubtedly reduce the cost of providing coverage for those employers that qualify and apply for the credit, the effect that they will have on small employers offering coverage beyond 2016 is questioned by some. First, as described above, the credits are temporary and may only be claimed for two years after 2014. Second, the employers that are eligible to receive the credits will not be subjected to a financial penalty if they do not offer coverage. Therefore, the incentive to offer coverage in order to avoid a penalty does not exist.

Minimum Medical Loss Ratio

In the individual and small group insurance markets, the ACA requires insurers to spend at least 80% of the premium received on providing health care services or improving those services. Insurers that do not meet that standard must pay rebates to their customers. These requirements became effective January 1, 2011, and are expected to change many insurers' pricing arrangements. A review of 2010 Annual Statutory Financial Statements filed by the primary insurers in the District's individual and small group markets confirms that these new requirements are likely to have premium implications for District consumers in the small group market, in or out of the Exchange, relative to premium levels in the absence of the minimum MLR requirement.

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

While individual carriers achieved an aggregate MLR in 2010 that is likely to meet the federal requirement, after making allowable adjustments for taxes, quality improvement programs and credibility, small group carriers did not. A few of the District's largest small group carriers experienced loss ratios significantly below 80%. This means some carriers would have been required to issue premium refunds in 2010, had the MLR requirement been in effect. We reviewed recent rate filings for these carriers and found that the largest of these small group carriers has recently implemented significant rate decreases. Given 2010 experience was utilized as a basis for our modeling, we needed to ensure this impact of the MLR was reflected.

Grandfathered Plans

The ACA allows health plans that existed on March 23, 2010 to maintain "grandfathered" status. This status means that these plans are exempt from several of the requirements of the ACA and can only make minor changes to their coverage without being subject to all of the ACA requirements. Specifically, with respect to ACA provisions related to the individual and small group markets, grandfathered plans:

- Are not subject to the new rating rules
- Are not subject to essential health benefit package coverage standards
- Are not included in risk pooling for the purposes of premium development
- Are not included in risk adjustment arrangements
- Cannot be offered through the Exchange

To the extent that grandfathered plans represent healthier than average risk, high rates of grandfathering will tend to cause remaining market premiums to be higher than they would be otherwise. This is due to the fact that grandfathered status is most beneficial to young, healthy groups and individuals as it exempts them from many of the ACA changes that would result in premium increases — in many cases significant premium increases. Should extremely high grandfathering rates develop and persist into 2014 and beyond, the size and stability of the market risk pools could be affected. To retain "grandfathered" status, plans cannot:

- Significantly cut or reduce benefits
- Raise coinsurance charges/percentages
- Significantly raise copayment charges (no more than $5, adjusted annually for medical inflation or by a percentage equal to medical inflation plus 15%)
- Significantly raise deductibles (no more than a percentage equal to medical inflation plus 15%)
- Significantly lower employer contributions (no more than 5%)
- Add or tighten an annual limit on what an insurer pays

By 2014, there will likely be fewer grandfathered plans than observed in this first year after ACA passage, but the precise number cannot be known. It is expected that small employers and individuals will be more likely than large employers to make changes in the next few years that cause them to lose grandfathered status. Shortly after ACA passage, the Federal Government

estimated that 70% of small employers might maintain grandfathered status in the first year, dropping to approximately 33% over several years. Individual grandfathered rates were expected to be lower.[25] However, more recent surveys of insurers and employers suggest that this conclusion may not hold. A Hewitt survey found that out of 466 companies — representing 6.9 million employees — almost all (90%) expect to lose grandfathered status by 2014 because of health plan design changes (72%) and/or changes to company premium contribution levels (39%).[26]

Inclusion of High Risk Pool Insureds in the Individual Market

The Pre-existing Condition Insurance Plan (PCIP) is a new temporary high-risk pool that is offered under the ACA. The program was designed to provide coverage to individuals who, due to their health, were denied coverage in the private individual insurance market or are unable to purchase affordable coverage, and are not eligible for coverage through public programs such as Medicaid and Medicare. Applicants may qualify for the PCIP if they have been uninsured for at least six months and have a pre-existing condition or have been denied coverage or excluded coverage for the pre-existing condition by a private insurance company. The PCIP must provide coverage with an actuarial value of at least 0.65 and rates must be 100% of the standard risk rates.

States could elect to run their own program or elect to have HHS operate the program in their states; HHS administers the PCIP in the District. The program will continue until 2014 when these individuals will be eligible to purchase coverage through the Exchange. At that point, it is expected that individuals in the PCIP will enter the individual market. Given these individuals have higher morbidity than those currently covered through the individual market, upward pressure will placed on rates in the individual market as a result.

Mandated Benefits

A health insurance benefit mandate is a state requirement that an insurer cover certain benefits, health care providers, or patient populations on fully insured products in a particular market. Section 1311(d)(3)(b) of the ACA requires states to reimburse enrollees (or health plans on behalf of enrollees) for the cost of any mandates that exceed benefits included in the EHB package. Thus, an important policy consideration for states will include evaluation of their existing mandates as compared to the EHB and estimation of costs associated with any mandates that exceed the EHB. This issue is explored in detail further in Section 7.

[25] See analysis and projections available at http://www.healthcare.gov/news/factsheets/keeping_the_health_plan_you_have_grandfathered.html. Note that these projections were made prior to a rule revision allowing group grandfathered status to be retained despite a change in insurer.

[26] http://www.aon.com/attachments/Employer_Reaction_HC_Reform_GF_SC.pdf

Risk Adjustment, Reinsurance and Risk Corridors

The ACA introduces three new programs for addressing risk that will be introduced into the commercial market in 2014: risk adjustment, reinsurance and risk corridors. The first is a permanent program and the other two are temporary until 2016. These risk-spreading mechanisms are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets.

Risk Adjustment[27]

The risk adjustment program will effectively require plans with healthier participants to make payments to plans with less healthy participants. Risk adjustment will occur among non-grandfathered plans, separately within the individual and small group markets, but across plans sold inside and outside the Exchanges.

Risk adjustment can reduce the incentives for competing plans to avoid issuing policies to individuals with higher health care needs, and may also help stabilize the experience among carriers which can reduce disruption for policyholders. Risk adjustment can help to reduce adverse selection between carriers; however, it cannot reduce adverse selection against the market as a whole. It is important to understand that while risk adjustment can help adjust for differences in spending across carriers, no risk adjustment mechanism can perfectly adjust for the effects of adverse selection and some level of adverse selection against specific carriers will remain.

Temporary Reinsurance Program[28]

For the years 2014 through 2016, states will be required to establish a temporary reinsurance program. The intent of the program is to help stabilize premiums in the individual market for coverage during the first three years after significant reforms take effect, by protecting carriers from very high-cost members entering the market. Initial costs may be higher in the individual market if more high-risk individuals enroll (those that were previously covered under the PCIP or were uninsured) than individuals with average or low risks.

Health insurance issuers and third party administrators of self insured health plans will be required to make payments to the program for each of these three years. Total contributions will total $25 billion over the three years with $10 billion redistributed for 2014, $8 billion redistributed for 2015 and $4 billion redistributed for 2016. The reinsurance program will make payments to issuers that cover high-risk beneficiaries in the individual market (excluding grandfathered plans). The details as to how carriers in the individual Exchange market will be reimbursed for high-risk individuals are still undefined.

[27] Section 1343 of the ACA.

[28] Section 1341 of the ACA.

Temporary Risk Corridors[29]

A temporary, federally administered and funded risk corridor program will be established for the first three years of implementation of the Exchanges (2014-2016). The risk corridor program will protect carriers participating in the Exchanges against the uncertainty of setting rates during the first three years of operation. It will also prevent carriers from receiving significant financial gain. The program will apply to individual and small group plans sold within the Exchange. Payments will be provided to carriers if their cost of benefits (net of payments under the risk adjustment and reinsurance programs) exceed premium collected less administrative costs by more than 3%. If a carrier's cost of benefits is less than premium less administrative costs by more than 3% a carrier will have to make a payment to the program. The payment will be equal to 50% of the amount between 3% and 8% plus 80% of the amount over 8%.

Of these three ACA programs only the temporary reinsurance program is explicitly reflected in the Oliver Wyman HRM model. Theoretically, risk adjustment and risk corridors do not impact aggregate average gross premium rates and would possibly result in a slightly lower risk charge incorporated into the rates. This is because there are no new funds coming into the individual and small group markets from external sources under these programs (either from the Federal Government or from assessments to large employers).[30] Therefore, they involve exchanging premium dollars among the carriers in the individual and small group markets, and we have assumed that this will have no overall impact on premium rates.

New Taxes and Assessments Affecting Premiums

The ACA will impose new taxes and fees on health insurers, brand name pharmaceuticals and medical device manufacturers. Given these new fees will increase the cost of providing coverage, it is more than likely that they will be passed along to consumers in the form of higher premiums, to the extent possible.

Insurer Tax[31]

A non-tax deductible assessment of $8.0 billion will be allocated across the health insurance industry based on net premium written in 2014. This amount will gradually increase to $14.3 billion in 2018, with the amount increasing by at the rate of premium growth thereafter. In May 2011 the Joint Committee on Taxation recognized the likely pass through of this tax to

[29] Section 1342 of the ACA.

[30] The ACA does not specify a specific funding source for any short fall that may occur if the losses for health plans participating in the Exchanges are greater than the gains. General discussions seem to imply that HHS does not anticipate this situation to occur, based upon the experience of Medicare Part D, which also incorporated risk corridors. For Medicare Part D, the gains were materially greater than the losses. Since there is no specific funding source and no specific authorization to provide additional funds if necessary, we are assuming that the only sources for funding the health plans sustaining losses are from the shared gains from the health plans with positive financial results. Therefore, while there may be monies distributed among the health plans within the Exchanges, the average premium will not change.

[31] Section 9010 of the ACA and Section 1406 of the HCERA of 2010.

consumers, estimating premiums would increase between 2.0% and 2.5% as a result of the insurer tax.[32]

Tax on Pharmaceutical Manufacturers[33]

A new fee was imposed on manufacturers and importers of brand name prescriptions beginning in 2011. The cost will be allocated among manufacturers in proportion to drug sales to government programs. Because these fees would not be imposed on prescriptions sold in the private market, the CBO estimates that it would not result in measurably higher premiums in the commercial market.[34] However, it is likely that at least a portion of these tax assessments will be transferred to the private market through higher drug costs.

Tax on Medical Devices[35]

Starting in 2013, the ACA places a 2.9% excise tax on most medical devices (certain devices such as eyeglasses, contact lenses and hearing aids are exempt). In order to avoid this new tax, companies may begin to manufacture more of these devices overseas. The extent to which this happens will impact the increased costs that consumers will see as the net effect of these taxes are passed along to them in the form of higher premiums.

Other Key Benefit Changes Required Prior to 2014

In addition to the changes described above, there are several other aspects of the ACA that that will affect premium rates which go into effect prior to 2014, many of which have already become effective, but are not fully reflected in the 2010 base period experience used for our modeling.

Guarantee Issue Without Pre-existing Conditions Exclusions for Children

Starting September 23, 2010, insurers were no longer able to deny claims for children under 19 years of age related to a pre-existing condition. With the issuance of interim final regulations,[36] the waiver of the pre-existing condition exclusion was expanded to require guarantee issue of coverage for all children younger than age 19. The addition of the guarantee issue requirement materially increases the cost of a policy over the cost of a policy with only a prohibition on the application of exclusions for pre-existing conditions. Given this additional cost will not be mitigated by the individual mandate until 2014, the additional cost associated with covering these children will put immediate upward pressure on premiums, while at the same time expanding coverage opportunities for children with pre-existing conditions.

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[32] Joint Committee on Taxation, letter the Honorable Jon Kyl. May 12, 2011.

[33] Section 9008 of the ACA and Section 1404 of the HCERA of 2010.

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

[35] Section 9009 of the ACA and Section 1405 of the HCERA of 2010.

[36] "Patient Protection and Affordable Care Act; Requirements for Group Health Plans and Health Insurance Issuers Under the Patient Protection and Affordable Care Act Relating to Preexisting Condition Exclusions, Lifetime and Annual Limits, Rescissions, and Patient Protections; Final Rule and Proposed Rule." Issued by HHS on June 28, 2010.

Other Changes Effective September 23, 2010

In addition to requiring health insurers to guarantee issue coverage to children under age 19, there are several other changes that became effective on September 23, 2010. The primary changes that impact premiums in the individual and small group markets are:

- Coverage for preventive services without cost sharing[37]
- Prohibition of lifetime limits on EHB[38]
- Mandatory coverage of adult children up to age 26 (only required for grandfathered groups/policies if the dependent child does not have access to coverage through his/her own employer until 2014)[39]
- Limited annual dollar limits on EHB until 2014 when annual limits are prohibited[40, 41]
- Cost sharing for emergency services out-of-network may not be higher than for services provided in-network[42]

Given the EHB package is not yet defined, insurers were required to make good faith efforts in determining from which services annual and lifetime limits were excluded. All of the items included in the list above increased the cost of providing insurance coverage under a given policy; however, the impact will vary by benefit plan. For example, some plans previously covered preventive services without cost sharing and the cost for this aspect of the ACA would not increase premiums for these policies. In addition, plans with lower actuarial values, and therefore lower premiums, that previously covered preventive services subject to cost sharing saw higher increases in premium as a result of the requirement to remove cost sharing from preventive services than did plans with higher actuarial values.

Coverage of Women's Preventive Benefits Without Cost Sharing

Beginning August 1, 2012, individual and group health plans will be required to cover certain benefits related to women's health and well being, in accordance with HHS guidelines. Specifically, the following services must be covered without cost sharing:

- Annual well-women visits to obtain recommended preventive services, including preconception and prenatal care
- Screening for gestational diabetes
- Human papillomavirus DNA testing every three years for women age 30 and older
- Annual screening for HIV and other sexually transmitted infections

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[37] Section 1001 of the ACA amending Section 2713 of the PHSA.

[38] Section 1001 of the ACA amending Section 2711 of the PHSA and Section 2301 of the HCERA of 2010.

[39] Section 1001 of the ACA amending Section 2714 of the PHSA and Section 2301 of the HCERA of 2010.

[40] Section 1001 of the ACA amending Section 2711 of the PHSA and Section 2301 of the HCERA of 2010.

[41] Grandfathered policies in the individual market are exempt from this restriction.

[42] Section 10101 of the ACA amending Section 2719A(b) of the PHSA.

- Coverage for contraceptives and contraceptive counseling for FDA approved contraceptive methods and sterilization procedures
- Comprehensive lactation support and counseling, and costs of renting breastfeeding equipment
- Screening and counseling for domestic violence

Many of the services in the list above are covered today by most plans, but in many cases are subject to cost sharing. One notable exception is the fact that it is common for policies in the individual market today to exclude coverage for contraceptives. Therefore, the impact of these changes will have greater upward pressure on premiums in the individual market than they will in the group market.

It is also important to consider the fact that in some cases the lack of cost sharing for these services may increase costs by more than the value of any deductibles, coinsurance or copayments that are waived. In addition to increases in utilization that occurs when cost sharing is removed, services may be substituted for other lower cost services that have cost sharing. For example, if tubal ligation is required to be covered with no cost sharing, these services in some cases may be substituted for much lower cost vasectomies. The net effect is a much larger increase on costs.

5

Model Design, Methodology and Assumptions

In this section, we describe the design, methodology and basic assumptions underlying the reform modeling performed for the District. We present a general overview of the model, describing the basic methodology employed. For the interested reader, we have included a technical discussion with additional detail in Appendix A. The modeling was performed using Oliver Wyman's HRM Model. Many aspects of the model are similar to the CBO's and/or The RAND Corporation's simulation models. As will be shown in the next section, the results of our modeling are generally consistent with those from these other models. However, in this work, our model was calibrated to a much more granular level using very detailed, District-specific information on premium rates, benefits, demographics and group composition and not to the higher level, nationwide average information generally used in these other models. As a result, the model captures the many unique characteristics specific to the District.

Model Design and Methodology

The Oliver Wyman HRM Model is comprised of three primary modules. The first module generates a synthetic population made up of individuals, families, employer groups and government programs. The second module uses the synthetic population to calibrate the model by solving for various model parameters, such that the model reproduces the District's current insurance marketplace. Using the simulated population, the solved-for model parameters and many other economic variables, the third module introduces the changes to the marketplace that will come about as a result of the ACA, which are described in the previous section, and projects the migration of individuals among the various coverage statuses that will be available to them in the post-reform insurance marketplace.

Similar to the CBO's model, a key underlying assumption of our model is that it assumes decisions related to the purchase of health insurance are made at the HIU[43] level, and that the decisions made by these HIUs follow rational choice theory.[44] In reality, consumers will not always behave in an economically rational manner, and for this and other reasons, actual results will vary from those produced by our model. All options available to the HIU for obtaining health insurance are evaluated (i.e., they select among various insurance options with various premiums and OOP cost sharing, public programs or chose to remain uninsured), and the option with the highest economic utility is selected. We have chosen to use a utility function consistent

[43] A Health Insurance Unit (HIU) is defined as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy.

[44] Rational choice theory is based on the assumption that individuals act as if comparing the costs against the benefits of various choices to arrive at the action that maximizes their personal satisfaction.

with that used by The RAND Corporation in its model,[45] but have calibrated it to reproduce the District's current insurance marketplace. We chose a utility function over an elasticity function (which postulates that behavior can be modeled on changes to historical prices) given the choices consumers will face in the reformed market are in many cases significantly different from those they have faced in the past.

While the individual purchasing decision will change significantly with the introduction of the Individual Exchange, premium and cost sharing subsidies, ACR, and the individual mandate, the decision from the employer perspective will remain essentially the same. That is, the employer will choose between offering their employees health insurance benefits or higher wages based on price. Therefore, we have based the employer's decision of whether to offer ESI coverage to their employees, and if so at what level, on demand price elasticity theory. In an effort to obtain the strongest assumptions available, we reviewed numerous published sources. In particular, we relied on a review of existing research into price elasticity of the demand for health insurance as published by Mathematica.[46] In addition, we also relied on the CBO's assumptions employed in its micro-simulation model.

A significant portion of the cost of operating any business is related to employee payroll. Therefore, we assume employers view projected increases in payroll as budgeted costs of doing business, and base the elasticity of any insurance purchasing decision on the excess of rate increases they are being asked to pay over the increase in per capita payroll. For example, if the employer is faced with a 7% increase in insurance premiums and per capita payroll is projected to increase at 3%, the impact that the 4% excess cost will have on employer behavior is evaluated using the selected elasticity curve. For each year modeled, the elasticity curve is applied to this excess amount, if any, and the employer chooses to adjust the actuarial value of benefits offered in a manner consistent with the demand elasticity curve. In our modeling, we assume that employers continue to "buy down" benefits until the point at which the actuarial value falls below the minimum level of 0.60 that may be offered in the small group market in 2014 and later, at which point the employer elects to drop coverage. As the results in the following section show, many employers reach this minimum actuarial value in 2014 due to significant rate shock that is introduced by the many changes under the ACA.

Steady State Population

A key underlying assumption of the model is a steady state population. By this we mean that the underlying mix of the population does not change with respect to most variables. Annual increases in income and population growth are included, which also include anticipated changes in the distribution of the population by age to reflect the increasing age of the population as the baby boomers age. However, the distribution of the District's overall population by income,

[45] The utility function utilized by The RAND Corporation was previously justified by research performed by Goldman, Buchanan and Keeler (2000).

[46] "Price and Income Elasticity of the Demand for Health Insurance and Health Care Services: A Critical Review of the Literature." Mathematica. http://www.mathematica-mpr.com/publications/pdfs/priceincome.pdf

gender, health status, occupation, family size and other variables is assumed to remain relatively constant over the projection period. For example, we have not attempted to project rates of employment in 2014, but have assumed that rates of employment in 2014 will be the same as in 2010. This steady state assumption does not mean that the health status or specific individuals will not change over time, only that the overall relative health status by specific subsets of the population (e.g., by FPL and age) do not change. However, as will be described below, as people move between various insured statuses (e.g., small group, individual and uninsured), changes in the average morbidity of those markets will change. Similarly, the family composition of a given household may change, however it is assumed that the overall distribution of the District's population by family composition does not change.

Market Simulation Module

As mentioned above, the first module in the Oliver Wyman HRM Model creates a synthetic population and a synthetic insurance marketplace using a simulation process. The process of simulating this marketplace utilizes a substantial amount of information, including but not limited to information on demographics, income, employment status, health status, availability of ESI, health insurance premiums and eligibility to participate in public programs.

District Residents and Employees

Information from the AC Survey[47] was used as the basis for assigning many of the characteristics to each simulated District resident and employee. Because not all of the individual characteristics needed for the model were included on the AC Survey records, other sources were relied upon for this additional information. For example, while the AC Survey contains information on age, gender, income and current health insurance coverage, it does not capture information on health status. We relied on self-reported data from the Census Bureau's Current Population Survey (CPS) for this information. Through a simulation process, the additional information that was not included on the AC Survey data were synthesized onto the AC Survey records.

Synthetic Employer Groups

In addition to creating the individual District resident and employee population, this module creates synthetic employer groups in order to model the impact that the ACA reforms will have on the rate and level at which employers offer ESI coverage to their employees. By creating synthetic employer groups and placing individual District employees in them, the model more accurately reflects the fact that an individual's access to ESI coverage, and the associated premiums, is dependent upon all members of the group. Further, it recognizes that the employer's decision to offer coverage is based on the characteristics of the entire group.

[47] In the Background Research Report, we referred to the American Community Survey as the ACS data. In order to avoid potential confusion with Information Technology vendors with the same acronym that were also reviewed in this project, we are referring to the American Community Survey as the AC Survey going forward.

Information from D&B was used to determine the current make up of the District's employer market by size and industry. Individuals from the AC Survey were assigned to groups based on their reported state of employment and occupation, and the industry of the employer. This information was blended with employer offering rates, employee eligibility rates and employee take-up rates from the MEPS to determine which groups would be populated with employees that had current ESI coverage. MEPS data reflects variations in these offering and coverage statistics by group size and this variation is reflected in the assignments we make in the model.

The assignment was further controlled to ensure that the number of individuals with ESI coverage through small employers was, in aggregate, consistent with the number of individuals known to have ESI coverage through small employers in 2010 based on an examination of financial statement information for all carriers that wrote small group business in the District. Likewise, the model controls the assignment of individuals within large employers.

Synthetic Health Insurers

Synthetic health insurers are also created within the market simulation module. With the assistance of the DISB, we were able to obtain a significant amount of detailed information related to the groups and individuals covered by private health insurance in the District. As described in Section 3, a data call was issued to the carriers with the largest market share. Enrollment for the subset of carriers providing responses represented 95% of the individual market and 83% of the small group market.

The information gathered included premium, claims, membership and distributions of the amounts by various rating factors including age, gender, underwriting load, group size and industry. In addition, the small group information included a detailed listing with a record for each group insured in 2010. This information, along with information obtained from rate filings, allowed us to create a synthetic rating manual for each carrier. Separate rating manuals were developed for the individual and small group markets. Using this information we were also able to model the changes to the rating manual that are anticipated to occur in 2014 as a result of the change to an ACR methodology, and the corresponding rate shock that each group and individual would observe.

The synthetic rating manuals were then used to develop premiums for each HIU with current coverage in the small group market. Groups were randomly assigned a carrier based on each carrier's market share, and further assigned a benefit plan based on the distribution of benefit plans in force with that carrier in 2010. Base period premiums were then developed using the assigned carrier's rating manual and the demographics and health status of the individuals within the group. Since the model evaluates the option of enrolling in individual coverage for all individuals, regardless of current coverage status (though we considered only non-Medicaid-eligible individuals would be allowed to enroll in individual coverage in 2014 and later), an individual premium was developed for each HIU in a similar manner. As with group coverage, individuals were randomly assigned a carrier based on each carrier's market share, and further assigned a benefit plan based on the distribution of benefit plans in force with that

carrier in 2010. The assigned carrier's rating manual was then used to develop a premium based on the age, gender and health status of the members of the HIU.

Calibration Module

The second module in the Oliver Wyman HRM Model is a calibration module. The purpose of the calibration module is to adjust the underlying parameters of the simulation module and the migration module until they replicate the status quo at various sub-population levels. In calibrating the market simulation module, model parameters are adjusted so that across multiple iterations the results are representative of the 2010 District insurance marketplace. Results are examined to ensure that the simulation produces:

- The appropriate number of individuals with each type of coverage (e.g., Medicaid, small group, individual and uninsured)
- The correct average premiums that were present in the individual and small group markets in 2010
- A distribution of rate shock anticipated to occur in 2014 which is consistent with that anticipated based on the raw carrier data received

If the simulation repeated for several iterations did not produce the desired results, the model parameters were adjusted until the desired results were achieved.

The market migration module will be described in detail in the next section, but in brief it predicts the market into which individuals will enroll, based on an evaluation of the options available to them. To calibrate the market migration module, output from the calibrated market simulation module are input into the market migration module; however, the actual market into which the HIU was enrolled in the base period is temporarily ignored as the goal of the calibration is to have the model reproduce the enrollment choices actually made during the base period. Premiums for ESI coverage (where applicable) and individual coverage are passed from the calibrated market simulation module to the market migration module for each HIU. This process is repeated for each simulated market created by successive iterations of the market simulation module, and the results are aggregated across all simulations. The underlying parameters of the individual utility function employed in the market migration module are adjusted until the current market distribution is replicated across several key sub-populations. The following table lists the sub populations to which the model was calibrated and demonstrates that parameters for the utility function were found such that the market migration module produced base period results consistent with the calibrated simulation module.

	Known Distribution	Migration Module
Uninsured (District Residents) <=200% FPL	17.3%	18.4%
Uninsured (District Residents) 201%-400% FPL	4.6%	4.8%
Uninsured (District Residents) >400% FPL	4.4%	4.6%
Individual (District Residents)	8.8%	9.2%

	Known Distribution	Migration Module
Small Group (District Residents; Work in District)	10.7%	10.5%
Small Group (Non-District Residents; Work In District)	32.8%	32.2%
Mid-group (District Residents; Work in District)	5.8%	5.6%
Mid-group (Non-District Residents; Work in District)	15.5%	14.8%
Total	**100.0%**	**100.0%**

Market Migration Module

The final module in Oliver Wyman's HRM Model is the market migration module. The purpose of the calibrated market migration module is to use the simulated marketplace, along with many other medical and economic input variables and the introduction of the changes that will occur in 2014 and beyond as a result of the ACA, and project the migration of individuals among the various coverage statuses that will be available to them in the post-reform insurance marketplace. Population growth, household incomes for each HIU, and personal claims cost (PCC) for each member of the HIU, are projected forward for each year.

Projected incomes are used to determine the household's Modified Adjusted Gross Income (MAGI), which in turn is used to determine their income as a percentage of projected FPL levels. Once the HIU's income as a percent of FPL is determined, it is used to further determine the HIU's eligibility for Medicaid, CHIP, premium subsidies, cost sharing subsidies and exemption from penalties under the individual mandate.

Using the employer elasticity curve, the small employer decision to offer coverage, and if so at what level, is made. As described above, the employer elasticity curve is applied to the excess of the requested rate increase over the increase in per capita employee wages. In our model, we have characterized an employer's response to increasing premiums by decreasing the benefits that the employer offers in their health plan. For example, an increase in premium might cause an employer to offer a Silver plan instead of a Gold plan.

The employer responds to subsequent increases in premiums this way until the actuarial value of coverage the employer is willing to offer falls below the minimum allowable level in the post reform market of 0.60 (i.e., Bronze level coverage). Once coverage has been reduced to the Bronze level, the model assumes that additional decreases in employer costs are instead shifted to the employee through higher premium contributions. The employer maintains Bronze level coverage and shifts additional costs until the point at which the employee has been asked to contribute an additional 10% of premium beyond the baseline level developed from the MEPS data. As the actuarial value of coverage that the employer is willing to offer falls below this level (i.e., employee contributions would have to increase by more than 10%), the employer makes the decision to no longer offer coverage.

As will be seen in the following section, the shock that is introduced as a result of the change to an ACR methodology in 2014 will be significant. In the first year of implementation, it will increase costs substantially for some employers (beyond our threshold) compelling many of them to drop coverage.

Individual purchasing decisions in the modeled years are based on the calibrated utility function resulting from the calibration module. The utility function is used to evaluate many different purchasing options available to consumers in the reformed market. The model only considers options for which HIUs are eligible. For example, the model does not consider Medicaid as an option for HIUs with high household incomes. Nor does it consider ESI for an HIU where the AC Survey respondent in the HIU is not simulated to work for an employer that currently offers ESI.

The District is unique in that roughly two-thirds of those insured through its private insurance markets are not residents of the District. If these non-resident employees do not have ESI coverage offered to them, or work for an employer that decides to no longer offer ESI coverage, they are essentially dropped from the model. This is because they are not eligible to enroll in public programs or the Individual Exchange within the District, but rather their eligibility for coverage is through their state of residence.

This is important to understand in interpreting the results that are presented in the next section. Nationwide, 94% of workers live in the same state where they work. Therefore, in most states, when an employer with 50 employees drops coverage, almost all of these 50 employees and their dependents will evaluate the option of enrolling in that state's Individual Exchange. However, in the District when an employer with 50 employees decides to no longer offer coverage, only about 17 of these employees and their dependents will be potential candidates for enrollment in the District's Individual Exchange. This means that as District employers drop coverage, the size of the District's total private insurance market will decrease, all else equal. In reality, there is the possibility these workers have a spouse that also works in the District for an employer that offers ESI coverage into which these employees could enroll, which would cause them to remain within the District's insurance marketplace, however the complexity of this scenario is not included in the model.

Key Underlying Assumptions

The previous discussion focused on the underlying framework upon which the model was built. We now turn to a discussion of the key underlying assumptions on which the model was built. We follow this with a discussion of the assumptions that are direct inputs to the model and can be changed to test the sensitivity of the results to the change.

Carrier Participation and Product Offerings in the District's Individual and Small Group Markets

We made the following assumptions regarding carrier participation:

- All major carriers participating in the District's individual and small group markets during the base period continue to participate in 2014 and beyond
- No new carriers enter the market and obtain significant market share
- All carriers participate in both the inside and outside Exchange markets
- Products offered inside the Individual and SHOP Exchanges are similar to products offered outside the Individual and SHOP Exchanges, and premium rates are the same inside and outside the Exchanges for the same benefit package

Individuals Currently Enrolled in Medicaid/CHIP/Alliance

Individuals currently enrolled in the District's Medicaid, CHIP or Alliance programs are not specifically included in our model and are assumed to remain enrolled in these programs in 2014 and beyond. Factors are applied to this set of individuals to reflect general population growth. Individuals who are currently eligible for these programs but are not enrolled are addressed later in this section.

Large Employers Continue to Offer ESI

We have assumed that large employers (defined as those with 101+ employees) continue to offer ESI coverage at the same rate they did in 2010, and we have assumed that employees who are eligible and enroll in this coverage do so at the same rate they do today. Employees who are not eligible to enroll, or those who are eligible to enroll but choose to remain uninsured, are reflected in our modeling. It is assumed that the combination of the employer penalty for not offering qualified coverage, along with the fact that benefits are many times a significant factor for large groups when attracting and retaining employees, will cause large employers to continue to offer coverage through the period over which we have modeled.

Small Employers Not Offering Coverage During the Base Period Do Not Offer Coverage in 2014 and Beyond

The model assumes that small employers that did not offer coverage in 2010 will not begin to offer coverage in 2014. We note that the small employer tax credits were introduced in 2010 and it is assumed that any small employers electing to offer coverage as a result of these credits would have done so in 2010, and as a result are reflected in the base experience used for our modeling. It is true that some employers may have elected not to offer coverage today due to high premiums presented to them, resulting from an employee or dependent with significant health needs, and they will see premiums in the post reform market decrease under the ACR methodology. However, the employees of these employers will also be able to access the Individual Exchange and see these same reductions in premium, in addition to any subsidies for which they may qualify.

To the extent that coverage is newly offered by small employers in 2014 and beyond, the projected enrollment figures we develop in this report may be understated.

Government Workers

If either the primary AC Survey respondent or the spouse is identified as working for the government, and the HIU is identified as currently having ESI coverage, we have assumed that the ESI coverage is provided through a government employer. Our model assumes that these individuals, with the exception of Congressional staff described below, will continue to receive this coverage and will not enroll in the Individual Exchange.

Congressional Staff

Section 1312(d)(3)(D) of the ACA requires that beginning January 1, 2014, Members of Congress and their personal staff may no longer receive coverage through the FEHBP and that these individuals must purchase coverage through a health plan created or offered through an exchange established under the ACA. While for most states the impact of the inflow of these individuals into the state based exchange will be negligible, this may not be the case for the District. First, many of these roughly 5,000 Congressional staffers may live in the District and be eligible to enroll in the District's Individual Exchange. Second, the District's population is much smaller than most states', so the addition of these individuals into the Exchange may represent a measurable impact.

We attempted to identify these individuals, or at a minimum a distribution by state of residency. After an exhaustive Internet search did not provide this information, we contacted the US Office of Personnel Management (OPM). While OPM was ultimately able to provide information on the number of non-postal federal employees who are District residents and enrolled in the FEHBP program, they were not able to provide information for the subset of individuals we were interested in. As a result, these individuals are not included in the modeling results we present and our results are understated by the number of these individuals that ultimately enroll in the District's Individual Exchange.

Grandfathered Policies

As described in Section 4, a recent survey found that out of 466 companies — representing 6.9 million employees — almost all (90%) expect to lose grandfathered status by 2014 because of health plan design changes (72%) and/or changes to company premium contribution levels (39%).[48] Given the limitations on benefit changes that can be made and still maintain grandfathered status and the pressure that the current economic conditions are putting on employers and individuals to limit premium increases, our model assumes that there will be no individual or small group policies with grandfathered status in 2014.

[48] http://www.aon.com/attachments/Employer_Reaction_HC_Reform_GF_SC.pdf

Self Insurance

As previously described, an ACR methodology will have the impact of increasing rates for young, healthy groups and individuals. In some cases these groups will have a financial incentive to self insure their benefits rather than purchase coverage through the fully insured risk pool. The exit of these healthier than average groups from the fully insured small group market could increase the average morbidity of those that remain, and put upward pressure on rates. The impact of this phenomenon is not reflected in the baseline modeling that is the subject of this report.

Private Exchanges

Recently, there has been much discussion about the development of private health exchanges. Wellpoint recently purchased an exchange vendor and Aon Hewitt launched an exchange in April 2011. It is unclear how these private exchanges will compete against the state and federal run ACA exchanges. It is also unclear whether more private exchanges will develop. While a lot is not known about them, we do know that individuals who are subsidy eligible will not be able to enroll in a private exchange and receive Federal premium and cost sharing subsidies. Our model does not consider the impact that these private exchanges may have on the enrollment in the District's Individual or SHOP Exchanges.

Undocumented Individuals

With the introduction of the District's current 138%-200% FPL Waiver programs, all documented individuals in this income range were migrated from the Alliance program to the new Waiver program. Therefore, it is likely that many of those that remain in the Alliance program are undocumented individuals. Undocumented individuals will not be eligible to enroll in the District's Individual Exchange. Our model does not specifically handle these undocumented individuals, as they are not separately identifiable in the AC Survey data. Rather, our modeling assumes that these individuals are not likely to respond to the AC Survey and are therefore not included in the AC Survey data used as a basis to develop the simulated marketplace.

Model Input Assumptions

In addition to the underlying assumptions upon which the model is built, there are numerous inputs and variables that can be adjusted in Oliver Wyman's HRM Model. Changing multiple assumptions at once does not allow one to observe the sensitivity to changes from any one variable. Therefore, in each of the four scenarios presented in the next section the assumptions described below remain constant. This allows the District to understand the sensitivity to changes in only the assumptions that are varied in each scenario (i.e., definition of small group, merging of individual and small group pools). While sensitivity to changes in many of the baseline assumptions listed above and any of the variables listed below may be modeled, additional modeling to test the sensitivity to these other assumptions is outside the scope of this project.

Guarantee Issue

Under ACA, coverage must be offered on a guarantee basis. In our modeling, we do not evaluate certain coverage options for individuals unless they meet eligibility requirements (e.g., meet Medicaid eligibility requirements or work for an employer that offers coverage). However, due to the guarantee issue provision in the ACA, our model does not restrict individuals from evaluating coverage options due to their own health status, nor do the calculated premium rates vary based on their individual health status.

Medical Trend

Based on our own independent analysis, research of analyses performed by other consulting firms, results from the Society of Actuaries' Long Term Healthcare Cost Trends Resource Model,[49] and analysis performed by the CBO, we have selected and employed in our model an annual medical trend rate of 7%.

Targeted Medical Loss Ratios

As discussed in Section 4, health insurers will be required to meet new loss ratio requirements of 80% beginning in 2011 in the individual and small group markets and 85% in the large group market. Our model assumes that insurers will prospectively develop their 2014 premiums based on loss ratio targets consistent with these loss ratios to which they will be held to on a retrospective basis.

ACA Changes Effective September 23, 2010

As described in Section 4, the ACA required several changes to eligibility, coverage and benefits effective on the first policy anniversary date on or after September 23, 2010. Given the base period experience used for our modeling reflects calendar year 2010, only a very small portion these changes are reflected in the experience. We increased the base period experience premiums by 5% in the individual market and 3% in the small group market to reflect the following changes:

- Coverage of dependents up to age 26
- Elimination of cost sharing on preventive services
- Removal of lifetime limits on EHB
- Restriction of annual limits on EHB
- Increase in cost sharing for out-of-network emergency services to in-network levels
- Guarantee issue with no pre-existing condition exclusions for children up to age 19

Benefits and Actuarial Values

In order to model benefits and premiums in 2014 and beyond, we first needed to understand how current District insurance products compare to the ACA coverage tiers. Oliver Wyman actuaries obtained information from the largest carriers in the District. For small group business,

[49] "Modeling Long Term Healthcare Cost Trends." Society of Actuaries. December 2007.

this information contained premium, claims, membership and the various rating factors (e.g., age/gender, group size, industry and underwriting load) assigned to each group in 2010. The actuarial value of the benefit plan underlying each small group's premium was not provided. Using the information obtained, each group's premium was normalized for all rating factors provided, which in effect resulted in normalized premiums that reflected only benefit differences.

In 2010, carriers were not yet designing products targeted to specific actuarial values (as they will in the reformed market); the observed benefit differences did not cluster around specific actuarial value levels. After removing outliers at both extremes, estimates of actuarial values were assigned to the various groups. By examining rate filing information for the carriers included in the data call, we were able to discern the level and approximate actuarial value of the richest plans offered in the market in 2010. We assigned the richest normalized premiums an actuarial value consistent with the actuarial value of the richest plans offered in 2010. Small groups were then pooled into ranges based on their normalized premium, where the average actuarial value of each range was approximately 10% lower than the average actuarial value of the previous range. The following table shows the estimated average actuarial value for each range and the distribution of groups by these actuarial value ranges.

Actuarial Value	Distribution of Groups
0.953	11%
0.854	16%
0.756	22%
0.656	25%
0.547	25%
0.716	**100%**

**Totals do not sum due to rounding*

The table above shows that current product offerings in the small group market appear to be distributed fairly evenly over coverage levels that are comparable to Silver and Bronze coverage, with the average actuarial value of 0.716 being close to Silver coverage. The table also shows that a significant percentage of small groups have coverage today that is likely to fall below Bronze coverage.

We performed a similar analysis for the current individual market. The following table shows that the average actuarial value in the individual market is approximately 12% lower than in the small group market. The average actuarial value of 0.629 is in line with the CBO's estimate that the average actuarial value of individual policies is 0.60 under current law.[50]

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

Actuarial Value	Distribution of Groups
0.950	3%
0.853	5%
0.753	13%
0.653	37%
0.523	43%
0.629	**100%**

**Totals do not sum due to rounding*

The impact of the EHB package will have a significant impact on premiums in the District's individual market. The table above shows that roughly half of the individual plans offered today have an actuarial value below Bronze level coverage. In addition, the average package of services covered in the current individual market is on average leaner than in the small group market. In many cases, the coverage excludes maternity and/or prescription drugs. The CBO estimates that average premiums in the individual market in 2014 will be 27% to 30% higher because of greater coverage requirements. These increases result from the average insurance policy covering a substantially larger share of an enrollee's costs for health care and a wider range of covered benefits as a result of the EHB package.[51] Our modeling indicates that the average impact in the District will result in individual premiums that are roughly 25% higher for these items. We suspect this figure for the District is below the low end of the CBO's range because the District already mandates coverage for MHSA services in the individual market, where as 32 other states do not.[52]

Actuarial values associated with a particular product option can change over time, especially for product options with fixed dollar cost sharing elements such as deductibles or service specific copayments. For example, as the general level of health care expense increases, a given deductible (or copayment) value represents a lower proportion of expected service cost, and thus it will produce a higher actuarial value. The presence of coinsurance can mitigate that leveraging effect, because it moves proportionately with health care expense levels until an OOP maximum is reached. Thus, between 2010 and 2014 when the coverage tiers become effective, a particular product option that is now modeled as Bronze may require cost sharing changes to remain at the Bronze level.

Starting with the underlying 2010 cost of coverage in the District, we projected these costs forward to 2014. We then calibrated Oliver Wyman's Benefit Rating Model to this 2014 cost and developed benefit design and cost sharing options that would meet each of the actuarial levels permissible under the ACA. A wide range of deductibles, coinsurance, copayments and OOP limit combinations are offered in the market today, leading to almost an endless number of

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

[52] http://www.statehealthfacts.org/comparereport.jsp?rep=1&cat=7

possible benefit combinations. Even with the restricted actuarial values in the future, we anticipate variation in benefit design within each metallic level.

For simplicity and ease of comparison, we developed plans where all services are subject to an overall deductible, coinsurance and OOP maximum. In reality, plans offered will likely include copayment for various services as they do in many cases today. We restricted the deductible and OOP maximum to meet the requirements of the EHB package. The following table presents various benefit offerings anticipated at each metallic level in 2014.

Coverage Level	Deductible	Coinsurance	OOP Max
Platinum	$200	90%	$1,000
	$50	100%	$1,000
Gold	$250	70%	$2,500
	$500	80%	$2,500
	$750	90%	$2,500
Silver	$500	65%	$5,500
	$750	70%	$5,000
	$1,000	80%	$5,950
	$1,500	85%	$3,500
Bronze	$1,500	60%	$6,000
	$2,000	70%	$6,000
	$2,500*	80%	$5,000
	$3,000*	90%	$5,000

*Not available in the Small Group market

Coverage for Individuals with Incomes Between 138% and 200% FPL

Based on guidance from the District, we were directed to assume that the District will either continue the current 138% up to 200% FPL Waiver program beyond 2013 or establish a BHP. Therefore, our modeling does not allow individuals with household incomes in this range to enroll in the Individual Exchange and receive premium and cost sharing subsidies.

Coverage for Women's Preventive Services

A 1.5% increase to premiums was applied to reflect the coverage of women's preventive services without cost sharing effective August 1, 2012.

Uninsured Utilization and Pent-up Demand

Individuals without current health insurance do not seek medical services at the same level as those with insurance. The CBO estimates that the uninsured currently use about 60% as much medical care as insured individuals, after taking into consideration differences in age and

morbidity.[53] We have used this assumption in our model and therefore multiply an individual's expected PCC by a factor of 0.60 when evaluating the utility associated with becoming or remaining uninsured.

Because of the fact that individuals who are currently uninsured do not utilize services at the same level as those with insurance, they will have pent-up demand and utilize services at a higher rate during their first year that they are insured. We estimate the impact of pent-up demand will cause the expected claims costs for a newly insured individual, relative to an individual of the same age, gender and health status that has insurance, to be 10% higher in the first year. Therefore, when calculating the utility associated with various purchasing options for an individual that is currently uninsured, the individual's PCC is multiplied by a factor of 1.10 for each health insurance option evaluated. The pent-up demand factor is not included in calculating the utility associated with the person remaining uninsured. If the individual elects to take-up coverage, their expected claims cost in subsequent years is assumed to be the same as the average insured individual of the same age, gender and health status. In other words, the pent-up demand adjustment is removed after the first year of insurance.

Adverse Selection Due to Risk Pool Composition Changes

A critical consideration in premium development is the relative morbidity associated with individuals and small group enrollees that depart the market, as well as new market entrants. To the extent that the risk pool composition changes, those changes will influence premium levels. Some of the factors impacting the average morbidity level of the pools are discussed below.

Residents with Current Individual Insurance Leaving the Pool

Residents currently covered by policies through the District's individual market that experience significant rate shock resulting from the ACR methodology may find it economically beneficial to become uninsured. Given young and healthy individuals will experience the most upward pressure on rates resulting from a shift to an ACR methodology, the exit of these healthy individuals can lead to an increase in the average morbidity of the individual pool.

Residents Currently Uninsured Entering the Pool

Residents who are currently uninsured and were previously denied coverage in the individual market due to their health status will increase the average morbidity of the pool as they enter the individual market under guarantee issue rules. In addition, these individuals will have pent-up demand, as described above, which will put further upward pressure on the anticipated utilization rates of the individual pool.

Participants in the PCIP High Risk Pool

Residents currently enrolled in the PCIP high risk pool will be allowed to enter the District's Individual Exchange in 2014. Given these individuals have average morbidity that is higher than

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

those currently enrolled in the individual market, their entrance will put additional upward pressure on rates. However, as of August 31, 2011, there were only 36 District residents enrolled in the PCIP.[54] As a result, the impact of transitioning these individuals to the Individual Exchange will likely have minimal impact on rates. Therefore, we did not specifically model the migration of these individuals to the District's Individual Exchange and the results presented in the following section do not include these individuals.

Those with Current Employer Sponsored Coverage that Lose Coverage

Individuals with current ESI coverage will have the option to enter the Individual Exchange if their employer terminates coverage. Employers with low-income employees may be more likely to terminate coverage as a result of premium and cost sharing subsidies that will be available to their employees in the Individual Exchange.

Our model assumes that health insurance carriers will anticipate adverse selection associated with the four items discussed above and prospectively price for it, to the extent they are allowed (with the exception that we have not included the PCIP participants as described above). Assumptions for these relative morbidity levels were derived based on iterative testing by applying adverse selection loads to premiums and observing the resulting changes in morbidity of the pool due the new market entrants and exits. As significant enrollment of new market entrants who were previously uninsured bring a pent-up demand for services, as previously described, and the impact of that phenomenon was also included in premium development. We found that the upward pressure on rates in the individual market resulting from this migration was 9.6% in the Baseline Scenario.[55] Therefore, rates in the individual market in 2014 were increased 9.6% in anticipation of this shift in average morbidity. We found no significant change in the risk pool composition of the small group pool in 2014 under the Baseline Scenario.

Increases in the Consumer Price Index

We have used increases in the Consumer Price Index (CPI) consistent with the middle estimate as reported in the 2011 Social Security Trustees Report, Table V.B.1.[56] The following table shows the estimates employed in our modeling for the District.

Year	CPI Estimate
2010	1.6%
2011	1.2%
2012	1.7%
2013	1.9%

[54] http://www.healthcare.gov/news/factsheets/2011/10/pcip10142011a.html

[55] The baseline scenario assumes separate individual and small group risk pools, and a small group definition of 50 employees until 2016.

[56] http://www.ssa.gov/oact/tr/2011/lr5b1.html

Year	CPI Estimate
2014	2.0%
2015	2.0%
2016	2.0%
2017	2.2%
2018	2.6%

Penalties under the Individual Mandate

Penalties for 2014 through 2016 are prescribed in the ACA. The ACA specifies that after 2016, the flat dollar penalty is increased based on the cost of living, with any increase that is not a multiple of $50 rounded to the next lowest multiple of $50. Therefore, using this formula and the increases in CPI outlined above, we project that the penalties under the individual mandate will be as follows and have used these values in our model.

Year	Dollar Penalty	Percentage Penalty
2014	$95	1.00%
2015	$325	2.00%
2016	$695	2.50%
2017	$700	2.50%
2018	$700	2.50%

Increases in Annual Average Wages

We have used increases in the average annual wage from the middle estimate as reported in the 2011 Social Security Trustees Report, Table V.B.1, “Annual Percentage Change in Average Annual Wage in Covered Employment.”[57] The following table shows the estimates employed in our modeling for the District.

Year	Salary Inflation
2010	4.0%
2011	4.1%
2012	4.5%
2013	4.6%
2014	4.2%
2015	3.9%
2016	4.0%

[57] http://www.ssa.gov/oact/tr/2011/lr5b1.html

Year	Salary Inflation
2017	4.0%
2018	4.4%

Premium Subsidies

Premium subsidies consistent with those outlined in the ACA were employed. Our model places individuals into income ranges and applies the same subsidy to all individuals within a given range. This is slightly different from the ACA, in that subsidies at specified income levels are prescribed and subsidies for HIUs are interpolated between these points based on the HIU's actual income. Therefore, we translated the subsidies included in the ACA into an average premium subsidy for each income range used in our model. The income ranges used were selected to coincide with thresholds for eligibility for various public programs, premium subsidies and cost sharing subsidies, and are narrow enough so as not to introduce bias or lack significant specificity. The following table compares the subsidy levels included in the ACA with the income range subsidies employed in our model.

ACA Subsity		Modeled Subsidy	
Federal FPL Percentage	**Maximum Premium Contribution**	**Modeled FPL Range**	**Maximum Premium Contribution**
100%	2.00%	100%-138%	2.50%
133%	3.00%	139%-150%	3.50%
150%	4.00%	151%-200%	5.15%
200%	6.30%	201%-250%	7.18%
250%	8.05%	251%-300%	8.78%
300%	9.50%	301%-350%	9.50%
400%	9.50%	351%-400%	9.50%

Tax Considerations

An employee's premium contributions under an ESI health plan may be purchased with pre-tax dollars. Our model takes this into consideration when applying the utility function for individual purchasing decisions. We estimated District and federal tax rates for various MAGI ranges. We used current tax rates as reported by the Office of the Chief Financial Officer to estimate District tax rates for various MAGI levels.[58] Federal tax rates were modeled using an analysis conducted by the CBO which examined federal tax rates by pre-tax income quintile.[59] We considered Federal Insurance Contributions Act (FICA) taxes at 2010 levels and assume the temporary reduction in the employee's portion of the rate from 6.2% to 4.2% for 2011 will not continue, and

[58] http://www.cfo.dc.gov/cfo/cwp/view,a,1324,q,610984,cfoNav,|33210|.asp

[59] http://www.cbo.gov/publications/collections/tax/2010/AverageFedTaxRates2007.pdf

that 2014 rates will correspond with 2010 rates.[60] We have also considered Medicare taxes at the current 1.45% rate for both employees and employers.

In factoring FICA and Medicare taxes in, we have used both the employee and employer portion, recognizing that the employer paid portion is effectively in the employee's wages. We have also reflected the income cap on which individuals and employers are required to pay FICA taxes, which results in a lower effective rate as income increases. Using this information we developed the following tax rates for various MAGI ranges and employed these estimates in our model.

MAGI	DC Tax Rate	Federal Tax Rate	FICA Tax Rate	Medicare Tax Rate	Total Tax Rate
$0-$10,000	4.00%	1.00%	12.40%	2.90%	20.30%
$10,001-$20,000	4.25%	2.00%	12.40%	2.90%	21.55%
$20,001-$30,000	4.50%	4.00%	12.40%	2.90%	23.80%
$30,001-$40,000	5.00%	6.00%	12.40%	2.90%	26.30%
$40,001-$50,000	5.50%	8.00%	12.40%	2.90%	28.80%
$50,001-$75,000	6.00%	11.00%	12.40%	2.90%	32.30%
$75,001-$100,000	6.25%	14.00%	12.40%	2.90%	35.55%
$100,001-$200,000	6.50%	17.00%	8.83%	2.90%	35.23%
$200,001-$300,000	7.00%	21.00%	5.30%	2.90%	36.20%
$300,001-$350,000	7.50%	25.00%	4.07%	2.90%	39.47%
$350,001-$400,000	8.00%	25.00%	3.53%	2.90%	39.43%
$400,001-$500,000	8.50%	25.00%	2.94%	2.90%	39.34%
$500,001+	8.50%	25.00%	2.65%	2.90%	39.05%

Temporary Reinsurance Program

As described in the previous section, a temporary reinsurance pool will be established for three years (2014 through 2016) to transition into rates the impact of the adverse selection that will occur due to changes in the risk of the population insured in the individual market. The reinsurance program is anticipated to allocate $10 billion to carriers in the individual market in 2014, $6 billion in 2015 and $4 billion in 2016. These payments to carriers in the individual market are anticipated to be roughly 10% of premium in 2014, all else equal, and this reduction will be phased out over the next three years as the level of payments in each subsequent year is reduced. These payments to the individual market will result in assessments against all markets, including the individual market, of about 1% of premium in 2014. The following table shows the annual impact of the reinsurance program on premiums in the individual and small group markets that are built into our model. The 9.1% reduction in the individual market in 2014 is the

[60] http://ssa.gov/pubs/10003.pdf

net of the 10% reduction due to reinsurance payments to the market and a 1% of premium assessment against the individual market.

Year	Individual Market	Small Group Market
2014	-9.1%	1.0%
2015	4.1%	-0.3%
2016	1.9%	-0.2%
2017	3.7%	-0.4%

Take-up of Medicaid Coverage among Those Eligible but Not Enrolled

As with most states, there are residents of the District that are eligible for Medicaid but not enrolled today. However, the Background Research Report demonstrated that the percent of the District's population that falls into this category is lower than nationwide. There are many possible reasons why these individuals may choose not to enroll in Medicaid. Some may make this election based on the fact that they are healthy and do not currently need services, knowing they can enroll when they do. A US Government Accountability Office study found that many do not enroll because of the perceived stigma associated with filing for public assistance.[61] The same study reported that some individuals found completing the application and gathering the required documentation to be burdensome.

With a "single front door" integrated approach to the exchanges and Medicaid, some of the stigma associated with enrolling in Medicaid today may be reduced. In addition, the navigators and their mission to educate consumers, raise awareness of the exchanges, and facilitate enrollment may also increase the number of these individuals that enroll in Medicaid. The District has also informed us that additional outreach to this segment of the population is already underway. For these reasons, we have included in our modeling the assumption that 20% of the individuals currently eligible for Medicaid, but not enrolled, will enroll by 2014. An additional 5% are assumed to enroll by 2015 and another 5% by 2016.

Participation in the Individual Exchange

Premium and cost sharing subsidies will only be made available within the Individual Exchange. Therefore, individuals qualifying for subsidies will have strong financial incentives to purchase coverage through the exchange rather than in the outside market. Our model assumes that individuals eligible for premium and cost sharing subsidies will not enroll in the outside market.

Lower participation in the Individual Exchange is assumed among HIUs with incomes in excess of 400% FPL. A recent Kaiser survey of people with individual insurance found that 36% purchased their coverage with the use of an insurance broker.[62] Roughly three-quarters of the

[61] http://archive.gao.gov/t2pbat4/150626.pdf

[62] http:/www.kff.org/kaiserpolls/upload/8077-R.pdf

remaining individuals purchased coverage directly from the insurance company while only one-quarter, or 13%, purchased coverage through the Internet. We note that the survey did not report these statistics separately by income range. A recent Pew Research study found that those with incomes over $40,000 are twice as likely to consider themselves high-access Internet users as compared to those with incomes under $40,000.[63] Therefore, we estimate that the rate at which individuals with incomes over 400% FPL purchase coverage over the Internet today is at least twice the average 13% figure reflected in the Kaiser survey.

Once the Individual Exchange is up and running in 2014, there will be even more exposure to on-line purchasing of insurance than there is today. National attention given to exchanges as an alternate vehicle for purchasing insurance is sure to increase the rate at which this method of purchase is used today. In addition, the navigator's role in conducting public education and raising awareness of the availability of QHPs will also increase awareness. Additional advertising and outreach by the District can work to increase the awareness even more. Based on the research above and our discussions with the District about planned efforts to make the public aware of the Individual Exchange, we have assumed in our modeling that 50% of the individuals with incomes over 400% FPL that purchase coverage in the individual market will do so through the District's Individual Exchange.

Participation in the SHOP Exchange

Small groups that are eligible for the temporary small business tax credits must enroll in the SHOP Exchange in order to receive those credits beginning in 2014. Therefore, our model assumes that for any small employer that is both eligible for the tax credits and is modeled as offering coverage will enroll in the SHOP Exchange. Once the temporary tax credit program expires, these small employers will need to decide whether they can afford to continue to offer coverage. Given that premium rates must be the same inside and outside the SHOP Exchange for the same benefits, we think it is unlikely that employers will not have access to plans with significantly lower benefits or premiums in the outside market. Therefore, our model assumes that if these employers continue to offer coverage beyond 2016, they will continue to do so within the SHOP Exchange.

Among employers that do not qualify for the tax credits, enrollment in the SHOP Exchange is projected to be much lower. Given the exchanges created under the ACA are new, there is no empirical evidence upon which to base an assumption related to employer participation. An examination of enrollment by small employers in the Massachusetts Connector, the Utah Health Exchange, and HealthPass New York reveal that significantly less than 10% of the small groups are enrolled.[64] While these "exchanges" are different from the District's planned SHOP Exchange that will be established under the ACA, they do provide a starting point for setting enrollment estimates.

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[63] http://www.pewinternet.org/~/media//Files/Reports/2007/Pew_UI_LibrariesReport.pdf.pdf

[64] http://www.smallbusinessmajority.org/reports/shop_exchange.pdf

One feature of the District's SHOP Exchange that could lead to higher enrollment is the fact that employers must be offered the option of selecting a metallic level, and then allowing employees to select among the various plan choices available at that level. This option is not required in the outside market and may result in attracting employers into the SHOP Exchange. We have assumed in our modeling that 10% of small employers that offer coverage and do not qualify for the small business tax credit will enroll in the District's SHOP Exchange. This assumption is higher than the enrollment levels observed by existing exchanges and reflects the fact that the employee choice option is expected to draw in some employers. We note this assumption is consistent with those employed by other states in similar modeling that we have reviewed. At the same time, these other states recognize the need to explore options to increase enrollment, such as strong outreach to insurers and employers, broker engagement, and the value-added benefits and services that can be offered through the SHOP Exchange.

Insurer Tax

As described in Section 4, a new insurer tax equal to $8 billion in 2014 and increasing to $14 billion in 2018 will be allocated across all insurers based on net premiums written. Our analysis indicates that the value of this new tax as a percent of premium will be as follows, and we have incorporated these increases into the projected premiums in both the individual and small group markets:

Year	Insurer Tax as a % of Premium
2014	2.10%
2015	2.70%
2016	2.70%
2017	3.30%
2018	3.30%

Inertia Factor

A 10% inertia factor was used in the model. This factor requires that the utility associated with any source of coverage evaluated be at least 10% greater than the utility associated with the HIU's current source of coverage, in order for them to make a change to the new coverage status.

6

Modeling Results

To understand how certain design scenarios could impact enrollment and premiums in the Individual and SHOP Exchanges, we used the Oliver Wyman HRM Model to test potential results for four scenarios identified by the District. The focus of the following modeling results is on Exchange design scenarios and the sensitivity of results to those scenarios.

As previously described, the model is based upon the assumption that consumers will select the option that maximizes the utility for the HIU. Employers' decisions to offer or continue offering coverage is based on a demand elasticity curve. Significant rate shock for some small groups and individuals in the District will result in dropped coverage or movement among coverage levels in the new market, as healthier consumers react to premium increases associated with the new rating rules. Other consumers who are currently not covered may be attracted to the marketplace as premiums become more affordable for them, or as financial penalties associated with the individual mandate reduces the utility associated with remaining uninsured. Finally, other consumers, many of whom will be newly eligible for Medicaid, will leave the insurance market to participate in that program.

The District requested scenarios that test the impact of merging the small group and individual markets, as well as the definition of small group. A merger of the small group and individual markets would require carriers to blend the experience in the two markets for the purposes of premium development and to apply a consistent set of rating rules. Carriers doing business in one market would by default be required to participate in both. The ACA defines small group as employers with up to 100 employees, but it offers the option to use the District's current definition of up to 50 employees for plan years beginning in 2014 and 2015. The first scenario that follows presents the results in the case where separate pools are maintained for the individual and small group markets, and the small group definition remains at 50. We refer to this as our Baseline Reform Scenario. We then present three alternate scenarios, one where the small group definition is increased to 100 in 2014, one where the individual and small group markets are merged, and one where both of these changes occur.

Baseline Reform Scenario

In the Baseline Reform Scenario separate individual and small group markets are maintained, and the definition of small group remains at 50 until 2016. The following table presents the modeled enrollment and premiums in the individual and small group markets, both inside and outside the Exchange. While premium subsidies are considered in the model, the premiums shown in the table below are prior to reduction for any subsidies, and therefore reflect total premium dollars flowing to insurers.

It should be noted that a variety of factors and influences will affect how District enrollment and premiums develop between 2011 and 2014, and beyond. The results shown here will be different from actual results to the extent that experience emerges differently than the assumptions used. These results should be considered point estimates within a wide range of possible outcomes. In particular, longer projection timeframes introduce greater uncertainty so the projections for later years are even more uncertain than those for the earlier years in the projections.

	Baseline Scenario								
	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	14,500	$4,710	$68,341,000	37,500	$5,440	$204,143,000	52,000	$5,240	$272,484,000
2015	14,000	$4,900	$68,559,000	38,000	$5,620	$213,457,000	52,000	$5,420	$282,016,000
2016	17,500	$5,320	$93,117,000	39,000	$5,980	$233,135,000	56,500	$5,770	$326,252,000
2017	17,000	$5,620	$95,540,000	41,000	$6,470	$265,429,000	58,000	$6,220	$360,969,000
2018	16,750	$5,870	$98,301,000	42,500	$6,880	$292,508,000	59,250	$6,600	$390,809,000

	Baseline Scenario								
	External Markets								
	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	65,750	$4,510	$296,722,000	23,750	$5,230	$124,159,000	89,500	$4,700	$420,881,000
2015	64,250	$4,740	$304,481,000	24,250	$5,210	$126,421,000	88,500	$4,870	$430,902,000
2016	101,500	$5,160	$523,387,000	25,000	$5,620	$140,578,000	126,500	$5,250	$663,965,000
2017	99,250	$5,460	$541,818,000	25,000	$6,140	$153,424,000	124,250	$5,600	$695,242,000
2018	98,000	$5,770	$565,073,000	26,000	$6,480	$168,524,000	124,000	$5,920	$733,597,000

	Baseline Scenario								
	District Total Individual and Small Group Insurance Markets								
	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	80,250	$4,550	$365,063,000	61,250	$5,360	$328,302,000	141,500	$4,900	$693,365,000
2015	78,250	$4,770	$373,040,000	62,250	$5,460	$339,878,000	140,500	$5,070	$712,918,000
2016	119,000	$5,180	$616,504,000	64,000	$5,840	$373,713,000	183,000	$5,410	$990,217,000
2017	116,250	$5,480	$637,358,000	66,000	$6,350	$418,853,000	182,250	$5,800	$1,056,211,000
2018	114,750	$5,780	$663,374,000	68,500	$6,730	$461,032,000	183,250	$6,140	$1,124,406,000

** Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest $10,000*

Key observations for calendar year 2014 (as compared to 2010) when employing the assumptions previously described include:

- Enrollment in the District's individual market is projected to more than triple, from roughly 20,000 members in 2010 to 61,250 members in 2014, with 61% of covered individuals

enrolled in the Individual Exchange, and 22% of those with individual coverage receiving subsidies. (We note the percentage of people receiving subsidies is much lower than the estimate by the CBO that 57% of people with individual coverage would.) First, the CBO's estimate includes individuals between 138% up to 200% FPL; in our model those individuals were assumed to remain in a 138%-200% FPL Waiver program or enroll in a BHP, which ever the District decides to pursue. Second, the background research showed that 72% of individuals currently purchasing coverage in the District's individual market are above 400% FPL.

- Enrollment in the District's small group market is projected to decline by approximately 13% in 2014, to 80,250 members, with roughly 18% of covered individuals enrolled in the SHOP Exchange. Roughly one half of the members projected to enroll in the SHOP Exchange are employed by small employers eligible for the temporary small business tax credit.
- The small group market will increase by almost 40,000 members in 2016 when the definition of small group is increased to 100, however, the enrollment in the SHOP Exchange will only increase by roughly 3,500 members.
- Enrollment in Medicaid/CHIP (based on coverage up to 200% FPL) is projected to increase by roughly 9,500 lives by 2014, over 2010 levels.
- The uninsured population in 2014 is projected to be roughly half of the 2009 level,[65] decreasing to roughly 21,000 individuals, or approximately 3.5% of the District's population, keeping in mind the underlying assumption that 20% of those currently eligible for Medicaid but uninsured would enroll by 2014.[66] By 2018, the uninsured rate is projected to be 3.0% if the District achieves the assumption of enrolling 30% of those eligible for Medicaid but not enrolled today.

Premiums are projected to change in 2014 for several reasons. In addition to increases for medical trend, required increases in benefits, and new taxes and assessment, premiums for each market will adjust based on the individuals that enroll in the market. As members change markets, their claims morbidity moves with them and impacts premiums in the market to which they migrate.

- Average premiums on a per capita basis in the small group market are projected to increase by only 6% from 2010 to 2014. In addition to increases due to medical trend, required increases in benefits covered and new taxes and assessments, this change reflects changes in demographics, average morbidity of those enrolled, and benefit buydowns made by employers. It also reflects significant rate decreases (averaging 12.2%) resulting from carriers not meeting the minimum loss ratio requirement, and recently significant rate decreases by one major carrier.

[65] The current uninsured rate is based on the 2009 American Community Survey data that was used for the background research. As of the time this analysis was completed, 2010 American Community Survey data was not available to update this statistic.

[66] Note not all individuals eligible for Medicaid but not enrolled are currently uninsured; many of these individuals have current ESI coverage.

- Average premium on a per capita basis in the individual market, prior to application of premium subsidies, are projected to increase by 45% from 2013 to 2014. In addition to increases due to medical trend, additional mandated covered benefits as a result of the EHB package and new taxes and assessments, this change reflects changes in demographics, benefit plan changes, and changes in the average morbidity of those enrolled. Required increases due to the EHB package (i.e., required coverage for EHB and the required increase to an actuarial value of at least 0.60) account for roughly 25% of the increase in premiums. The average morbidity of the individual pool is projected to increase by roughly 10.3% in 2014, primarily due to the influx of individuals who were previously uninsured, however this increase is offset in 2014 by the temporary reinsurance program. The remaining difference is due to one year of trend, changes in demographics, and the fact that individuals receiving subsidies in the Individual Exchange are modeled to enroll in a Silver plan, which leads to a higher average benefit than is found in the individual market today.
- In the Exchange, individual premiums are projected to be 15% higher than small group premiums in 2014. This compares to premiums in the individual market today that are approximately 25% lower than in the small group market. This difference can be reconciled as follows:
  - The EHB package and the requirement to bring benefits up to at least a 0.60 actuarial value increases individual rates by approximately 22% more than it increases small group rates.
  - The impact of recent and projected decreases in small group rates to comply with the minimum loss ratio requirement results in small group rate decreases of 12% with no change to individual rates.
  - The impact of higher morbidity from the uninsured entering the individual market increases rates 10.3%, however this is offset by the 10% reduction in rates in 2014 due to the temporary reinsurance program.
  - The ACA benefit changes required in 2010 (i.e., no cost sharing for preventive services, no lifetime limits, etc.) are projected to have increased individual premiums by 2% more than small group premiums.
  - The remaining difference is due to changes in average demographics and benefits between the two markets.

Alternate Reform Scenario 1

This scenario assumes that the District elects to define a small group as employers with 50 or fewer eligible employees until 2016, but decides to merge the individual and small group pools into one. Merging these markets would mean that the rates for the individual and small group markets would be based on the combined morbidity of the two pools.

Merging the individual and small group insurance markets would have the effect of spreading risk across a wider pool of participants and potentially provide greater rate stability for all. The District's current individual insurance market is significantly smaller than the small employer market in terms of covered lives. However, based on information from the Census Bureau, we have assumed the average morbidity of the two pools is not significantly different today (the

average morbidity of the current individual pool is roughly 2% lower than the average morbidity of the current small group pool) and a market merger of the District's current individual and small group pools would appear more of a merger of equals.

However, the entrance of those who are currently uninsured into the individual pool, as was seen in the results from the Baseline Scenario, has the effect of increasing the average morbidity of the individual market to levels above that of the current small group pool. Without a merger, the average morbidity of the individual pool would be roughly 7.3% higher than the average morbidity of the small group pool, after the uninsured enter the pool. Therefore, a merger would provide a moderate amount of premium relief to the individual market at a small cost to the small group market.

This result is very different than was experienced by the only state to merge its markets to date, Massachusetts. In Massachusetts, a small individual market with high premiums was merged with a much larger small group market that had more moderate premiums. Significant premium relief was provided to individual enrollees at the cost of only a small increase in small group premiums.

The tables below present the results from this scenario.

	Alternate Reform Scenario 1								
	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	13,750	$4,760	$65,447,000	38,500	$5,210	$200,690,000	52,250	$5,090	$266,137,000
2015	12,750	$5,100	$64,981,000	39,500	$5,410	$213,686,000	52,250	$5,330	$278,667,000
2016	17,250	$5,250	$90,548,000	39,750	$5,780	$229,676,000	57,000	$5,620	$320,224,000
2017	16,750	$5,550	$92,907,000	41,750	$6,250	$260,863,000	58,500	$6,050	$353,770,000
2018	16,250	$5,910	$96,040,000	43,250	$6,650	$287,798,000	59,500	$6,450	$383,838,000

	Alternate Reform Scenario 1								
	External Markets								
	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	62,500	$4,560	$284,964,000	25,250	$4,970	$125,601,000	87,750	$4,680	$410,565,000
2015	59,000	$4,880	$287,942,000	25,750	$5,000	$128,846,000	84,750	$4,920	$416,788,000
2016	99,250	$5,130	$509,286,000	26,250	$5,380	$141,224,000	125,500	$5,180	$650,510,000
2017	97,250	$5,420	$527,188,000	26,250	$5,860	$153,696,000	123,500	$5,510	$680,884,000
2018	96,250	$5,740	$552,120,000	27,000	$6,250	$168,721,000	123,250	$5,850	$720,841,000

	Alternate Reform Scenario 1								
	District Total Individual and Small Group Insurance Markets								
	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	76,250	$4,600	$350,411,000	63,750	$5,120	$326,291,000	140,000	$4,830	$676,702,000
2015	71,750	$4,920	$352,923,000	65,250	$5,250	$342,532,000	137,000	$5,080	$695,455,000
2016	116,500	$5,150	$599,834,000	66,000	$5,620	$370,900,000	182,500	$5,320	$970,734,000
2017	114,000	$5,440	$620,095,000	68,000	$6,100	$414,559,000	182,000	$5,680	$1,034,654,000
2018	112,500	$5,760	$648,160,000	70,250	$6,500	$456,519,000	182,750	$6,040	$1,104,679,000

** Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest $10,000*

Key observations relative to the Baseline Scenario include:

- Premium levels do differ as a result of the market merger; however, the variance is not so extreme that take-up patterns are markedly different.
- Premiums in the individual market are 3.5% lower in 2014 in a merged market, relative to the Baseline Scenario.
- Premiums in the small group markets are 3.6% higher in 2014 in a merged market, relative to the Baseline Scenario.
- Individual market consumers react to the somewhat lower premiums with slightly higher take-up rates than in the Baseline Scenario. Small employers and their employees react to higher premiums with somewhat lower take-up rates.
- The average enrollment in the combined Individual and SHOP Exchanges is not significantly different than under the Baseline Scenario.
- Most of the difference in the results in this scenario relative to the Baseline Scenario is migration from the small group market to the individual market, such that the size of the overall insurance market in the District is relatively the same.

Additional Considerations for Merging the Individual and Small Group Pools in 2014

In addition to the direct financial impact that merging the individual and small group pools may have on the rates for each market, there are other considerations when making the decision of whether or not to merge the pools.

Advantages to Merging the Pools

- Merging of the two markets would result in a larger risk pool, and perhaps more rate stability.
- If the markets are kept separate, individual and small group rates may be materially different for identically suited people.
- Carriers' administrative expenses may be lower in a merged market due to consistent product portfolios, a reduced number of rate flings, etc. These savings should theoretically be passed along to District residents and businesses.

- Individuals leaving groups or in groups that no longer offer coverage would be able to continue their coverage at their current level of benefits.
- Theoretically, a single pool could prompt the highest number of carrier options, since it could conceivably require carriers operating only in the existing individual market — as well as carriers operating only in the existing small group market — to participate in both markets, resulting in more competition and choice for consumers. The dominance of one carrier in each of these markets today may make this particular consideration for the District less important than it would in some other states.
- If more employers move toward a defined contribution approach, the small employer market would function more like the individual market. Even if employers do not adopt a defined contribution approach, the fact that the SHOP Exchange must allow individual choice among a given metallic level of coverage means that a merged market that is based on an individual rather than group rating structure may be more conducive to these arrangements.
- Some managed care entities that, until now have focused only on those markets that did not require underwriting expertise, (e.g., Medicaid or Medicare Advantage markets) may perceive a combined market as a greater business opportunity than separate markets, and may be more willing to assume the risk of expanding into the commercial sector.

Disadvantages to Merging the Pools

- Merging the markets could lead to even more market disruption than that which will occur from the rate shock resulting from the required changes under the ACA (e.g., ACR, guarantee issue), and the markets can always be merged at a later date.
- A single pool could result in fewer total carriers and less competition if those carriers that specialize in only one of the existing separate markets choose not to participate in the new combined market.
- A merged market might limit the Exchange's flexibility to address the differing needs of individuals and small groups.
- Products in the individual market could potentially look very different from those in the small group market, unless restricted by the District. This could require benefit changes for these individuals migrating from small group coverage to individual coverage.
- In the District, we expect that merging the markets will raise premiums for small groups and reduce premiums for individuals. Higher small group rates in a merged market could lead to more groups dropping coverage. If more small employers drop coverage, the costs to taxpayers will increase as more individuals become eligible for subsidies.
- Upward pressure on small group rates resulting from merging the markets could cause more small groups to consider self insuring, which could in turn result in healthier risks leaving the market.
- Merging the markets could complicate the Exchange's operations. As an example, the Exchange would have to enforce one set of open enrollment rules for individuals and another set for small groups.
- While our modeling results do not show tremendous disruption from merging the markets, we would note that there is more uncertainty surrounding premiums in the small group

market after 2014 due to the difficulty in estimating the costs associated with covering those who were previously uninsured.

- For these reasons, the District may want to keep the markets separate initially.

Alternate Reform Scenario 2

This scenario assumes that the District elects to define a small group as employers with 100 or fewer eligible immediately in 2014, but decides not to merge the individual and small group pools into one. Disruption for groups size 51-100 is likely to occur as these groups must be rated on an ACR basis. Today, many of these groups are, in part, rated on their own experience. Groups with 51-100 employees are less likely to participate in the SHOP Exchange unless significant administrative savings exist. Groups with good experience may see a significant increase in rates as a result of community rating and these groups will be more likely to self insure. Without concerted effort to provide either value-added services for larger small employers or significantly lower premiums, the Exchange may not be able to attract those consumers.

Defining small group in the District to include employers with up to 100 employees in 2014 and 2015 may enlarge and strengthen the small group risk pool in the near term, but it does not produce significantly higher levels of Exchange enrollment in the long term. This is because the current 51-100 market is roughly half the size of the current small group market, and groups size 51-100 will not be eligible for small business tax credits, which is projected to attract a fair number of small groups into the Exchange.

A key assumption that could have a significant impact on the results is the fact that one of the underlying baseline assumptions is that carriers with under 100 employees would not self insure.

	Alternate Reform Scenario 2								
	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,750	$4,810	$90,095,000	37,500	$5,450	$204,550,000	56,250	$5,240	$294,645,000
2015	18,250	$5,000	$91,309,000	38,000	$5,630	$213,883,000	56,250	$5,430	$305,192,000
2016	18,000	$5,260	$94,769,000	38,500	$6,010	$231,453,000	56,500	$5,770	$326,222,000
2017	17,500	$5,600	$98,018,000	40,500	$6,480	$262,436,000	58,000	$6,210	$360,454,000
2018	17,250	$5,870	$101,316,000	42,000	$6,900	$289,919,000	59,250	$6,600	$391,235,000

	Alternate Reform Scenario 2								
	External Markets								
	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	104,500	$4,750	$496,210,000	23,750	$5,240	$124,451,000	128,250	$4,840	$620,661,000
2015	103,500	$4,940	$511,186,000	24,500	$5,170	$126,752,000	128,000	$4,980	$637,938,000
2016	103,000	$5,200	$535,259,000	25,000	$5,590	$139,781,000	128,000	$5,270	$675,040,000
2017	101,500	$5,510	$559,390,000	24,750	$6,130	$151,833,000	126,250	$5,630	$711,223,000
2018	99,750	$5,820	$580,844,000	25,750	$6,490	$167,220,000	125,500	$5,960	$748,064,000

	Alternate Reform Scenario 2								
	District Total Individual and Small Group Insurance Markets								
	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	123,250	$4,760	$586,305,000	61,250	$5,370	$329,001,000	184,500	$4,960	$915,306,000
2015	121,750	$4,950	$602,495,000	62,500	$5,450	$340,635,000	184,250	$5,120	$943,130,000
2016	121,000	$5,210	$630,028,000	63,500	$5,850	$371,234,000	184,500	$5,430	$1,001,262,000
2017	119,000	$5,520	$657,408,000	65,250	$6,350	$414,269,000	184,250	$5,820	$1,071,677,000
2018	117,000	$5,830	$682,160,000	67,750	$6,750	$457,139,000	184,750	$6,170	$1,139,299,000

** Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest $10,000*

Key observations for this scenario, relative to the Baseline Scenario, include:

- An additional 4,250 members are projected to enroll in the SHOP Exchange in 2014 due to inclusion of the 51-100 population in the small group pool.
- The early entrance of the 51-100 life groups into the small group pool has the impact of increasing premiums in the expanded small group market, slightly. This is due to differences in demographics and benefits of these two sub-populations (the under 50 population and the 51-100 population).
- The early expansion of the small group market has almost no impact on either premiums or enrollment in the individual market.

Given the fact that the District will be required to ultimately change its current definition of small group to 1-100, it may be easier to make the change along with the host of other changes that will occur in 2014. On the other hand, if carriers are allowed to continue rating groups size 51-100 using current methods until 2016, it may postpone the number of groups that decide to self insure or drop coverage. Much of the market disruption that will occur in 2014 will have worked through the system and postponing the small group expansion until 2016 will allow these groups time to understand the new system. Further, it will give the District more time to implement programs such as value-added benefits and services which could work to draw more groups into the SHOP Exchange; groups size 51-100 may see value in these benefits and services as well.

Alternate Reform Scenario 3

This final scenario assumes that the District elects to define a small group as employers with 100 or fewer eligible employees immediately in 2014, and also decides to merge the individual and small group pools into one. As previously discussed, merging the individual and small group insurance markets would have the effect of spreading risk across a wider pool of participants and potentially provide greater rate stability for all.

The results for this scenario are similar to those of Alternate Scenario 1, because the early expansion of small group to 100 employees had little impact on the projected results. However, given the merger in Alternate Scenario 1 had the effect of lowering premiums for the individual market in 2014, merging with a larger small group pool will result in larger decreases for the individual market. The results of this scenario are shown in the following tables.

	Alternate Reform Scenario 3								
	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,250	$4,840	$88,313,000	38,500	$5,200	$200,288,500	56,750	$5,090	$288,601,500
2015	17,250	$5,160	$88,941,000	39,500	$5,390	$212,748,500	56,750	$5,320	$301,689,500
2016	17,250	$5,380	$92,728,000	39,750	$5,790	$230,197,500	57,000	$5,670	$322,925,500
2017	16,750	$5,680	$95,205,500	41,750	$6,260	$261,517,000	58,500	$6,100	$356,722,500
2018	16,250	$6,060	$98,467,500	43,250	$6,660	$287,971,500	59,500	$6,490	$386,439,000

	Alternate Reform Scenario 3								
	External Markets								
	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	102,250	$4,780	$489,186,000	25,250	$4,970	$125,528,500	127,500	$4,820	$614,714,500
2015	99,250	$5,050	$501,661,500	25,750	$5,000	$128,803,000	125,000	$5,040	$630,464,500
2016	99,000	$5,330	$527,728,000	26,250	$5,400	$141,702,000	125,250	$5,340	$669,430,000
2017	97,000	$5,630	$546,288,000	26,250	$5,880	$154,239,500	123,250	$5,680	$700,527,500
2018	96,250	$5,950	$572,685,000	27,000	$6,260	$169,011,000	123,250	$6,020	$741,696,000

	Alternate Reform Scenario 3								
	District Total Individual and Small Group Insurance Markets								
	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	120,500	$4,790	$577,499,000	63,750	$5,110	$325,817,000	184,250	$4,900	$903,316,000
2015	116,500	$5,070	$590,602,500	65,250	$5,230	$341,551,500	181,750	$5,130	$932,154,000
2016	116,250	$5,340	$620,456,000	66,000	$5,630	$371,899,500	182,250	$5,450	$992,355,500
2017	113,750	$5,640	$641,493,500	68,000	$6,110	$415,756,500	181,750	$5,820	$1,057,250,000
2018	112,500	$5,970	$671,152,500	70,250	$6,510	$456,982,500	182,750	$6,170	$1,128,135,000

** Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest $10,000*

Key observations for this scenario include:

- Under this scenario, premiums in the individual market are expected to be 4.2% lower than under the Baseline Scenario. This compares with only a 3.5% reduction when the individual market is merged with a small group market defined as 2-50 employees.
- Under this scenario, premiums in the expanded small market are expected to be 2.8% higher than for the small group market under the Baseline Scenario or Alternate Scenario 2. This compares with a 3.6% increase when the individual market is merged with a small group market defined as 2-50 employees.
- Total enrollment in the Exchange is relatively the same as under the Baseline Scenario.

This scenario produces the largest decrease in rates for the individual market. This premium relief for the individual market comes at the cost of increased premiums to the small group market, however the cost is lower than in Alternate Scenario 1 where only groups size 2-50 were merged with the individual market. We remind the reader of the underlying assumption that small groups do not self insure. If small groups were to find it attractive to self insure, the premium relief projected for the individual market will not emerge at the levels presented in this report.

Increased Participation in the Exchange

As part of their planning, states are studying what actions they could take to maximize participation in their Exchange. It will be important that an adequate mix of affordable plan choices be made available within the Exchange in order to incentivize individuals and small groups who are not eligible for subsidies to participate. If broad choices at affordable rates cannot be found in the Exchange, these individuals and small groups will look to additional options made available in the outside market. Under the ACA, carriers are only required to offer coverage at the Silver and Gold level inside the Exchanges. To increase Exchange participation, the District may consider requiring health insurance carriers to offer coverage at the Bronze level inside the Exchanges as well. This will eliminate the scenario where carriers only sell Bronze level coverage in the outside market and individuals cannot find this low level of affordable coverage within the Exchanges.

While premium and cost sharing subsidies will draw many into the Individual Exchange, there are no comparable financial incentives to draw small groups into the SHOP Exchange with the exception of small business tax credits, which are temporary, and only apply to a small number of groups. In our modeling, we assumed 10% of all small groups offering coverage that are not eligible for a small business tax credit would enroll in the SHOP Exchange. This assumption is higher than the enrollment levels observed by existing exchanges to date, but it is reasonable because of the employee choice option that must be made available inside the Exchange. This flexibility is expected to draw some employers in. At the same time, states recognize the need to explore options to increase enrollment in order to have a financially sustainable SHOP Exchange, and they are beginning to study methods to do this.

In order to have a viable SHOP Exchange, efforts beyond just attracting small employers will be required. Benefits and other options will also be needed to attract employees; the engagement of brokers will also be critical. Attracting carriers to participate in the Exchange will be a necessity for both the Individual and SHOP Exchanges. Below, we discuss several items we recommend the District consider when establishing its Exchange, all of which may help to increase participation in the Exchange.

Attract a Sufficient Number of Carriers

In order to have a viable Exchange and ensure affordable rates, participation in the Exchange must be attractive to carriers. Participation by a number of carriers will mean more choices for individuals and small groups and a greater chance that they will purchase coverage through the Exchange. Greater carrier participation will also likely mean more competition for a fixed pool of individuals, which may in turn help to keep rates affordable. In order to encourage carriers to participate though, the Exchange must be able to demonstrate that they have “rules” in place to control adverse selection; carriers who perceive they will be selected against inside the Exchange may choose not participate. At the extreme, the District could require that all carriers that wish to do business in the District participate in the Exchange; however, this option must be explored with caution, as it could lead carriers that planned to participate only in the outside market to exit the District altogether.

Ensure a Broad Selection of Product Choices

Having a number of carriers participate in the Exchange increases the chances that offerings inside the Exchange will provide a wide variety of deductibles, coinsurance and providers from which individuals and small employers may choose. A wide variety of products is needed to ensure enough choice to attract individuals and small groups; it is also needed to create robust competition among carriers. If the choices inside the Exchange are more limited than those available in the outside market, participation by non-subsidized individuals and small groups could be reduced. Options are available to the Exchange to limit or standardize the benefit offerings; however, if this same restriction is not applied to the outside market, these restrictions may also hinder enrollment. Therefore, if the District does decide to standardize benefits, a balance must be struck to ensure a variety of deductible and coinsurance options are available at each metallic level.

While choice will be important, the District should also take care to ensure the Exchange does not overwhelm individuals and small employers with so many options that the process of selecting a plan becomes overly complicated. The standardized benefit form that will be required for all products sold inside the Exchange will assist individuals and small groups when comparing plans. Different plans offered by the same carrier should be meaningfully different.

Ensure Easy Access to Information

Individuals and small group carriers must be able to access carrier and benefit information with relative ease. The process should be no more cumbersome than obtaining this same information from the market outside of the Exchange. Exchanges are required to contract with navigators to assist with providing information to consumers, which could lead to greater enrollment in the Exchange. One of the roles of the navigator is to facilitate the distribution of information about plans in a culturally and linguistically appropriate manner. Given the District's diverse population, the navigator's role will be particularly important. To the extent that the outside market does not meet these diverse needs at the same level, the Exchange may have an advantage.
Some of the functions related to facilitation of information might include:

- Information related to price and quality should be easily accessible through the navigator program in a single location.
- Provide small groups with a summary of each employee's benefit plan choice, coverage tier and premium to facilitate employee premium contribution calculations.
- Provide small employers with estimated small business tax credits.

Engage Brokers and Agents

Brokers and agents play a significant role in the current market. They advise individuals and small businesses of the most appropriate coverage for them, and they help them shop among different carriers. While the navigator will perform these functions, brokers and agents provide additional advisory services and many small businesses rely heavily on their brokers for this advice. The Exchange must recognize the need to rely on brokers and agents to help them build their market and ensure affordable rates. To protect against a scenario where agents and brokers are not as active within the Exchange as they are in the outside market, the Exchange should ensure that navigators are able to assist agents with their functions. At the same time, rules must be in place to ensure agents are not incentivized to steer small groups comprised of unhealthy individuals into the exchange while steering healthy groups only to the outside market.

Consider Offering Value-added Services and Benefits Inside the Exchange

Many small businesses do not have human resource departments, and the small business owner fills this role. This takes time that they could otherwise spend focusing on their business. An exchange that could provide business services might be especially appealing to a small group. Additional services the SHOP Exchange could consider providing include:

- New employee education and enrollment facilitation
- COBRA administration
- Flexible spending account administration
- HSA administration
- Payroll services

- Human resource reference desk
- Business counseling

A successful SHOP Exchange would not only draw small employers into the SHOP Exchange, but maintain them. While the initial “sale” is primarily targeted at the employer, employees play a role in retention. If the employees do not like the plan or service they receive from the Exchange, they will likely complain to their employer. In addition to value-added services, the District may want to explore the option of providing value-added benefits. Many of these benefits are directed more toward the employees than the employer, and they may work to increase employee satisfaction with the Exchange. Some examples of additional benefits that could be attractive to SHOP Exchange enrollees if they could be made available at little or not cost include:

- Discounts programs for employees (e.g., health club memberships, vision hardware)
- Discount programs for employers (e.g., printing and shipping services)
- Nurse advice lines
- Health appraisals and lifestyle coaching
- Employee assistance programs
- One stop shopping for ancillary insurance products (e.g., life, dental, vision, auto, homeowner’s)
- Assistance helping employees understand explanation of benefits forms
- Negotiating with providers on employee’s behalf to reduce OOP cost sharing

States are performing cost/benefit analysis to study these options, and we recommend the District do so as well.

7

Services Beyond Federally Mandated Benefits

According to the ACA, states will be required to cover the cost of any benefits provided by a QHP inside the Individual and SHOP Exchanges that are not included in the EHB package. So, for those policies sold inside the Exchanges, the District will bear the cost for those benefits mandated by the District that are not included in the EHB package.

The District's benefit mandates are found in Title 31 of the District of Columbia Official Code; we have summarized them in the following table.

Section	Benefit*
31-3103	Alcoholism/Substance Abuse Treatment
31-3272	Autism
31-3832	Breast Reconstruction
31-2902	Cervical Cancer/HPV Screening
31-2931	Colorectal Cancer Screening
31-3002	Diabetes Self Management
31-3002	Diabetic Supplies
31-2802	Emergency Room Services
31-3272	Habilitative Services for Congenital/Genetic Defects
31-3834	Hormone Replacement Therapy
31-2902	Mammography Screening
31-3161	Maternity Minimum Stay
31-3104	Mental Illness
31-2952	Prostate Cancer Screening
31-3272	Speech/Hearing Therapy

**No Long-term or Well Child Care*

(Please note that the Council for Affordable Health Insurance also identified Long-Term Care and Child Wellness visits as District mandated benefits; because we were unable to find those benefits in the Code, we have excluded them from our analysis.) The long awaited (and recently released) report from the IOM did not include recommendations for specific services in the EHB package. The report indicates that the committee was not tasked with recommending specific services for the EHB package; further, the report suggests that HHS should establish its initial draft of the EHB package by May 2012. With this uncertainty around the EHB package, it is not

clear what services that are mandated by District will be excluded from the EHB. Ultimately, we cannot perform a complete analysis of the potential cost to the District to cover these benefits. However, we can highlight some of the topics from the IOM's report and from those highlights suggest some services that are not likely to be included in the EHB package.

Before we begin a discussion of the EHB package and the services it might exclude, it is important that we first clarify that there are many services explicitly included through the ACA. For example, services related to emergencies, maternity, mental health/substance abuse treatment and preventive care (i.e., mammography screening, colorectal screening, etc.) are specifically included by the ACA in the EHB package. The remaining benefits that are either not yet implemented or not scheduled for implementation include services for the following: Autism, Breast Reconstruction, Habilitative Services, Hormone Replacement Therapy and Speech/Hearing Therapy.

According to the IOM's report, HHS has a number of considerations that they must balance in designing the EHB package. Among other things, these considerations include the following:

1. HHS should take into account the cost and efficacy of certain services
2. They should emphasize the services currently provided to a typical small group
3. HHS should design the EHB package so that the cost is generally consistent with current costs

We are unable to anticipate how HHS' interpretation of considerations 1 and 3 might interact with the District's mandated benefits. However, for consideration 2, we were able to infer the frequency of certain mandated benefits from a report published by the Council for Affordable Health Insurance (CAHI). Specifically, CAHI's report identifies those states with laws mandating certain services. For example, Breast Reconstruction is mandated in all 50 states; Hormone Replacement Therapy is mandated in only four states.

From CAHI's report, we found that the services included in the ACA are all mandated in over 50% of the states. Along with those services, Autism and Breast Reconstruction are also mandated in at least 50% of the states. Using small group employment in the nation's nine most populous states, we found similar results (i.e., of the states we reviewed, over 50% of small group employees were in states mandating those benefits). Speech/Hearing Therapy was also mandated for over 50% of employees when weighting the results by small group employment in those states. From CAHI's report, it would seem that Autism and Breast Reconstruction could satisfy the "typical" small group consideration put forth by the IOM. However, it is not clear that HHS will consider these services essential if they ultimately cause benefit costs to exceed their pre-ACA levels.

For the services that were not represented in over 50% of states, we estimated their costs by relying on other sources. Please note that, although a benefit may be mandated in more than one state, the scope of the benefit may be quite different from state to state. For example, some

states mandate chiropractic care, but impose limits on the number of visits that must be allowed; other states mandate chiropractic care and require that carriers cover it as they would any other physician. Our survey of available information did not account for these differences in mandates between states.

Our estimates of costs are the following:

- Autism: $0.70 PMPM to $1.00 PMPM
- Habilitative services for congenital/genetic defects: $0.20 PMPM
- Hormone replacement therapy: $0.14 PMPM
- Speech and hearing therapy: $0.03 PMPM

These costs total $1.07 PMPM to $1.37 PMPM. The estimated cost for covering Autism assumes a benefit maximum of approximately $35,000; they are taken from analysis Oliver Wyman has performed for Pennsylvania and Virginia. The estimates for Habilitative Services are taken from data that Oliver Wyman has purchased from MarketScan. Finally, the Hormone Replacement Therapy and Speech/Hearing Therapy estimates were both prepared by the Commonwealth of Massachusetts in an examination of their own mandated benefits.

In total, these estimates suggest that under the Baseline Scenario the District would have to pay approximately $650,000 to $850,000 in 2014, increasing to $750,000 to $950,000 in 2018, to cover these benefits. This range assumes that the District's other mandated benefits are included in the EHB package. It also assumes that the scope of the District's coverage (e.g., age limits, annual visits, etc.) is consistent between the District and those states for which the estimates were prepared. We recommend the District perform a more detailed analysis of these benefit costs once the official EHB packaged is released. In addition to estimating cost changes, the analysis should include a complete medical, financial and social impact analysis for any mandated benefits the District may consider eliminating.

8

Potential Adverse Selection and Options for Mitigation

Adverse selection can occur when the average risk profile of the individuals enrolled in a product is higher than the risk profile embedded (or assumed) in that product's rates. Whenever individuals and employers have choices among health insurance options (including the option to forgo insurance altogether), there is potential for this type of selection to occur. Unlike other types of insurance, such as automobile or homeowner's coverage, the upcoming year's health care expenditures are relatively predictable for most people. Unrestrained risk selection can produce an unstable marketplace; so, striking a balance between preserving choice and mitigating the potential for adverse selection is a key challenge for states implementing Exchanges.

There are three primary types of adverse selection that have the potential to influence the District's individual and small group health insurance marketplace in the reformed environment that will exist beginning in 2014:

- Adverse selection against the market, if healthier individuals and groups choose not to participate in the fully insured market, either by going uninsured or self insuring.
- Adverse selection against the Exchange, if its design causes the Exchange to be more attractive to higher risk populations while healthier populations stay in the outside market.
- Selection among carriers and products offered inside the Exchange.

The ACA includes a number of provisions designed to discourage adverse selection, but many sources of selection remain. This section of the report discusses each type of selection further, describes the ACA's provisions designed to address them, and identifies additional options we recommend the District evaluate to further mitigate potential selection.

Adverse Selection Against the Market

Guarantee issue and ACR rules, described earlier, could cause groups and individuals to delay purchase of insurance until they need it. Without enough healthy individuals in the risk pool, premiums will be higher. In the past, states that have adopted issue and rating rules similar to those specified by the ACA have experienced challenges in their individual markets related to the departure of healthy populations and resulting premium increases.

In a given health insurance marketplace, individuals with greater health needs are more likely to enroll in products with higher actuarial values than other individuals. Individuals purchasing insurance could be influenced in their coverage choice if they expect that their claims will be

higher than normal. The carriers typically do not have this information or are unable to price known information fully into rates due to restrictions imposed on them.

The ACA includes a “carrot and stick” approach to mitigating the potential for this type of selection against the insurance market. The premium and cost sharing subsidies are available to defray the cost of individual insurance, while the individual mandate will introduce a penalty for not having insurance. Both of these provisions are designed to draw more individuals into the market and provide a cross section of risks.

In combination, the subsidy and responsibility provisions included in the legislation could provide sufficient incentive to mitigate some of the potential for adverse selection against the market. However, some feel that the individual mandate is too weak to produce the incentive required to ensure a good cross section of risk. The penalty costs are lower than the cost of maintaining coverage, and it is possible that some healthy individuals will choose to pay the penalty rather than to enroll in coverage. In theory, states could establish a state individual insurance mandate and apply additional penalties for non-compliance, strengthening the financial incentive for individuals to purchase coverage. We are not aware of any states considering this type of action at this time.

Another potential source of selection against the small group market is self insurance. Rate shock introduced by an ACR methodology will cause large increases for groups comprised of healthy individuals, as these groups are likely receiving underwriting discounts today that will be prohibited under the ACA. Some small groups could choose to self insure if they are in good health and are able to obtain attractively priced reinsurance at relatively low attachment points. An incentive to self insure could result in more of the preferred risks staying out of the fully insured risk pool. In turn, it could reduce the size of the risk pool and lead to adverse selection and reduced rate stability. The availability of value-added services could be used to make the SHOP Exchange attractive to these small employers and keep them in the risk pool.

Adverse Selection Against the Exchange

One of the main concerns to states in the post-reform marketplace is the adverse selection that can occur against the Exchange. In states that maintain individual and/or small group markets outside the Exchange, it is possible that the Exchange could disproportionately attract less healthy enrollees than the outside market. This type of environment could discourage carriers from offering coverage through the Exchange, reducing consumer choice and threatening the ongoing viability of the Exchange. There are a number of ACA provisions designed to discourage this type of selection, but there remain a number of areas that could contribute to it.

The concept of a “level playing field” between products in the Exchange and products in the outside market is another critical component of minimizing selection against the Exchange. If carriers and products in both markets are subject to the same rules, the opportunity for selection is reduced. To this end, ACA provides a number of rules meant to put the Exchange and outside markets on a consistent basis:

- Reforms related to rating, issue and renewal in the individual and small group markets apply to both QHPs in the Exchange and the outside market.
- Plans inside and outside the Exchange must contain the EHB, must abide by the same cost sharing limitations and must standardize benefit packages into the Bronze, Silver, Gold and Platinum levels of coverage.
- Carriers must consider all enrollees in their individual products, inside or outside the Exchange, as a single risk pool, and they must establish their small group risk pool similarly.
- Carriers who offer a QHP on the Exchange must agree to charge the same premium rate for that product whether it is offered inside or outside the Exchange.
- States are required to administer a risk adjustment mechanism that applies across non-grandfathered individual health plans both inside and outside the Exchange; a similar risk adjustment must apply across non-grandfathered small groups both inside and outside the exchange.
- If a disproportionate share of high-risk individuals enrolls in plans in the Individual Exchange, the temporary reinsurance program will compensate these plans for the additional risk.

However, even with these leveling features, there are several possible sources of selection against the Exchange that remain.

Product Offerings

The ACA does not require that all products offered inside the Exchange also be offered outside the Exchange. Likewise, some products may be offered only outside the Exchange. While there is a requirement that carriers operating in the Exchange offer at least Silver and Gold product levels, no such requirement exists for carriers operating outside the Exchange. Therefore, carriers could choose to offer only Bronze plans in the outside market, which would be most attractive to relatively healthy populations.

Network Design

The ACA places requirements regarding provider network access standards on products sold within the Exchange. Lack of these same requirements outside the Exchange can drive adverse selection. Minimum standards of network adequacy and quality should also apply outside the Exchange to avoid wide disparities between networks inside and outside the Exchange. Network design could be used to avoid enrollment of members with certain chronic conditions. Therefore, minimum network requirements need to be established outside the Exchange.

Grandfathered Plans

The presence of grandfathered plans outside the Exchange also has the potential to cause adverse selection inside the Exchange. Maintaining grandfathered status will be most valuable to young, healthy individuals and groups since carriers will be allowed to continue using pre-ACA rating rules for these plans. This provision could allow lower age factors and underwriting discounts for these grandfathered groups and individuals; in turn, it could produce lower rates than are available inside the Exchange. The exclusion of these plans from the risk

pool will affect risk-sharing mechanisms, such as risk adjustment and risk corridors set by the ACA for addressing adverse selection.

Self Funded Multiple Employer Welfare Arrangements

MEWAs provide health and welfare benefits to employees of two or more unrelated employers who are not parties to bona fide collective bargaining agreements.[67] An example of a MEWA would be a plan sponsored by a trade association for its members. MEWAs can be fully insured, or self insured. Fully insured MEWAs covering small employers will be subject to the same rating rules that will govern the small employer market in general in 2014 and beyond, (e.g., 3:1 rate bands for age, and premiums based on experience pooled across the entire small group market). However, self insured MEWAs would be able to have the cost of their benefits be based on the experience of the MEWA. This would be attractive to those groups that expect their health claims to be lower than the small group pool as a whole. The ACA includes several provisions related to MEWAs, including giving the Secretary of Labor the authority to make a MEWA subject to state regulatory jurisdiction.[68] The District may want to consider a means for monitoring the extent to which MEWAs are selecting against in the Exchange or the small group market in general, and may want to begin developing options for addressing the situation should it begin to occur.

Exchange Fees

If Exchange fees are assessed only inside the Exchange and some carriers sell only outside the Exchange, this could lead to adverse selection. This adverse selection would occur when carriers outside the Exchange are able to avoid the fees and offer comparable products at a lower price. Carriers that sell inside and outside the Exchange would be assessed these fees against all of their products. Since these carriers are required to charge the same premium for a plan sold both inside and outside the Exchange, the fees assessed against their policies sold inside the Exchange would essentially be spread across their policies outside the Exchange as well.

Employee Contributions

Employers could set employee contributions at a level high enough so that the contribution for single coverage exceeds 9.5% of the employee's household income. At this point, the coverage would be deemed unaffordable, and if the employee's household income is less that 400% FPL, the employee would be eligible to enroll in the Exchange and receive premium subsidies. Employers could take this action in order to avoid covering low wage individuals with health conditions while still continuing coverage for other employees. This approach could lead to adverse selection against the Exchange.

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[67] 29 U.S.C. 1002(40)

[68] ACA Sec. 6604.

Other ACA Provisions that Apply Only to Plans Inside the Exchange

In §1311(c)(1), the ACA includes certain requirements that apply only to plans sold inside the Exchange. Some of these requirements may influence risk attraction patterns, while others might lead to higher administrative costs. The list below summarizes the minimum requirements for QHPs. QHPs must:

- Not employ marketing practices or benefit packages that discourage enrollment of individuals with significant health needs
- Ensure a sufficient choice of providers and provide information to consumers regarding provider availability and network status
- Include essential community providers in their provider networks
- Maintain accreditation related to quality standards
- Implement a quality improvement strategy
- Use a uniform enrollment form and a standardized format for presenting benefit plan options.
- Provide information to the Secretary of HHS, the Exchange and consumers on certain quality measures

As a result of the factors outlined above, it is possible for carriers to choose to operate only outside the Exchange and in such a manner that they are able to attract the healthiest risk. Reallocation of premium through the risk adjustment mechanisms will address this type of risk selection to some extent, but current risk adjustment tools are imperfect predictors of risk.

There are two additional areas where careful evaluation and appropriate policy setting can assist in mitigating risk against the Exchange. First, health insurance brokers and agents play an important role in the current market; they help individuals and small groups to choose health insurance products. If Exchanges do not include a role for brokers and agents with comparable compensation inside and outside the Exchange, there is potential for steering patterns that produce disproportionate risk enrollment between the Exchange and the outside market. Second, the ACA provides states the option to allow large employers (over 100 employees) to purchase insurance on the Exchange beginning in 2017.[69] This option, if the District elects to enact it, would have distinct potential to produce adverse selection against the Exchange. It is much easier for larger groups to self insure. As a result, it is likely that the large employers that elect to purchase insurance through the Exchange will have higher than average risk profiles.

Selection Among Carriers and Products Inside the Exchange

The third type of selection is selection among plans and insurers offering products inside the Exchange. When provided a choice among health insurance products, individuals tend to choose the plans that provide the most value to them. Healthier individuals tend to favor products with low premiums, and they are not deterred by the narrow networks and higher cost sharing that may go along with those low premiums. Higher utilizing individuals will look for

[69] Section 1312(f)(2)(B) of the ACA

products with broader provider networks and low cost sharing; they are willing to accept the higher prices those products require. If high- and low-risk enrollees concentrate among different insurers on the Exchange, some of this selection may be reflected in the premiums. These premium differences could lead to lower affordability for some consumers and fewer insurers willing to participate in the Exchange.

Certain provisions in the ACA are expected to influence the risk distribution within the Exchange.

- Insurers that participate in the Exchange must offer at least one QHP in each of the Silver and Gold coverage levels.[70]
- Premium tax credits for qualified individuals are based on the cost of the second lowest cost Silver product available.[71] It is likely that this policy will cause many subsidized individuals to select coverage in the Bronze or Silver tiers to minimize the OOP premium cost they must pay.
- Cost sharing reductions for eligible individuals are available only if they are enrolled in Silver coverage level plans.[72]
- States may decide to offer a BHP to individuals with incomes below 200% FPL who are ineligible for Medicaid.[73] This policy decision is likely to reduce considerably the enrollment in the Silver plans that would otherwise be produced by the cost sharing reductions.

It seems likely that, because the premium subsidy and cost sharing reductions are tied to the Silver plan level, these incentives will cause significant enrollment in the individual market to concentrate at the Silver plan level. Healthier individuals, particularly those at higher income levels (e.g., above 250% FPL) may be attracted to Bronze level products as well. Without additional state action, there may be little incentive for insurers to offer robust Platinum level products. Those that do offer Platinum level products may experience significant selection in those products. Risk pooling across all individual market enrollees, combined with the risk adjustment mechanism may mitigate the premium effects of that selection somewhat. However, insurers that do not achieve sufficient enrollment of healthy individuals at lower coverage levels may still experience poor results on rich products.

Carriers could choose to be late market entrants to avoid the initial risks of adverse selection; they could also pull out and re-enter markets, which could cause adverse selection concerns for carriers offering products inside the Exchange. Not allowing late entrants inside the Exchange could help address this issue.

[70] Section 1301 of the ACA

[71] Section 1401 of the ACA

[72] Section 1402(b)(1) of the ACA

[73] Section 1331 of the ACA

Techniques for Mitigating Selection against the Exchange

There are several measures that the District could take to address the various sources of adverse selection against the Exchange. While each of the options presented below has the potential for mitigating adverse selection, they should be studied with care and considered alongside other design aspects of the Exchange; they may have unexpected ramifications on the broader insurance market in the District.

Eliminate the Outside Market

The District could decide to make the Exchange the sole distribution channel for individual and/or small group insurance coverage. Under this option, all products available to individuals and/or small groups would be required to be offered through the Exchange and meet the standards for QHPs. This policy option would eliminate the opportunity for adverse selection against the Exchange in a particular market, because the Exchange would be the only source of coverage available for that market. It would also potentially allow carriers to shift more administrative costs to the Exchange where economies of scale might produce overall administrative cost reductions and lower premiums.

Despite its effectiveness as a solution to the adverse selection issue, there are a number of disadvantages to this option. First, there could be distinct political challenges with this policy. Second, elimination of the outside market could constrain the District's ability to selectively certify plans offered in the Exchange if the Exchange decides to take an active role in selecting plans. Third, the additional requirements under §1311(c)(1) could ultimately raise administrative costs with no offsetting efficiencies. If that occurs, an unintended side effect might be increased costs and premiums across the entire market.

Extend Some or All QHP Requirements to the Outside Market

This policy would extend the concept of the "level playing field" further than the existing ACA provisions do. A common set of requirements would neutralize any selective or cost influences of the additional QHP requirements. The primary disadvantage associated with this policy option is the potential for increasing administrative costs in the outside market through the imposition of new requirements. An alternative is to extend some, but not all, of the additional requirements to the outside market.

Require Carriers to Participate in the Exchange

A third option the District could consider is to require carriers to offer products in the Exchange as a condition of offering small group and/or individual products in the District. This policy would protect against carriers targeting a particularly healthy risk outside the Exchange and benefiting from known imperfections in risk adjustment. It would also protect against carriers establishing a subsidiary to avoid the requirement that experience inside and outside the Exchange be pooled for pricing purposes. The ACA provision that carriers must pool their risk inside and outside the Exchange is effective in managing risk selection only to the extent that carriers participate in both marketplaces.

While requiring carriers to participate in the Exchange may have some intuitive appeal, there may be limitations to its effectiveness. Requiring carriers to participate in the Exchange does not necessarily ensure that they will design and offer attractive Exchange products at competitive prices. The rate review process may prevent premium levels that are excessive, but carriers determined to avoid risks that may be present in the Exchange could be creative in network or benefit design (i.e., they could produce products that are unattractive to Exchange populations).

Require Carriers Participating Only in the Outside Market to Offer Gold and Silver Products

Because healthier individuals tend to be attracted to lower cost insurance products (e.g., Bronze and Silver coverage levels rather than Gold and Platinum), there is a distinct opportunity for adverse selection if carriers have the opportunity to specialize solely in low-cost plans in the outside market. With this approach, they may be successful at attracting a lower than average risk, without being required to pool that risk with higher-cost consumers in other product levels. Premiums for the remainder of the market will be higher than they would be if these individuals were included in the risk pools. The risk adjustment mechanism is designed to address this kind of risk selection, but it will not produce a perfect reallocation of funds.

Require Carriers Participating in the Exchange to Offer Bronze Products

Absent this requirement, there is the potential for carriers to offer only rich plans inside the Exchange while offering leaner Bronze plans outside. This could allow carriers to enroll only the least healthy individuals inside the Exchange and draw healthier risks out. The District could require carriers participating in the Exchange to offer Bronze plans, in addition to Silver and Gold plans. This requirement would ensure that there will be more low-cost options offered inside the Exchange; these low-cost options typically attract a healthier population. The presence of these low-cost plans would improve the chances that healthier individuals would enroll in the Exchange.

Control the Minimum Level for Specific and Aggregate Stop Loss

As described earlier, another risk of selection against the market, and therefore against the Exchange, is adverse selection that might occur if small employers self insure. The District may wish to set minimum levels for stop loss coverage in an effort to control this selection. For example, if small groups are allowed to self insure and purchase specific stop loss with a $5,000 attachment point, the risk is not much different than that of a $5,000 deductible fully insured plan offered in the market today. However, the cost of self insuring could be much lower than the cost of a fully insured plan for certain employers with younger, healthier employees. This rate difference could occur for several reasons including:

- The ability to have the cost of coverage reflect the group’s actual experience rather than subsidizing older, sicker groups
- The ERISA exemption from the requirement to cover state mandates

- Elimination of the carrier's risk and profit charge on the self funded portion of costs
- Potential for lower administrative expenses

We find that some states are regulating this coverage in an effort to control this potential for selection. These states will require minimum specific stop loss attachment points of $10,000 to $15,000 and an attachment point for aggregate stop loss of at least 115% of expected claims.

Take Actions to Increase Enrollment in the Exchange

The risk of adverse selection is closely tied to overall enrollment in the Exchange. If the Exchange is large, it will be much less likely to have an imbalance of risk. Outreach and enrollment efforts will help the stability of the Exchange, however additional targeted efforts may be needed to reach and draw in healthier consumers, since consumers with health problems are the most receptive to information about new coverage options.

While the presence of premium and cost sharing subsidies will attract those eligible for them into the Individual Exchange, there are limited financial incentives to attract small employers into the SHOP Exchange. (There are small business tax credits which are temporarily available to only a limited subset of employers.) Therefore, additional efforts to engage brokers and offer value-added benefits and services to draw in small employers should be explored.

Place Restrictions on Plan Designs Offered Outside the Exchange

Plans with many different cost sharing combinations (e.g., deductibles, coinsurance, copayments) can be configured to achieve a specific actuarial value, and some cost sharing designs can be used to attract low-risk individuals. In addition, plans with narrow networks will also tend to attract healthier individuals, all else equal. The District may consider placing restrictions on the benefit plans that can be offered outside the Exchange. At the extreme, the District could consider requiring that only plans offered inside the Exchange can be offered outside the Exchange in order to prevent this type of selection from occurring. However, this could stifle innovation such as some of the value based benefit packages that are starting to emerge.

Do Not Allow Employees in the Shop Exchange to Select From All Products

The Exchange must make available the option for an employer that purchases coverage in the SHOP Exchange to select a metallic level from which their employees then have the option to select any plan (from all carriers). This flexibility inside the Exchange is required under the ACA, but it is unlikely to be available outside the Exchange, and as a result may draw employers in. However, this flexibility also comes with the risk of increased selection among carriers. The ACA also affords exchanges the option to decide whether or not to open up further this employee choice model. At the discretion of the states, the ACA allows employees to select from any available plan offered inside the SHOP Exchange. This option introduces selection at yet another level. Healthy employees could select low-cost Bronze coverage while unhealthy employees could select richer Gold and Platinum plans. Given plans will be priced based on the

average morbidity of the carriers' pool, the amount by which the Bronze plan is overpriced for a healthier than average individual is not likely to be enough to offset the amount by which the Gold or Platinum plan is underpriced for the less healthy individual. This premium shortfall will put upward pressure on rates, all else equal. Offering this additional choice may be attractive to employers, and therefore it could be helpful in raising the level of participation in the SHOP Exchange. However, we recommend the District study this potential for adverse selection carefully before deciding the level of choice offered inside the SHOP Exchange.

Several of the options discussed above could have material repercussions on the individual and small group markets in the District. It is important to balance the need to discourage adverse selection with the need to retain choice, flexibility and innovation in the marketplace. There are important provisions established by the ACA that may be successful at managing some selection, however many sources for selection remain. We recommend the District study these and similar options further.

9

Exchange Models and Insurance Standards Outside the Exchange

Exchanges can play various roles in developing a fair insurance market place for consumers depending on the philosophy, the insurance environment, and the goals of the Exchange. The ACA requires Exchanges to only offer QHPs that cover the EHB package, offer prescribed actuarial value plans and meet cost sharing standards. In addition to these requirements, QHPs also need to meet certification criteria such as marketing, network adequacy, accreditation, quality, standardization and transparency standards as described below.

Certification of QHPs is one of the important responsibilities of a Health Benefit Exchange. The comments here apply equally to a SHOP Exchange, Individual Exchange or an Exchange where the SHOP Exchange and the Individual Exchanges have been merged. The certification process has to be repeated periodically, and the Exchanges could also decertify plans based on plans or carriers' inability to meet the criteria set forth by the Exchange. Some of the criteria for certification of QHPs are established under the ACA but the Exchange has considerable latitude in setting and enforcing additional guidelines to manage adverse selection and to help ensure an optimal set of insurance options inside the Exchange.

Per the ACA, carriers offering QHPs should be licensed and in good standing to offer health insurance coverage in the District. Additional requirements include:

- QHPs must cover the EHB under Section 1302(b) and offer plans with an actuarial value (implies plan covers at least the stated percentage of covered benefits for a standard population) at one of four defined levels; Bronze (60%), Silver (70%), Gold (80%) or Platinum (90%), as required by 1302(a)(3). In addition, QHPs may also offer a catastrophic plan to individuals age 30 or younger.
- Carriers participating in the Exchange must offer at a minimum at least one Silver plan and one Gold plan.
- QHPs must abide by insurance market regulations relating to pre-existing condition exclusions, guaranteed issue, etc.
- Pediatric dental benefits should be covered by the QHPs unless one qualified dental plan in the Exchange can supplement coverage of other plans.
- The same rates must be charged for the same plan inside and outside the Exchange, regardless of the source of purchase being through an Exchange, or directly from a carrier or an agent.
- Premium rates and contract language need to be approved by the Exchange for the plans offered within the Exchange. This task could be coordinated with DISB's rate review responsibilities.

- The OOP cost sharing requirements should not exceed the limits for qualified HDHPs,[74] and for the SHOP Exchange the deductible must not exceed $2,000 for single coverage and $4,000 for other coverage tiers in 2014, indexed annually thereafter.[75]
- QHPs must comply with the risk adjustment program as outlined in 45 CFR Part 153.
- QHPs must provide to the Exchange on at least an annual basis rates, covered benefits, and cost sharing requirements for each plan offered within the Exchange.
- SHOP Exchange enrollment records must be reconciled with the Exchange data at least on a monthly basis.
- QHPs must implement a quality improvement program which should include improvement of health outcomes through care coordination, case management, improved patient safety, implementation of wellness and health improvement activities and reduction in health care disparities.
- Information on health care quality measures must be disclosed and reported to enrollees and prospective enrollees, as well as the results of an appropriate enrollee satisfaction survey.[76]
- Standardized formats for presenting health benefit coverage options (not to exceed four pages), uniform enrollment forms and quality measures must be used.
- QHPs must provide cost sharing and out-of-network coverage information.
- QHPs must be accredited as meeting quality measures during standard periods of time as defined by the Exchange.
- Networks offered by QHPs based on provider networks must be robust enough to include sufficient choice of providers, including those that serve predominantly low-income and medically needy individuals.
- QHPs must meet marketing standards and not discourage application of individuals with significant health care needs.
- Selective contracting with QHP issuers is allowed while some standards on exclusions of plans are provided. The Exchange cannot exclude a plan because it pays providers on a fee-for-service basis or because the plans provide treatments to prevent patients' deaths deemed costly by the Exchange.
- Additional benefits (including current state-mandated benefits) beyond the EHB are allowed, however, states are responsible for covering costs associated with these additional benefits through direct payment to individuals or carriers, for all members enrolled in the Exchange.
- Premium increase justification must be submitted by QHP issuers to the Exchange prior to implementation of a rate increase. The Exchange should take into consideration patterns of excessive or unjustified premium increases and excessive premium growth inside versus outside the Exchange before allowing plans to participate.

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[74] 1302(c)(1) of the ACA

[75] 1302(c)(2) of the ACA

[76] Sections 1311(c)(1)(H) and (I) of the ACA

- Carriers must post justification for premium increases on its website; price, benefit and provider network changes should be posted on a timely basis on a publicly accessible Internet website.
- Carriers should provide cost sharing information for a specific service that the individual would be responsible for paying upon request and in a timely manner. This information can be provided through the Internet or by other means for individuals without access to the Internet.
- Accurate and timely information on claims payment policy and procedures, data on enrollment and disenrollment and other data parameters, as required, should be submitted to the Exchange, the Secretary, the State Insurance Commissioner and the public in plain and clear language.

Even though the ACA sets minimum federal standards for QHPs and QHP issuers to be able to participate in the Exchange, the states have considerable flexibility to set state specific standards to meet public health, provider access, delivery system reform, quality and transparency needs.

Exchange models can vary from a passive model of market organizer/aggregator of QHPs to a more active purchaser or even a hybrid model combining some features of each model.

Active Purchaser Model

The Exchange as an active purchaser of health care could selectively contract with QHPs, set standards and have the ability to impact health care costs, access and quality. The Exchange could consider implementing a bidding process, recertify restrictively, be actively involved with setting standards, monitoring compliance with these standards and have the ability to negotiate with QHPs and providers. The Exchange could recruit new entrants into the Exchange if desired, limit the number of products offered, standardize cost sharing, encourage new delivery system strategies, require application of new health technology initiatives, and align with other District health purchasers such as District employee plans or Medicaid. An active purchasing strategy will be resource intensive and will need market research, infrastructure, outreach to stakeholders and expertise to monitor the impact of various actions and initiatives. Advantages of an active purchaser model would be the ability to impact different aspects of the health delivery system. It is a well known fact that Medicaid Programs have been able to impact health care trends nation wide, set up a bidding process for Medicaid, set provider fee schedules and require plans to meet key criteria including network standards imposed by these programs. Medicaid programs have also demonstrated selective contracting and negotiating with issuers/health plans and are a good example of an active purchaser model. The District could consider a similar strategy for their Exchange model but would face challenges since the small group and individual markets are dominated by a few carriers. As previously mentioned this is a resource intensive model, and additional expenses would be incurred to cover resources needed before adopting such a strategy. It is also important to include a cost benefit analysis and evaluate the impact of this strategy on the financial sustainability of the Exchange.

The Massachusetts Connector model is an active purchaser model and similar in many ways to the model under the ACA. The Massachusetts model has been able to limit the number of plan options inside the Exchange but has not been able to control costs or attract small group employers into the Exchange. The presence of subsidies, community rating, mandated benefits and guaranteed issue have increased health care costs.

Market Organizer/Aggregator Model

A passive Exchange would act more like a clearinghouse for QHPs and set minimum standards for participation in the Exchange. The Exchange would play the more facilitative role of a market organizer. While this would provide non-group and small group markets with more organized health care purchasing opportunities than they have had before, it would not leverage the collective power of the combined markets to negotiate better health care value. Advantages of a passive model are that it would likely reflect more consumer choice, less market disruption and encourage more carriers to participate. On the other hand, disadvantages are that it could result in confusion when faced with numerous choices for members making health care purchase decisions. It would also be challenging to implement any changes such as provider reform, quality improvement and other cost containment initiatives easily over a short-term period. Changes in the health care space would be gradual and over time depending on voluntary market based change and cooperation from many stakeholders. This model would definitely be less resource intensive and less expensive than the active purchaser approach. Given the market domination by a few carriers this would be easier to implement and could work easily with any type of administrative model selected by the District.

The Utah Health Exchange is an example of a market organizer which facilitates and aggregates health plan options in the Exchange. This model basically lets the market shape itself and facilitates insurance options for consumers by acting as a clearinghouse. This is a good example of a passive certification model which facilitates the development of an insurance marketplace but does not get involved on an active basis. The Utah Health Exchange has been successful in enabling small employers to provide more employee choice, defined contribution options for health care purchasing, good carrier participation and collective decision making on items such as risk adjustment and reinsurance. Some traditional risk mechanisms such as underwriting load have been retained and this model reflects many of the current risk management mechanisms which would definitely encourage carrier participation. In some ways the Utah model is successful in increasing consumer choice, encouraging greater dialog between carriers, etc. However, achievement of goals of cost containment, quality and health technology initiatives may take much longer and be achievable through gradual self reform by the marketplace.

Hybrid Model

A hybrid model would reflect a combination of the active purchaser and the passive market organizer models. The Exchange could selectively choose to impose stricter criteria on certain issues such as standardizing cost sharing and limiting the number of products offered. In markets dominated by a few carriers, it could encourage and assist new entrants into the Exchange. Depending on the needs or the environment in the District, it could choose to focus on delivery system reform, align with other District purchasers, or work to sponsor pilots on

ACOs, medical homes etc. Strategies under this type of a model could be phased in and could be worked on over time depending on the need and as the Exchange matures. Resources and infrastructure could also be added over time with increased evidence of financial sustainability. This is a good model for the District to consider given the market concentration in the District by a few carriers and less initial financial outlay compared to an active purchaser model. This would help the District select a more balanced approach and allow the Exchange to be able to enforce some standards while letting the market shape other considerations in the insurance markets.

The CBIA model in Connecticut is a hybrid between the passive market organizer to active purchaser of care, and plays a role in between the two models. While the CBIA does not perform some of the roles that a typical active purchaser would, such as negotiating with carriers regarding rates, it does take on active purchaser roles such as limiting the number of plans that can be offered in the Exchange to encourage competition etc.[77]

There are various factors that are unique to the District's insurance market that need to be considered in the selection of the model most appropriate for the District. The Background Research Report showed that about 32% of those insured through the private insurance marketplace reside in the District while 68% reside outside the District. Currently the 68% residing outside of the District purchase insurance in the District through their employer, and their participation in the SHOP Exchange could depend on the decisions made by their employer. Another characteristic of the District's insurance market is that roughly 30.5% of the market is covered by Medicaid and other low-income programs, and the District currently has a 7% uninsured rate. The low-income market coverage is higher than what we see nationwide and the percentage of uninsured is lower. These statistics are reasonable given the expanded Medicaid and low-income programs provided in the District. Given these characteristics, the Exchange would be better served in selecting a hybrid purchaser model since it will help balance the roles it would need to play inside and outside the Exchange while continuing to meet the needs of those enrolled in the low-income programs.

A hybrid model will allow phasing in of various standards depending on employer and carrier actions, impacts of neighboring state Exchange decisions, and actions needed to balance network and quality standards. The Exchange can use any early lessons learned to adjust standards or negotiate better options for the insurance marketplace. Currently a few carriers dominate the District insurance market place and it is possible that this would continue. The District will want to shape the Exchange standards it sets taking into consideration feedback from various stakeholders since the small group market is heavily dependent on their brokers (producers). The potential size of the Individual Exchange and the SHOP Exchanges are much smaller than those in most other states. This issue of scale would impact financial sustainability parameters and therefore insurance standards. Finally, the model adopted by the Exchange for administration and governance, the impact of the ACA rating parameters on a merged versus non merged Exchange will have an impact on the type of model that would be best for the

[77] http://www.rwjf.org/files/research/72457healthexchange201106.pdf

District to adopt. All of these issues suggest that the use of a hybrid model would be the most appropriate for the District, providing opportunities for change in the future as needed and a degree of active purchasing that can be adjusted and phased in over time as necessary. The application of this model will give the Exchange opportunities to balance the needs of carriers and consumers, which will help establish a healthy insurance marketplace in the District. The District first needs to decide whether to have separate SHOP and Individual Exchange or a merged Exchange and the appropriate administrative and governance model that would support this decision. A careful evaluation of costs and benefits of a hybrid model should then be conducted and decisions should be made based on long-term financial sustainability.

Appendix A

Technical Discussion of Oliver Wyman HRM Model

The Oliver Wyman HRM Model was used to assess potential enrollment in a District sponsored Exchange. The model has three primary modules which are discussed in this technical appendix. The first module attempts to characterize the current population, the second module calibrates the simulated population to the current market, and the third module projects the simulated population in future years given coverage options, choice and market reforms.

Market Simulation Module

The first module has its origins in the Background Research Report that Oliver Wyman prepared for the District and delivered in its final form on September 28, 2011. In that report, we discussed the rationale for characterizing the District's population with AC Survey[78] rather than other potential data sources. In particular, we addressed the AC Survey's approach to the Medicaid undercount phenomena. We also identified a consistency of basis between the AC Survey's coverage questions and our models (i.e., coverage at a particular point in time rather than over the course of a year). Finally, we also identified the AC Survey's high response rate as a strength. For each person from the AC Survey, we examined their age, gender, income, industry, insurance coverage type, geographic place of work, geographic place of residence, employment and many other characteristics.

When preparing the AC Survey data for the first module, we first adjusted the basis on which the data are reported. The AC Survey requests information about households; we have built our models to reflect decisions for HIUs. We define these HIUs as any grouping of family members where each person within the HIU might be eligible for coverage under the same policy. So for example, an AC Survey household might consist of only a brother and sister; they would likely not be eligible for coverage under the same policy. In this example, we have created identifiers to treat them as separate HIUs for purposes of our modeling.

We have excluded a number of individuals who we assumed would not be materially affected by the presence of a District sponsored exchange. In particular, we excluded HIUs where either the primary person or their spouse (if a spouse is present) is identified as a government worker. We also ultimately excluded anyone identified as an undergraduate student with ESI or individual coverage. Consistent with the Background Research Report, we revised the coverage classification for anyone identified as having individual coverage with an income below 200% FPL; for the model, we assumed that these people were covered by Medicaid. Finally, we identified a number of individuals who were identified both as having ESI and as being

[78] In the Background Research Report, we referred to the American Community Survey as the ACS data. In order to avoid potential confusion with Information Technology vendors with the same acronym that were also reviewed in this project, we are referring to the American Community Survey as the AC Survey going forward.

unemployed. We assumed that these persons would behave in our modeled market as if they were uninsured.

Module Design and Data Restrictions

Ultimately, the Oliver Wyman HRM model is designed to assess the economic incentives related to insurance coverage for each HIU. In this sense, the design is almost that of a seriatim model. However, we faced several challenges with this approach. First, there is no single data source with all the information necessary to create a seriatim model. Although the AC Survey contains information about demographics, current insurance coverage, and income, it does not include insurance characteristics of a person's employer (e.g., group size), that person's health status, the source of coverage in the HIU (e.g., the husband or wife), or premiums for coverage. Also, the person record from the AC Survey does not correspond with a single individual in the population. Rather, each record is assigned weights so that one survey respondent might represent 250 individuals in the population while another respondent might only represent 50 individuals.

To address the issue of varying weights, we duplicated AC Survey records so that they roughly corresponded to the weight assigned to an individual. For example, a person with a weight of 250 might translate to 20 duplicated records (all with the same characteristics), while a person with a weight of 50 might translate to four duplicate records. Because of computing limitations, we were not able to represent the entire District market in this fashion, but we were able to reflect a robust, stratified subset of it.

To address the issue of incorporating non-AC Survey data (e.g., health status, insurance premium), we built a micro-simulation model. This model assigns health status to each person; it also assigns people with ESI to groups. This assignment of variables is then repeated many times to ensure that we have an accurate estimate of the range of possible results.

For health status, we developed coverage-specific assumptions from self-reported data in the Census Bureau's Current Population Survey (CPS). Individuals are classified into one of five health status categories, ranging from excellent to poor. We noticed that, within a coverage type, individuals generally had similar distributions across income levels. However, there was one exception to this observation: those uninsured individuals with higher incomes reported themselves as being in better health than their uninsured, lower-income counterparts. This dynamic likely results because individuals with the means to purchase insurance are less likely to do so if they have better health; individuals without the means to purchase insurance will remain uninsured regardless of their health status.

We also noticed that the health status reported by those with individual coverage was generally less favorable than the health status reported by those with ESI coverage. (We have noticed this dynamic in similar exchange studies sponsored by other states.) Because individual coverage is underwritten and insurers have the option not to offer coverage in most states today, this observation of higher morbidity in not consistent with our expectations. We would expect that

insurers would only offer coverage to the healthiest subset of individuals; this option not to offer coverage is not available to insurers in the small group market. We have assumed that this higher-than-expected morbidity in the individual population is an inaccuracy (e.g., it might occur if individual insureds perceive their own health differently than those with group coverage). We adjusted the health status distribution for the individual insureds so that they were more consistent with the self-reported status of the ESI market. Each person was then assigned a personal claim cost relative-value based on their self-reported health status.

Synthetic Insurance Carriers

With the assistance of DISB, a data call was issued to those carriers writing business in the District with the largest market share in 2010. The information obtained through the data call, in combination with information gathered through a review of recent rate filings, was specific enough to allow us to develop theoretical, or synthetic insurance carriers.

The information obtained from each small group carrier participating in the data call included premium, claims, enrollment, and the associated rating characteristics and variables (i.e., group size factor, age/gender factor, industry factor and underwriting load factor) for each small group with coverage in 2010. The actuarial value of the benefit plan underlying each small group's premium was not provided. Using the information obtained, each group's premium was normalized for all rating factors provided, which in effect resulted in normalized premiums that reflected only benefit differences.

Because carriers are not yet designing products targeted to specific actuarial values, as they will in the reformed market, the observed benefit differences did not cluster around specific actuarial value levels. After removing outliers at both extremes, estimated actuarial values were assigned to the various groups. By examining rate filing information for the carriers included in the data call, we were able discern the level and approximate actuarial value of the richest plans offered in the market in 2010. We assigned the richest normalized premiums an actuarial value consistent with the actuarial value of the richest plans offered by the carrier in 2010. Small groups were then grouped into ranges based on their normalized premium, where the average actuarial value of each range was approximately 10% lower than the average actuarial value of the previous range. This analysis was performed independently for each carrier.

Using this information, we were then able to develop a synthetic rating manual for each carrier. The observed premiums were normalized for all rating variables to arrive at a manual rate representing a 1.00 level for all rating variables. The range of current values for each rating variable were developed from the carrier data and validated against information included in rate filings.

A set of revised rating manuals for 2014 and beyond that reflects the ACR methodology required under the ACA were also developed. The District has passed its own law[79] which reflects the

[79] "Reasonable Health Insurance Ratemaking and Health Care Reform Act of 2010."

early adoption of certain aspects of the ACR methodology that will be required under the ACA in 2014 (e.g., elimination of gender rating and compression of range by which rates can vary by age). From these changes in the law, we were able in some cases to see how carriers' rates will be adjusted under the new ACR requirements.

For those carriers for which we did not have recent rate filings reflecting these changes, and for other changes that will be required in 2014, we developed new rating manual factors such that the average impact on rates across the carrier's entire block was premium neutral. Industry, group size and underwriting load factors were set to 1.0 to reflect the fact that rates will not be able to vary based on these characteristics in 2014 and the underlying manual base rate was adjusted based on the average in force factor under the current methodology. For example, if the average group size factor under the current rating methodology was 1.05, the base rate was increased by a factor of 1.05 to offset the fact that the average group size factor in 2014 will be required to be 1.00.

Synthetic Groups

In addition to assigning health status to each person, we also assigned each person with group coverage to a theoretical, or synthetic group. In describing their micro-simulation model, the CBO discusses their approach to creating these synthetic groups. As we understand it, the CBO pooled individuals with similar incomes to develop their synthetic groups;[80] in our model, we have pooled individuals in similar industries. The AC Survey data include industry classification for those persons that are employed. As we created synthetic groups, we ensured that health care providers were included in groups with other health care providers, we ensured that lawyers were included in groups with other lawyers, etc.

Our model also reflects the industries and corresponding group sizes in the District based on existing distributions of employers. For these distributions we relied on data prepared by D&B. The D&B data show each employer in the District, their industry, the number of employees at each establishment in the District, and the number of employees across the entire organization. As with the AC Survey data, we took care to remove any government employers (either based in the US or other countries) from the data. These D&B data do not provide any information related to employee health benefits; so, we used data from the MEPS to supplement the missing information. Specifically, we relied on the blended results from the 2009 and 2010 MEPS insurance/employer component data to establish the rates at which coverage was offered at various group sizes. We also used the MEPS data to examine rates of eligibility and enrollment at various group sizes.

Based on these assumptions, the micro-simulation model assigned employees from the AC Survey data to groups of similar industries (at various group sizes) until all covered employees in the AC Survey data were assigned. For example, a lawyer in one iteration might be assigned to a large law firm, and in the next iteration, that same lawyer would be assigned to a small

[80] http://www.cbo.gov/ftpdocs/87xx/doc8712/10-31-HealthInsurModel.pdf

practice. Employees in synthetic groups were then summarized, and assigned a carrier based on the carrier's market share. The groups were assigned a premium based on the groups' characteristics, their carriers' rating practices, and the synthetic rate manual of their assigned carriers. So, extending our example, the model might build a small group of lawyers, assign them a carrier, and then assign them rating factors from that carrier for health status, demographics (i.e., the age, gender, and family composition of each employee), group size and industry.

In addition to examining the premium based on the carriers' present rating practices, we also examined the rate change (called "rate shock") that each group would experience in 2014 as a result of new rating restriction imposed on carriers by the ACA. These restrictions will limit rating for age, while eliminating rating for gender, health status, group size, and industry. Consequently, groups that have benefited with lower premiums as a result of their characteristics (e.g., those who are younger and healthier) will potentially see very large rate increases, while groups that have paid higher premiums as a result of their characteristics (e.g., those who are older and more unhealthy) will see rate decreases. The original group premium and the group premium resulting from the rate shock are both carried with the employee into subsequent modules.

For each small group, we also estimate whether or not the group might be eligible for subsidies under the ACA. As discussed in the Background Research Report, small groups meeting certain size, average wage, and employer contribution requirements might be eligible for tax credits. Based on the simulated individuals in the synthetics groups, we have attempted to estimate eligibility for these credits.

Finally, we estimated the cost of individual coverage for every HIU in the model. This cost estimate is a key element in future modules. The cost of individual coverage is critical for estimating the behavior of those who currently have individual coverage, but it is equally important for those with ESI or even those who are uninsured. As employers choose to eliminate coverage and tax credits become eligible for certain individuals in the Exchange, many persons beyond the existing individual market will begin to examine coverage there.

As with our estimates for group costs, we assigned a carrier to each HIU based on the carrier's market share. We then built a premium for that HIU based on the carrier's rating practice and the rating characteristics of the HIU. Finally, we estimated a rate shock that the HIU would experience as a result of new rating restrictions under the ACA (e.g., elimination of rating based on health status, gender, etc.) The original individual premium and the individual premium resulting from the rate shock are both carried with the HIU in subsequent modules.

Market Calibration Module

The second module in the Oliver Wyman's HRM Model is a calibration module. The purpose of the calibration module is to solve for the model parameters that replicate the known insurance marketplace in 2010. The steps in the simulation module described above represent one

iteration. These steps are repeated multiple times until the average results across multiple iterations replicate the known current population. If the known results are not replicated, model parameters are adjusted and the simulations are repeated.

The results are calibrated at a number of different levels. First, results are examined to ensure the appropriate number of people were simulated to have each type of current coverage (e.g., individual, small group, Medicaid, etc.). Within the individual and small group markets, the average premiums developed through the application of the synthetic rating manuals were also reviewed to ensure they were consistent with known premiums of $263 PMPM in the individual market and $355 PMPM in the small group market.

Next, the distribution of rate shock anticipated in 2014 is reviewed. Using the carrier data obtained for small group business, a rate shock due to the shift to an ACR methodology is developed for each group by adjusting each of the rating variables for the group to the average for the carrier's small group block. This distribution of rate shock is then compared with the distribution of rate shock simulated through the application of the synthetic insurer rate manuals. Since the groups included in the simulations may posses different combinations of age, gender, group size, industry and morbidity characteristics, the calibration process ensures that the distribution of overall rate shock resulting from the aggregation these individual factors is consistent with the distribution of overall rate shock from the known carrier data. A similar process is employed for the individual market.

Ensuring consistency of carriers' morbidity loads was the critical test of the rating calibration. We calculated the cumulative probability distribution for the morbidity loads as assigned by each carrier. We then mapped these morbidity loads to each synthetic group. During this process, we were careful to map morbidity loads so that the probability distribution of health statuses matched probability distribution of morbidity loads.

Once the simulation module is calibrated, the results are used to calibrate the market migration module (discussed in detail next). The market migration module uses the results of the 2010 populations created by the calibrated simulation module and projects the market into which individuals will enroll, based on the options available to them. For those individuals that were enrolled in ESI coverage, the premium for that coverage is also passed from the calibrated market simulation module. Premiums in the individual market are calculated for each HIU and passed from the market simulation module. In order to ensure that an appropriate utility function is utilized in the market migration module, the model is calibrated to reproduce the status quo.

While a utility function can model people's desire for consumption of health care services, as well as their aversion to financial risk, it cannot predict certain behaviors, such as why people eligible to enroll in Medicaid do not enroll, or why individuals with sufficient financial means to purchase health insurance chose to be uninsured. It is because of these behaviors that the model calibration is necessary.

To perform this calibration, all of the information resulting from the simulation module is considered except the known market in which the individual was enrolled in 2010. Individuals with coverage through Medicaid, Medicare, military coverage and coverage through District or Federal government employee programs were excluded from the calibration, as individuals with these types of coverage are assumed to continue with those coverages throughout the projection. For each of the remaining HIUs, the various coverage options available to them in 2010 are examined and the utility associated with each option is calculated. HIUs with household MAGI greater than 200% FPL are not allowed to evaluate the option of enrolling in Medicaid, the Alliance program or the 138%-200% FPL Waiver program. Once a utility is calculated for each of the allowable options, the option with the greatest utility is selected and the HIU is assumed to enroll in that health insurance option.

For HIUs where the current coverage is not the same for all family members, these “split decisions” were also an option that was evaluated. For example, if the primary respondent to the AC Survey is reported to have ESI coverage, but the spouse is reported to have individual coverage, an option where the primary individual enrolls in single coverage under the simulated employer group plan is evaluated in combination with the spouse enrolling in any of the five coverage levels modeled to be available in the individual market.

For most of 2010, the reforms that became effective September 23, 2010 were not in effect, in particular the requirement that dependents be allowed to remain on their parent’s coverage up to age 26. Therefore, in performing this calibration, dependents under age 19 were handled separately from those ages 19-26. For the 19-26 population, we examined the actual coverage that the 19-26 year old had in 2010, relative to the rest of the HIU. If the primary respondent to the AC Survey had ESI or individual coverage, but the 19-26 year old dependent did not, we assumed it was because they were not eligible to enroll under the same coverage as the primary individuals. In this case, the 19-26 year old was evaluated as a separate HIU for purposes of the calibration. It is important to note that this rule was only used for the calibration, as these 19-26 year olds would be eligible to enroll on their parent’s coverage in 2014 and beyond.

The process of determining which coverage option(s) each HIU would enroll in based on application of the utility maximization methodology was repeated for each iteration of results from the simulation module. The projected enrollment in each market was aggregated across all simulations and compared to the known 2010 distribution (the distribution resulting from each iteration of the simulation model is referred to here as the known 2010 distribution) by market at several sub-population levels.

If the projected enrollment results did not replicate the known 2010 distribution, the various parameters in the utility function were revised until the projected enrollment was consistent with the known enrollment at several key sub-population levels. The following table compares the known 2010 distribution of District residents (excluding those enrolled in public programs and those covered as government employees) and employees (including their covered dependents) with the projected distribution resulting from the migration model, across all model iterations.

	Known Distribution	Migration Module
Uninsured (District Residents) <=200% FPL	17.3%	18.4%
Uninsured (District Residents) 201%-400% FPL	4.6%	4.8%
Uninsured (District Residents) >400% FPL	4.4%	4.6%
Individual (District Residents)	8.8%	9.2%
Small Group (District Residents; Work in District)	10.7%	10.5%
Small Group (Non-District Residents; Work In District)	32.8%	32.2%
Mid-group (District Residents; Work in District)	5.8%	5.6%
Mid-group (Non-District Residents; Work in District)	15.5%	14.8%
Total	**100.0%**	**100.0%**

The table above demonstrates that we were able to calibrate our model to reproduce the distribution of individual purchasing decisions that were made in 2010.

Market Migration Module

The final module in the Oliver Wyman's HRM Model is the market migration module. The purpose of the market migration module is to project the migration of individuals between the various coverage statuses that will be available to them in the post-reform insurance marketplace. We developed these projections based on the simulated population, along with many other medical and economic input variables, and also based on the introduction of the ACA changes that will occur in 2014 and beyond.

Limited aspects of the module were described previously when describing the model calibration; however, here we provide a more detailed overview.

For each iteration of the market simulation module, the resulting simulated population is input into the calibrated market migration module, and the purchasing decisions for each HIU are modeled for each of the years 2014 through 2018. Individuals currently enrolled in Medicaid, Medicare, those having coverage through the military and those receiving coverage as a result of being an employee or a dependent of an employee that works for the District or Federal government are assumed to retain that coverage. In addition, as described in the body of the report, large groups are assumed to continue offering coverage at the same rate at which they do today. As a result, all of these individuals are not run through the market migration module. These populations are projected to grow at the same population growth rate assumed in the model. Additional individuals with current individual or ESI coverage, and those currently uninsured, are allowed to enter the Medicaid population as will be described below.

As described in the body of the report, the model assumes a steady state population from the perspective that the underlying mix of the population does not change with respect to many variables. Annual increases in population growth and income are projected. In projecting

population growth each individual in 2010 receives a population growth weight based on their age in 2010. These population growth weights allow each person in the 2010 population to represent an additional fraction of a person in 2014 and beyond, with the weight increasing each year by the population growth for the age range to which they belong.

Incomes are increased by the assumed salary inflation factors, and FPL levels are projected based on the statutory formula for calculating FPL. Based on the income, family size and composition of each HIU, the MAGI is calculated for each projection year. Projected MAGI levels for each HIU are then compared with projected FPL levels to determine each HIU's income as a percentage of FPL for each projection year. These FPL percentages are then used for:

- Determining whether the HIU is eligible for Medicaid or children within the HIU are eligible for CHIP
- Determining whether the HIU is eligible for premium subsidies within the Individual Exchange
- Determining whether the HIU is eligible for cost sharing subsidies within the Individual Exchange
- Determining whether the HIU is eligible for exemption from the individual mandate penalty if they elect not to enroll in coverage
- Determining whether the ESI coverage made available to HIU is deemed "unaffordable" and as a result the HIU is eligible to enroll in the Individual Exchange and receive premium and cost sharing subsidies

The market migration module evaluates several different options in which the HIU is eligible to enroll. The model calculates the utility for each one of these options. HIUs are only allowed to evaluate ESI coverage if they are currently enrolled in this market as the model does not assume new offerings of ESI coverage. HIUs are only allowed to evaluate the option of enrolling in Medicaid or subsidized coverage inside the Individual Exchange if they meet the income eligibility requirements.

The potential options that are evaluated for each HIU (where eligible) include:

- All individuals in the HIU enroll in ESI coverage at the level made available by the employer for the year modeled
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Bronze level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Silver level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Gold level coverage in the individual market

- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI enroll in Platinum level coverage in the individual market
- All individuals in the HIU currently enrolled in ESI coverage enroll in ESI coverage at the level made available by the employer for the year modeled, and those currently not enrolled in ESI remain uninsured
- All individuals in the HIU enroll in Silver coverage within the Individual Exchange and receive premium subsidies, and cost sharing subsidies where applicable
- All individuals in the HIU enroll in non-subsidized Bronze level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Silver level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Gold level coverage in the individual market
- All individuals in the HIU enroll in non-subsidized Platinum level coverage in the individual market
- All individuals in the HIU elect to remain uninsured

Individual Utility

Individual HIUs are assumed to make insurance purchasing decisions by evaluating the various options above and making an economically rational decision to select the option that maximizes the utility for the HIU. In cases where different members of an HIU enroll in different markets (e.g., the primary AC Survey respondent enrolls in ESI coverage but the spouse enrolls in individual coverage), the utilities for all members of the HIU are aggregated to develop the corresponding utility for the HIU under that option.

In order to model this behavior, a utility function and associated parameters were selected. As described in the previous section, the utility function and parameters selected were those that resulted in replicating the status quo upon application of the market migration module to the simulated population, across several iterations. The underlying utility function that resulted in this optimal model calibration is as follows:

$$U_{i,j} = -E(OOP_{i,j}) - premium_{i,j} - \frac{1}{2} rVAR(OOP_{i,j}) + u(H_{i,j})$$

In the equation above, $OOP_{i,j}$ is the OOP health expenditures for HIU i under purchasing option j, r is the risk aversion coefficient and $U(H_{i,j})$ is the utility associated with consuming health services. $U(H_{i,j})$ is assumed to be proportional to the expected value of the total expenditures for health care services with the ratio a. In calibrating the model, we elected to vary the parameters r and a at three different ranges of incomes to reflect the fact that individuals with higher incomes are more risk averse. The parameters for r and a that resulted from the market calibration module are:

Income as a % of FPL	r	a
<200%	0.0000025	0.10
201%-400%	0.000012	0.15
>400%	0.000016	0.15

Personal Claims Cost

Within the model, a PCC is developed for each District resident and employee for the base calibration year, and each subsequent year modeled. This PCC, or some multiple of it, is used as an approximation for the expected value of total expenditures for health care services utilized in the utility function above.

The PCC for each individual is calculated as the base claims cost for the insured market for the year, multiplied times an adjustment to reflect the relative level of claims expected for someone of their age/gender relative to someone of the age/gender underlying the base claims cost, multiplied times an adjustment to reflect the relative level of claims expected for someone of their health status relative to someone with the health status underlying the vase claims cost.

In evaluating the utility associated with being uninsured, the PCC for the individual is reduced by a factor to account for the fact that those without current health insurance do not seek medical services at the same level as those with insurance. In evaluating the utility associated with a currently uninsured individual taking up insurance, the PCC is increased by a factor to account for pent-up demand.

Employer Demand Elasticity

The response from employers to changes in premiums and other financial incentives, is a critical element of the model. Because of new rating requirements in the ACA, many groups will see substantial rate changes (both up and down). In addition, there are provisions in the ACA that we assume will only increase the cost of coverage (e.g., fees collected by the Federal government from insurers). These additional costs will generally discourage employers from offering coverage at their existing benefit levels. When trying to model the specific response a group will have to a price change, we rely on elasticity assumptions.
Generally speaking, these elasticities measure changes in behavior in response to changes in price (e.g., an increase in the price of bread causes a decrease in the quantity demanded). In our model, we have characterized an employer's response to increasing premiums by decreasing the benefits that the employer offers in their health plan. For example, an increase in premium might cause an employer to offer a Silver plan instead of a Gold plan. The employer responds to increasing premiums this way until the benefit levels no longer justify offering coverage.

One significant challenge with this particular assumption is the uncertainty associated with it. Employer coverage decisions occur in an environment with numerous financial incentives as

well as qualitative considerations. (For example, a small group employer in today's market may absorb very high premium changes as long as it means that her employee's ill spouse is able to receive their required care.) Any attempt to model behavior of this sort is going to have shortcomings. In an effort to obtain the strongest assumptions available, we reviewed numerous published sources. In particular, we relied on a review of existing research into price elasticity of the demand for health insurance as published by Mathematica. This report identifies ranges for price elasticity of employer offer from -0.14 to -5.80. In addition, we also relied on the CBO's assumptions employed in its own micro-simulation model. The final assumptions we employed varied by group size (identified as GS), were generally consistent with the results published in the Mathematica Report, and are characterized by the following equations:

GS 1 to 10:	-1.14
GS 11 to 50:	0.1722 * ln (GS) – 2.2273
GS 51 to 350:	0.1182 * ln (GS) – 0.8424

As we reviewed the results from the model, we found that the expected group behavior was generally consistent with other estimates we have seen from independent studies of the ACA's effect on small group coverage.

Inertia Factor

In many cases, the evaluation of two competing options using the selected utility function results in utility values that are very similar. For example, the utility associated with purchasing Bronze level coverage in the individual market may be only marginally different than the utility associated with being uninsured. From year to year, the impact of medical trend and the change in the penalty under the individual mandate for not taking coverage do not change at the same rate. This can result in individuals alternating back and forth between these two options in subsequent years under a pure utility maximization approach.

Several studies have documented the inertia related to individual decision making, where people elect the status quo even though utility theory indicates it is rational to elect an alternate option.[81, 82] Therefore, to reflect this behavior and add stability to the modeled results, we have built an inertia factor into the model such that if the utility associated with an option that has the maximum utility for a given year is not at least a stated percentage higher than the utility associated with the current option, the change in coverage is not made.

[81] Su, X. (2009). “A Model of Consumer Inertia with Applications to Dynamic Pricing. Production and Operations Management.” 18: 365–380. doi: 10.1111/j.1937-5956.2009.01038.x

[82] “The Power of Suggestion: Inertia in 401(k) Participation and Savings Behavior.” Brigitte Madrian and Dennis Shea.

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DISTRICT OF COLUMBIA HEALTH INFORMATION EXCHANGE FINAL STRATEGIC PLAN C.3.3.2.3

DEPARTMENT OF HEALTH CARE FINANCE

NOVEMBER 23, 2011

Government Human Services Consulting

MARSH & McLENNAN COMPANIES

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1

Executive Summary

C.3.3.2.3 Exchange Final Strategic Plan

The Contractor shall develop and provide a comprehensive discussion of each of the areas identified in the Exchange Strategic Outline to guide the successful implementation of the District's Exchange.

The District of Columbia (District) continues to make strides to ensure that all residents have access to high quality health care. With over 93% of residents insured, the District is second in the nation for providing health insurance coverage to its residents. federal health reform legislation, known as the Affordable Care Act of 2010 (ACA), established a number of provisions for strengthening and expanding federal and state health care programs to increase options for coverage for millions of uninsured Americans. The centerpiece of reform involves the establishment of state Health Insurance Exchanges (Exchanges) to create a new entity and provide the foundation for organizing the insurance market into a better-functioning market that improves choice and value for low and moderate income individuals, families and small businesses. The Exchanges are also intended to provide other functions including information on qualified available health plans, a web site and toll-free number and integration with existing health care programs offered by the State or District.

In May 2011, Mercer contracted with the District to analyze and report on several key aspects of ACA planning including whether the District should build its own Exchange and if so, how such an Exchange might be structured and implemented. Deeper analysis of DC HIX implementation will take place through Level I Establishment Grant activities.[1] These activities will begin the process of implementing the District's decisions that resulting through the Health Reform Implementation Committee's (HRIC) recommendations and decision making and Mercer's Planning Grant research and deliverables. Level I Establishment Grant activities are scheduled to begin in January 2012.[2]

On October 17, 2011, Mercer was informed of the following District decisions regarding ACA implementation. Decisions were made based on both the HRIC's and Mercer's recommendations:

1. Type of Exchange — District DC HIX

[1] Not part of Planning Grant activities

[2] Correspondence from the District regarding Level I Establishment begin date

2. Governance of the Exchange — Quasi-governmental agency
3. One or Two Exchanges — Single
4. Impact of existing DC Medicaid Expansion program — Decision pending
5. Ownership of Medicaid Eligibility — Decision pending
6. Program integration — Welfare and medical assistance eligibility programs should be linked

To aid the District in planning for the DC HIX Mercer has developed a DC HIX Strategic Plan Draft. The DC HIX Strategic Plan Draft is aligned with the District's vision, goals and capacities, as well as the particular opportunities and requirements set forth by the Office of Consumer Information and Insurance Oversight (OCIIO). Mercer prepared the DC HIX Strategic Plan through the completion of the following tasks:

- Business Operations Memo
- Program Integration Memo
- Technical Infrastructure Memo
- Financial Sustainability Memo
- Legal and Policy Memo
- DC HIX Insurance Marketplace Memo

On October 18, 2011, the HRIC submitted a report to the Mayor containing the HRIC's recommendations related to the DC HIX governance and structure. In developing this Strategic Plan Draft, Mercer took into consideration the HRIC's recommendations on governance and the District's decision to build its own Exchange administered through a quasi-governmental agency.

The following document outlines options, findings, District decisions regarding the Exchange (if applicable), planning considerations and Mercer's recommendations and next steps. Please note that some DC HIX decisions have not been formalized.

Business Operations Mercer Recommendations and Next Steps[3]

1. The District will create a quasi-governmental agency to operationalize the Exchange, with exemptions from obstacles in the general procurement policies of the District code, will provide for the DC HIX to more efficiently procure vendors and services.
   A. The HRIC recommended a quasi-governmental agency as the governance structure for the DC HIX. The District's personnel policies were viewed as an obstacle and the quasi-governmental agency should seek exemptions from these policies.
2. The District should determine whether it intends to establish an active purchaser or clearinghouse (passive) Exchange. This decision will determine the scope of the functions to be performed by the DC HIX and impact the type and number of staff needed.

[3] HRIC recommendations noted are from the HRIC report to the Mayor regarding DC HIX governance and structure, October 18, 2011.

   A. The HRIC recommended that enabling legislation require the Executive Board to consult with advisory boards and stakeholders prior to making a policy decision.
3. A common governance and administrative structure is recommended for the District's Small Business Health Options Program (SHOP) and individual market DC HIX to facilitate coordination and achieve efficiencies
   A. The HRIC recommended that the Executive Board consult with advisory boards and stakeholders regarding whether the SHOP DC HIX should be merged with the individual market.
4. With the passage of enabling legislation, the District should develop a process for Board appointments and immediately establish the Governing Board.
   A. In addition to the qualifications for Board members required by the United States (US) Department of Health and Human Services' (HHS') proposed rules, enabling legislation should include recommendations from stakeholders on member appointments.
      i. HRIC recommendations included the provision that at least one member of the DC HIX be a consumer advocate, which was included in stakeholder recommendations regarding Board composition.
   B. Four year terms are recommended for board members, with initial appointments serving staggered terms.
      i. This is consistent with the HRIC recommendation.
   C. Based on stakeholder input, it is recommended that every effort should be made to appoint District residents as members on the Governing Board.
      i. HRIC recommendation is that the majority of the appointed Executive Board members, excluding ex-officio members, be District residents.
      ii. The HRIC recommended that there be six non-voting ex-officio executive agency officials representing relevant District agencies. Mercer recommends that the Directors of DHCF and DISB should be designated as two of the non-voting, ex-officio members.
5. The District and Governing Board should create, recruit and hire a qualified Executive Director as soon as the governance structure is established.
6. Through Level 1 Establishment Grant activities, the District, Governing Board and Executive Director should develop a detailed business operations plan that includes all staffing levels of the DC HIX. The plan should be updated once a decision has been made as to the type of DC HIX to be established.
7. Key staff that should be recruited and hired in 2012 to support the establishment of the DC HIX include, at a minimum: Executive Director, Chief Information Technology (IT) Officer, Director of Finance, Chief General Council and Human Resources Director. All executive management staff positions and key mid-level management positions should be filled no later than the first quarter of 2013.
8. The District should develop a competitive compensation package to attract the most talented candidates.

Program Integration Mercer Recommendations and Next Steps

Due to the complexity of Program Integration, Mercer provides the following recommendations and considerations for the following components of Program Integration:

a. *The current public health care programs available in the District, including corresponding eligibility, covered benefits and operations;*
b. *The impact on Exchange implementation to the eligibility levels and operations of existing health care programs, including Medicaid, the Children's Health Insurance Program (CHIP) and the DC Health Care Alliance (Alliance);*
c. *Models for Medicaid screening under the new Medicaid eligibility guidelines, including maintaining eligibility in IMA/DHS, transferring the function to DHCF, transferring function to new Exchange entity (if any) or others models;*
d. *The transition of individuals from the Pre-existing Condition Insurance Plan (PCIP) to the Exchange;*
e. *The transition of members of Congress and Congressional personal office staff from their current insurance plans to the Exchange[4]; and*
f. *The transition of employees from current coverage to Employer Sponsored Insurance purchased through the Exchange.*

a. The current public health care programs available in the District, including corresponding eligibility, covered benefits and operations

- Recent Medicaid expansions up to 133% of the Federal Poverty Level (FPL) and CHIP Maintenance of Effort requirements will lessen the impact on integrating Medicaid coverage operations including eligibility determinations into the DC HIX environment.
- Some parents and guardians, youth above 18 years and childless adults whose incomes exceed the 133% FPL will no longer be Medicaid eligible in 2014 when the State Plan Amendment (SPA) and Waiver are set to expire. They would seek coverage through the DC HIX and receive federally subsidized premiums and out-of-pocket (OOP) costs. An estimated 30,000 individuals (between 133%-150% FPL) previously enrolled in Medicaid would be treated in the same manner as other low-income workers between 133%-400% FPL.
- The enactment of a Basic Health Program (BHP), financed in large part by the Federal Government, could help low-income immigrant workers under 150% FPL who otherwise are not Medicaid eligible or DC HIX eligible due to questionable legal status.
- Those individuals currently in the Alliance, about 32,710 people (or 18,750 if an enrollment cap is imposed in 2012) who remain undocumented (an estimated 52% or about 17,000 individuals) must remain outside the DC HIX and require annual eligibility assessments to verify their continued eligibility for the Alliance.
- Those individuals currently in the Alliance (<200% FPL) earning above 133%-200% FPL and those residents earning up to 400% FPL will require annual assessments to determine if

[4] Please note that the District has not published formal decisions regarding d and e above.

their incomes continue to qualify them for the Alliance or federal subsidies through the DC HIX.

b. The impact on Exchange implementation to the eligibility levels and operations of existing health care programs, including Medicaid, CHIP and the Alliance

A single point of entry for insurance consumers is designed to support consumers in the complex eligibility processes envisioned in the ACA. Merging Medicaid and Alliance business rules with the many contingencies available necessitates a consolidation of the business rules into an integrated environment within the DC HIX.

The very fact that eligibility is an annual requirement and involves large segments of the District's population, including for the first time workers who are continuously moving above or below the poverty levels as they find or lose work, adds a layer of complexity that requires close coordination of public programs and private health coverage not previously administered by the District's agencies.

- The focus for eligibility determinations is no longer limited to the District's safety net programs. Under the ACA, the focus shifts to assessing the near-poor and low-income workers for their eligibility for federal subsidy and access to private insurance coverage, not public programs.
- Large segments of the District's population will remain low income and yet continue not to be eligible for Medicaid coverage in 2014. Seeking affordable health coverage will require them to enter the DC HIX where assessments and guidance can assure their access to affordable coverage.
- Clearly, the impact to the District's Medicaid program is not an obstacle for those individuals who will continue to qualify for Medicaid support given recent expansions. On the other hand, the Alliance population raises significant issues and opportunities to direct significant portions of this population to receive federally subsidized coverage in the DC HIX or in a BHP.
- To accomplish this efficiently and accurately, the DC HIX environment is the most appropriate place to conduct an assessment of the many complex variables that need to be considered in making the "one-stop" eligibility determination and directing them (enrollment) to the most appropriate private insurance coverage.
- Given the changing focus of eligibility determination and the more complex analysis required, our recommendation is that the Modified Adjusted Gross Income (MAGI) and simplified Medicaid/CHIP eligibility should be integrated into the DC HIX through a consolidated rules engine that can support a seamless eligibility verification and enrollment process.

Further, our recommendation is that careful thought should be given to locating the determination of Medicaid/CHIP eligibility in the DHCF, which already has direct experience in

administering health plan contracting (Medicaid Managed Care Organizations [MCOs]), enrolling recipients and consumer support, among other experience. Culturally, the DHCF is best positioned to view the program city-wide and in a manner that will permit the full integration of both public and private sector interests.

c. Models for Medicaid screening under the new Medicaid eligibility guidelines, including maintaining eligibility in IMA/DHS, transferring the function to DHCF, transferring function to new Exchange entity (if any) or others models

- The decision process must include the possibility of a federal/state partnership that would result in the determination of Medicaid/CHIP eligibility becoming a federal function.
- IMA is currently in the process of a major systems procurement and replacement. This introduces significant implementation and timeline risk.
- The processes for the determination of Medicaid/CHIP eligibility are required to be integrated into the DC HIX. This includes MAGI calculation and simplified Medicaid Eligibility determination. As part of the creation of the “blueprint” of the DC HIX, the business rules that are required to support these processes should be identified and included in the DC HIX.
- The “one-stop” shopping eligibility and enrollment application will be a function of the DC HIX. As described above, the business rules Medicaid/CHIP eligibility will be integrated into the DC HIX. Transactions can be produced from the DC HIX for eligibility verification and enrollment, similar to a Qualified Health Plan (QHP) in the commercial market.
- The DHCF is best positioned to manage the integration of Medicaid/CHIP eligibility within the DC HIX. DHCF offers the most experience in managing the array of business processes related to insurance coverage and regulatory oversight of health plans; it offers an inclusive perspective for the expanded population being served which will now include low-income wage earners under 400% FPL. The need to serve all of the citizens needs in a single eligibility application should be of the main goals of the District.

In conclusion, regardless of the creation of a quasi-governmental entity or direct agency management, the DHCF is the most appropriate agency within the District to manage ACA implementation including integration of Medicaid/CHIP eligibility into the DC HIX.

d. The transition of individuals from the PCIP to the Exchange

- Wait for additional guidance from HHS as to how the close-out of the Pre-existing Condition Insurance Plan (PCIP) program and transition of the current enrollees to the DC HIX will occur.
- Conduct outreach to PCIP members to inform them of the forthcoming opportunity to participate in the DC HIX. Outreach program should include information on how to access and enroll in the DC HIX and ability to leverage consumer assistance programs (through the District Ombudsman office). Given the low number of enrollees (36), this should be achievable for each member.

- Work to obtain data from the current PCIP that not only identifies the current 36 program enrollees, but can be used to ensure a smooth transition into the DC HIX. Identifying the enrollees' current providers, specialists and/or Primary Care Physician (PCP) would allow for continuity of care for these enrollees'. Additionally, information about their current diagnosis and medications would permit these enrollees to locate providers and plans that allow patients to continue with their same treatment plans, as well as permit an understanding their OOP costs.

e. The transition of members of Congress and Congressional personal office staff from their current insurance plans to the Exchange

- Continue to monitor the situation and wait for Congress to enact amended legislation to correct the "drafting" errors noted by the Congressional Research Services (CRS).
- Await clarification as to the effective date of the new legislation for Congress and staff members.
- Await clarification as to whether the Federal Employee Health Benefits Program (FEHBP) will be considered a "grandfathered" plan, or if all plans in the FEHBP will move to the DC HIX.
- Await clarification as to whether the new laws apply to all 535 members of Congress and their Congressional Staffers.
- Await clarification on if Congressional staffers have the right to enroll in their home state Exchange or if they be required to enroll in the DC HIX.
- Once clarification is received, members of Congress and their staff should be treated like small businesses. Each state should enroll their Congressional members and staff into the DC HIX in the same manner that a small business entity would register. Once registered, Congressional members and staffers would receive notification that they are eligible to make benefit selections from the DC HIX. If the Federal Government elects to make a "defined" contribution or premium subsidy, this would be applied to each member or staffer's premium calculation, similar to an employee of a small business within the DC HIX. Additionally, having each state enroll its Congressional members and staff would afford the District the opportunity to manage the transition of Congressional members and staffers enrolling and dis-enrolling from the DC HIX.

f. The transition of employees from current coverage to Employer Sponsored Insurance purchased through the Exchange

In summary, a well-designed SHOP program will facilitate a smoother transition of small employers into the DC HIX and allow it to survive against other external markets. In the design of the SHOP environment, the District needs strategies for how to attract and retain small businesses within the DC HIX. The District must engage brokers and provide incentives for brokers to enroll small businesses into the DC HIX. The District should also offer incentives for wellness and preventive care (such as weight loss and smoking cessation) that not only help small businesses lower their overall risk and premiums, but lead to improved quality of life for individuals, and ultimately lower health care costs. The following highlights some of the key

factors and recommendations that will make the DC HIX attractive and viable for small businesses, thus facilitating a smoother transition:

- Focus on providing high-value, low-cost health care benefit options to attract small businesses to the DC HIX marketplace.
- Maximize participation to create a successful and sustainable SHOP environment.
- Develop an aggressive outreach program to market the DC HIX to the broker community and to small businesses.
- In designing the SHOP portion of the DC HIX, the District should look to the examples provided by other states, such as Massachusetts, New York and Connecticut.
- Determine if the District is going to use a “defined contribution” model.
- The DC HIX must be designed to compete with external markets and should not only provide cost and value, but also promote and reward wellness on the part of employees. To create a smooth transition for employers and employees to the DC HIX, it is incumbent upon the District to design the SHOP program to offer advantages (such as premium discounts) that cannot be obtained by small employers in the outside market.
- Engage the Broker community. This is one of the key lessons of the early DC HIXs (particularly Utah). The Brokers serve the role of providing outreach, education and communication for the DC HIX, helping to link commercial carriers, small business and DC HIX. Brokers can assist the District in the following manner:
  - Provide outreach to Small business employers.
  - Educate small business employers on the use and navigation of the DC HIX.
  - Educate small business employees on the benefit choices offered within the DC HIX.
  - Influence small employers and businesses to purchase coverage through the DC HIX.
- Define the role and compensation package for Brokers. Brokers provide vital aspects for recruiting and transitioning small employers to the DC HIX and ultimately helping to establish the viability of the DC HIX.

Technical Infrastructure Mercer Recommendations and Next Steps

The District has several options to create the DC HIX to comply with the requirements and timelines outlined in the ACA. The following series of options and recommendations are based on analysis by the Mercer Planning Team to-date and current federal guidance and direction for the establishment of a DC HIX.

The District should seek a Systems Integration (SI) vendor that can manage and oversee the implementation of the DC HIX, as well as ensure the seamless integration of eligibility and enrollment components into the DC HIX. Ideally, the SI could take on the administrative burden of procuring the solution modules based on the District’s requirements. The SI will be required to fill different roles in the establishment of the DC HIX — with the roles changing along with the continuing development and timeline of the DC HIX — from pre-implementation to ongoing operations and maintenance. The following are required for the DC HIX SI role:

1. Create the DC HIX architectural blueprint. These are steps that should be completed as part of the establishment of the DC HIX, which is part of the Level 1 Grant. The blueprint for the DC HIX will be in line with CCIIO guidelines, requirements and blueprints. The following deliverables should be created in this step:
   A. The DC HIX Concept of Operations
   B. The Logical Conceptual Model
   C. High-level Business Architecture and Business Requirements
2. Based on the completed blueprint, the second step of the process will be to create Requests for Information (RFIs) for system demonstrations. The SI will have the responsibility of creating the vendor RFI, scheduling the vendor demonstrations and assisting the District in evaluating the vendor demonstrations. During the course of the demonstrations, it will be critical to understand several key components of the vendors offering:
   A. Major functions, modules and capabilities the vendor offers and how these align with or complete the DC HIX blueprint.
   B. Vendor adherence to open standards — including the recommendations listed above — and allowing for an understanding of the vendors ability to integrate functionality, major functional areas, modules and the District's eligibility programs into the Enterprise Service Bus (ESB) of the vendor for the DC HIX.
   C. Cost of the vendor system, procurement options (including Software as a Service [SaaS]) or Cloud-based options for solution implementation.
3. The DC HIX system vendor(s) will need to be selected as part of this process. The District will have the option of determining the role of the SI in the evaluation and recommendation process, including bringing the entire solution. Some SI roles for the Medicaid Management Information System (MMIS) now include the option of the SI assisting in the evaluation process or bringing forth the entire systems solution. This will be a contracting option for the District.
4. As no one system will have all of the required modules and functionality, one of the primary functions of the SI is to identify options for obtaining any incomplete or missing functionality. The SI will have a number of options for obtaining various components, modules or capabilities, which will result in a "hybrid" solution. The following table outlines the options for functionality with a "hybrid" solution:

Hybrid Solution Implementation Options

Option	Description
Reuse	Reuse functional or technical components from existing DC IT assets.
Build	Develop the DC HIX solution using application development tools and supporting technology components (e.g., SQL Server, Oracle, .NET, Java, etc.).
Configure	Acquire, configure and integrate one or more Commercial Off-the-shelf (COTS) packages to build the DC HIX solution.
Leverage	Leverage solutions from Early Innovator states or the Federal Government; acquired systems would be configured and customized to meet the needs of the District.

Option	Description
Hybrid	This option could involve any of the above options. The SI will need to have the capability to select “best of breed” modules from available open source, early innovator, federal or private vendor solutions.

The resulting “hybrid” solution that combines leveraging of product-based vendor components with available federal, private or custom modules to complete the full functionality outlined in the “blueprint” of the DC HIX. The role of the SI is then defined as providing the steps, skills and expertise necessary to define, procure, establish, implement and potentially govern the DC HIX.

The role of the SI would evolve during the course of the project. As the procurement and implementation process (described above) is completed, the SI role changes to one of governance and oversight. The SI provides the monitoring and governance of the interface definitions and works to ensure the independence of modules within the DC HIX architecture. This ensures maximum flexibility for the District over time, allowing the District to replace individual modules of the DC HIX without impacting the functionality or interface requirements of other modules. The result is that the District is not “tethered” to any one solution vendor, technology or software. Over time, modules within the DC HIX (and Medicaid Information Technology Architecture [MITA]) will become commodities, allowing the District the freedom to procure and replace components of the solution down to the individual module level. This mitigates the risk of a single solution vendor, as well as minimizing risk for replacement or re-procurement of the system.

A summary of SI responsibilities include the following:

- Function as SI manager responsible for architecting the DC HIX, implementing the DC HIX solution framework, defining all interfaces and integrating all modular products.
- Develop the RFIs/Requests for Proposals (RFPs) for the solicitation of vendors and procurement of the hybrid system.
- At the District’s discretion, evaluate vendors during the procurement process. Additionally or alternatively, the SI can be asked to provide the solution (and vendors) to the District.
- Procure and coordinate the implementation of all of the required components for the system. The SI will evaluate vendor solutions versus the DC HIX “blueprint”, identify any gaps in functionality or missing components, then develop a plan to procure or develop (as necessary) the additional functionality.
- Ensure that all module interfaces are open and follow the defined Information Architecture of the system. The SI is responsible for the creation and maintenance of the Interface Control Document (ICD).
- Provide the Program Management Office Support/Independent Verification and Validation (PMO/IV&V) functions during the course of implementation of the system.
- Integrate the Ombudsman and Navigator Customer Assistance functions into the DC HIX call Center functionality.

- Provide the management of the systems framework that meets all District and federal security standards and requirements, including:
  - Business Rule Management System (BRMS) that provides for the separation of business rules from core programming and the availability of business rules in both human and machine-readable formats
  - Workflow Management System and Orchestration Process
  - Single sign-on infrastructure
  - System Interfaces (internal and external) based on the use of open interfaces and exposed application programming interfaces
  - Rules Engine Oversight/Configuration Management
  - Technical Integration
  - Single Sign-on Capability
  - Service Oriented Architecture (SOA) Infrastructure and Governance

Financial Sustainability Mercer Recommendations and Next Steps

Mercer recommends charging an insurer fee of approximately 0.9%-1.2% on all District carriers and on all District premiums (large group, small group and individual). This is due to the high percentage of premium, approximately 4.85%-5.33%, that would be required if the fees were only charged and collected on premiums inside the District's DC HIX. In addition, if actual enrollment falls well below the projections, the generated revenue may not cover the costs of the DC HIX. The main advantage of charging an insurer fee percentage on all District premiums is that if enrollment in the DC HIX falls well below projections, the District is more able to cover the costs of the DC HIX given that the fees will be collected regardless of DC HIX enrollment. Other advantages of this option are as follows:

- Fee could be imposed upon insurance carriers on an annual basis.
- Available revenue to the DC HIX would be stable and predictable, since it is not tied to participation levels, assisting financial and program planning for each year.
- Allocates costs of running the DC HIX across all carriers, which results in lower fees on a per policy basis.

The means to collect the premium tax are already operational and can be leveraged for this purpose.

The main disadvantages of this alternative are as follows:

- Fee not directly tied to those utilizing and benefiting from the DC HIX.
- Fee may require legislative action to implement.
- Perception of a new tax may result in difficult implementation.

The next steps for the District would be to finalize the method to fund the DC HIX. In addition, the District should assess the availability and use of existing District agencies to support functions of the DC HIX. This assessment should quantify the fiscal efficiencies generated by

use of current District agencies and functions being consolidated into the DC HIX. The availability of federal matching funds for Medicaid functions performed in the DC HIX should also be considered.

Legal and Policy Mercer Recommendations and Next Steps

Mercer recommends that the District take the following steps related to Legal and Policy:

1. Develop and pass legislation to provide DISB with general regulatory authority to enforce the market reform provisions of the ACA.
2. Develop and pass legislation to enact the ACA requirements regarding grievances and appeals, including establishing an external review process that meets HHS' standards.
3. Develop and pass legislation to amend or repeal DC Code provisions that might not be consistent with ACA requirements, including provisions identified in Part I of the Legal and Policy Summary Memo.
4. Prior to the January 1, 2014, the effective date of the "future" market reforms, issue a Bulletin to insurers describing compliance procedures.
5. Develop and pass legislation authorizing the DC HIX. This legislation addresses the application of provisions of the DC Code in the areas identified in Part II of the Legal and Policy Summary Memo.

DC HIX Insurance Market Mercer Recommendations and Next Steps

There are many considerations that must go into the decisions related to the structure and rules of the District's new insurance marketplace, and the information and findings above are just one of many pieces. One would be remiss to make decisions based on this information alone. These results and findings should be brought together with the results from other efforts undertaken by the District such as public meetings and focus groups held with consumers, small businesses and insurers.

Market Risk Pools

Given the fact that the District will ultimately be required to change its current definition of Small Group to 1-100, it may appear on the surface to be easier to make the change along with the host of other changes that will occur in 2014. However, if carriers are allowed to continue to use current methods (group size 51-100) until 2016, it may postpone the number of groups that decide to self-insured or drop coverage. Much of the market disruption that will occur in 2014 will have worked through the system and postponing the small group expansion until 2016 will allow these groups time to understand the new system. Given the above, Mercer recommends that the District not expand its definition of Small Group until 2016.

Further, a delay in expanding the definition will give the District more time to implement programs such as value-added benefit and services, which could work to draw more groups into the SHOP DC HIX; group size 51-100 may see value in these benefits and services as well. By delaying the expansion of the definition, additional information should also be available related

to the prevalence at which small groups decide to self-insure. These new self-insured products are currently emerging in the market and if the District finds that they become attractive to small groups, delaying the point at which the 51-100 groups are brought into the market would allow the District more time to study the expected impact these products will have on the fully insured risk pool, and allow time for making decisions and any changes to the rules for these products, such as requiring minimum specific and aggregate stop loss attachment points to control for this potential adverse selection.

There are also many considerations that should go into the decisions of whether to merge the individual and small group markets, beyond the modeled impact that these options would have on premium rates and DC HIX participation. The results of our modeling revealed that a market merger would have little impact on both rates and enrollment. Therefore, it is important that the District include additional factors in its decision of whether to merge the market and not base it on the results of this analysis alone.

Adverse Selection and Mitigation Techniques

As described above, there are several measures that the District could take to address the various sources of adverse selection that may occur against the DC HIX. While each of the options presented has the potential for mitigating adverse selection, they should be studied with care and considered alongside other design aspects of the DC HIX as they may have unexpected ramifications on the broader insurance market in the District.

Mercer recommends the District further study these possible sources of selection. We recommend a study that examines the implications of requiring carriers to offer the same plans inside and outside the DC HIXs, implications of the standardization of plan benefit offerings, the incentive/disincentives available in the market for small employers to self-insure, the implications of the penalties for non-enrollment and whether those penalties can and/or should be strengthened.

Perform a Detailed Analysis of Mandated Benefit not Included in the Essential Health Benefit Package

Mercer recommends that once the Essential Health Benefit (EHB) package is announced, the District perform an updated and in-depth study of the costs that the District would be anticipated to incur if they were to keep in place current mandates for benefits beyond those included in the EHB package. The District must understand the social, medical and financial effects of maintaining or eliminating mandated benefits. As a result, we recommend the District study the costs that they would incur in covering these mandated benefits and make decisions around whether or not to continue each mandate. The District should study how often those services are utilized, the cost of providing those services and how the covered service affects the overall health of District residents. It is important that this analysis include the collection of meaningful and timely feedback from those District residents who would be affected by the elimination of any benefit not included in the EHB package. This feedback could be collected through various

means such as town halls, group interviews and web-based and other forms of open comment periods.

Cost Benefit Analysis of Value Added Services and Benefits in the SHOP DC HIX

A successful DC HIX is highly dependent upon the level of participation and the spread of risks that enroll. In order to gain this success, the District must be pro-active in attracting small employers to purchase coverage through the SHOP DC HIX. We recommend the District consider conducting a detailed analysis of various value-added services and benefits that the DC HIX could offer that may be attractive to small employers. In particular, services that the DC HIX can offer at a lower cost, through purchasing power that would come with a larger pool of purchasers of those services, could lead to the DC HIX offering services at a lower cost than similar services could be offered in the outside market. This, in turn, could lead to greater participation in the SHOP DC HIX by small employers. We recommend the District gather information on the cost of providing these services and compare those costs with the anticipated benefits that would come with greater enrollment. To perform a robust analysis, information should also be gathered by holding focus groups of small employers to understand those services and benefits that would be most attractive to them.

2

Business Operations

C.3.3.1.3.1 Business Operations

The Contractor shall identify and describe the business operations requirements to provide the basic framework required to support and operate the District's selected Exchange Model in a Business Operations Summary Memo. The Business Operations Summary Memo shall include, but is not limited to:

a. An outline of operational responsibilities, divided among the District and other participants as applicable to the selected governance structure;
b. An outline describing the decision making body, including possible structure, requirements for member selection/appointment, and associated authorities;
c. An organizational chart for the Exchange entity, including staffing levels and corresponding responsibilities;
d. A plan to recruit and maintain human resources necessary to implement and operate the Exchange;
e. A strategy for procurement and vendor management; and
f. A plan outlining the Exchange's needs for office space, equipment, IT, and other business services.

Options

The two business operations models considered by the District were the quasi-governmental agency and an existing District agency being responsible for operating the DC HIX. The District did not elect to consider a non-profit agency to operate its DC HIX.

Findings

The following summarizes the findings of the Business Operations Summary Memo:

- A quasi-governmental agency could be created with exemptions to the general DC Code procurement and personnel policies. This would significantly reduce many of the barriers to hiring and vendor contracting that District agencies face. By exempting the quasi-governmental agency from these general policies, the DC HIX would be more nimble and flexible in its hiring and contracting practices, while maintaining a transparent and publicly accountable process.
- If a District agency is chosen to operate the DC HIX, then the DC HIX will be bound by the requirements of the DC Code, including the caps on salaries and onerous bureaucratic procedures regarding procurement and vendor management. These rules could make it difficult for the DC HIX to hire the most talented individuals and threaten the ability of the DC

HIX to be up and running within the timeframe established by the ACA and HHS proposed rules.

- A common governance and administrative structure for the District's SHOP and individual market DC HIX would facilitate coordination between the Exchanges and be more administrative and cost efficient.
- The number of staff needed to operate the DC HIX depends, in part, on the type of Exchange the District wishes to establish. An "active" Exchange, which selects QHPs to be sold on the DC HIX based on cost and quality, will require more staff to perform complex functions as compared to the more basic functions of a clearinghouse Exchange that allows any QHP to be sold on the DC HIX.
- Staffing for some positions within the DC HIX could be filled by existing District agency staff if the District chooses to operate the DC HIX within an existing District agency and establish a clearinghouse-type Exchange. However, most positions needed to operate an Exchange must be newly created and many require individuals with experience more often found in the private sector rather than government jobs.
- A review of salaries from national databases for positions relevant to the DC HIX indicate that the District may need to offer salaries beyond typical government compensation ranges if they wish to attract qualified candidates from the private sector.
- Initial enrollment in the DC HIX will begin in October 2013. For the DC HIX to be certified by HHS and operational in 2013, hiring for key executive positions should begin in 2012, followed by hiring of other senior level management staff in 2013.
- Following decisions by the District regarding the governance structure and type of Exchange to be established, a detailed business operations plan should be developed. This activity should occur as part of the Level 1 Establishment Grant activities, and include a detailed hiring plan and further analysis of the office space, equipment, IT and other business services, based on a detailed staffing plan.

District Decisions Regarding Business Operations

On October 18, 2011, the HRIC submitted a report to the Mayor containing the HRIC's recommendations related to the DC HIX governance and structure. There were a number of recommendations that affect business operations, many of which coincide with recommendations made by Mercer. See the following section on Mercer recommendations.

Below are HRIC recommendations, relevant to business operations, which were not included in Mercer's recommendations.

- [T]he Executive Board should be comprised of 15 members: five members appointed by the Executive; four appointed by Council; and six non-voting ex-officio executive agency officials representing the relevant District agencies.
- [M]embers of the DC HIX Executive Board shall have at least five years of experience in one of the following areas:
  - Individual or small employer health care coverage
  - Health benefits plan administration

  - Health care finance
  - Administering a public or private health care delivery system
  - Purchasing health plan coverage
  - Prior experience in commercial insurance management
  - Actuarial analysis
  - Health care economics
  - Human services administration
  - Health Care Consumer Interest Advocacy
- [A]n independent, non-lapsing DC HIX fund be established and used to support the operations of the DC HIX, and that the DC HIX be authorized to charge assessments and user fees to fund its operations.
- [T]he general requirements of the DC HIX, the duties of the DC HIX and HBP certification by the DC HIX be incorporated, as provided in the National Association of Insurance Commissioners (NAIC) Model Exchange Act, into any enabling legislation.
- [A]ny enabling legislation include language directing the Executive Board, prior to implementing any new policies or adopting any regulations, to consult with advisory boards and stakeholders regarding the following policy issues:
  - The feasibility and desirability of the DC HIX engaging in selective contracting (active purchaser), either through competitive bidding or a negotiation process similar to that used by large employers, to reduce health care costs and improve quality of care
  - The rules under which health benefits plans should be offered inside and outside the DC HIX in order to mitigate adverse selection and encourage enrollment in the DC HIX
  - The design and operation of the DC HIX's Navigator Program and any other appropriate consumer assistance mechanisms
  - The design and function of the SHOP HIX beyond the requirements of the ACA to promote quality, affordability, and portability, and whether the SHOP HIX should be merged with the individual market
  - Financial sustainability of the DC HIX in compliance with the ACA
  - How the DC HIX should conduct its public relations and advertising campaign, including what type of solicitation, if any, of individual consumers or employers, would be desirable and appropriate

Mercer Recommendations and Next Steps

1. The District will create a quasi-governmental agency to operationalize the Exchange, with exemptions from obstacles in the general procurement policies of the District code, will provide for the DC HIX to more efficiently procure vendors and services.
   A. The HRIC recommended a quasi-governmental agency as the governance structure for the DC HIX. The District's personnel policies were viewed as an obstacle and the quasi-governmental agency should seek exemptions from these policies.
2. The District should determine whether it intends to establish an active purchaser or clearinghouse (passive) Exchange. This decision will determine the scope of the functions to be performed by the DC HIX and impact the type and number of staff needed.

   A. The HRIC recommended that enabling legislation require the Executive Board to consult with advisory boards and stakeholders prior to making a policy decision.
3. A common governance and administrative structure is recommended for the District's SHOP and individual market DC HIX to facilitate coordination and achieve efficiencies
   A. The HRIC recommended that the Executive Board consult with advisory boards and stakeholders regarding whether the SHOP DC HIX should be merged with the individual market.
4. With the passage of enabling legislation, the District should develop a process for Board appointments and immediately establish the Governing Board.
   A. In addition to the qualifications for Board members required by the US HHS' proposed rules, enabling legislation should include recommendations from stakeholders on member appointments.
      i. HRIC recommendations included the provision that at least one member of the DC HIX be a consumer advocate, which was included in stakeholder recommendations regarding Board composition.
   B. Four year terms are recommended for board members, with initial appointments serving staggered terms.
      i. This is consistent with the HRIC recommendation.
   C. Based on stakeholder input, it is recommended that every effort should be made to appoint District residents as members on the Governing Board.
      i. HRIC recommendation is that the majority of the appointed Executive Board members, excluding ex-officio members, be District residents.
      ii. The HRIC recommended that there be six non-voting ex-officio executive agency officials representing relevant District agencies. Mercer recommends that the Directors of DHCF and DISB should be designated as two of the non-voting, ex-officio members.
5. The District and Governing Board should create, recruit and hire a qualified Executive Director as soon as the governance structure is established.
6. Through Level 1 Establishment Grant activities, the District, Governing Board and Executive Director should develop a detailed business operations plan that includes all staffing levels of the DC HIX. The plan should be updated once a decision has been made as to the type of DC HIX to be established.
7. Key staff that should be recruited and hired in 2012 to support the establishment of the DC HIX include, at a minimum: Executive Director, Chief IT Officer, Director of Finance, Chief General Council and Human Resources Director. All executive management staff positions and key mid-level management positions should be filled no later than the first quarter of 2013.
8. The District should develop a competitive compensation package to attract the most talented candidates.

3

Program Integration

C.3.3.1.3.2 Program Integration

The Contractor shall assess the program integration requirements related to the Exchange and develop plans for anticipated points of integration with Medicaid and other District health insurance programs. The Contractor shall provide a summary of the findings in a Program Integration Summary Memo. The Program Integration Summary Memo shall include, but is not limited to, analysis of:

a. *The current public health care programs available in DC, including corresponding eligibility, covered benefits, and operations;*
b. *The impact on Exchange implementation to the eligibility levels and operations of existing health care programs, including Medicaid, the Children's Health Insurance Program, and the DC Health Care Alliance;*
c. *Models for Medicaid screening under the new Medicaid eligibility guidelines, including maintaining eligibility in IMA/DHS, transferring the function to DHCF, transferring function to new Exchange entity (if any), or others models;*
d. *The transition of individuals from the Pre-Existing Condition Insurance Plan to the Exchange;*
e. *The transition of members of Congress and Congressional personal office staff from their current insurance plans to the Exchange; and*
f. *The transition of employees from current coverage to Employer Sponsored Insurance purchased through the Exchange.*

Options

The major discussion area for Program Integration is the determination of which Department should oversee the administration of Medicaid/CHIP eligibility for the District in relation to the anticipated changes resulting from the enactment of the ACA. Currently, the IMA performs this function based on a on a Memorandum of Understanding with the DHCF. With the introduction of Health Care Reform, the determination of Medicaid/CHIP eligibility is becoming more standardized and simplified with a focus on large segments of the District's population and with an expanded orientation beyond the traditional safety-net population.

In evaluating which agency is best positioned to administer the oversight of Medicaid/CHIP eligibility, the potential of a federal/state partnership model must also be accounted and understood. Under the federally facilitated or state/federal partnership, the computation of MAGI and determination of eligibility for MAGI-related eligibility categories is administered as part of the federal solution (as described in Model 1, below). Models 2 and 3 are applicable for District-based Exchanges only. In Model 2, IMA resumes responsibility for the oversight of both MAGI and non-MAGI eligibility categories. In the third model, DHCF assumes the responsibility for MAGI-based categories of eligibility and IMA retains oversight of non-MAGI-based eligibility. In all three models, it is assumed that MAGI calculations are part of the DC HIX.

The following provides an overview of the three models.

Model 1: Federal Government determines MAGI Eligibility and IMA Oversees Non-MAGI Eligibility.[5]

Determination of Medicaid/CHIP eligibility is supported by rules within the DC HIX and overseen by the Federal Government. This is true within both the federally facilitated and state/federal partnership options. In this model, IMA continues to perform non-DC HIX, non-MAGI eligibility determination and processing of enrollment for social/welfare systems as is currently the case.

Model 1 *This model is required for federally facilitated or federal/state partnerships*	
Exchange	**Other District Agencies**
• The DC HIX determines eligibility for all applicants within the DC HIX, including, MAGI- Medicaid, CHIP, premium subsidies, cost-sharing reductions and the BHP (if applicable). • Transmit information to IMA on individuals who are screened for non-MAGI and/or request a full Medicaid eligibility determination to determine if they are eligible for other Medicaid programs. • DC HIX transmits information to DHCF for enrollment in Medicaid	• IMA determines eligibility for non-MAGI individuals, i.e., individuals eligible for Medicaid based on disability, age-related, etc. • This process is performed through existing procedures and IMA's IT eligibility system. • IMA determines eligibility for all insurance affordability programs for applicants who apply through IMA instead of the DC HIX. • IMA would accept applications from individuals who prefer to apply through them instead of the DC HIX. • IMA would connect into the DC HIX's system in order to process the application using the MAGI. Through this system, IMA would determine if the person is eligible for Medicaid, CHIP, premium subsidies, cost-sharing reductions and the

[5] This option is mandatory under both the Federal or State/Federal Partnership Models

[6] HHS Proposed Rules state "The DC HIX may also facilitate delivery system and health plan selection, including transmitting enrollment transactions to health plans, if applicable, for individuals determined eligible for Medicaid or CHIP, if the agencies administering Medicaid or CHIP enter into an agreement authorizing the DC HIX to perform this function."

Model 1 *This model is required for federally facilitated or federal/state partnerships*	
Exchange	**Other District Agencies**
health plan or assists individuals with the enrollment in the plan.[6]	BHP (if applicable). • Note: IMA could develop within its own IT system mechanisms for determining eligibility through MAGI but it would be costly and duplicative. • IMA determines eligibility for other public assistance programs, including SNAP, TANF and DC Alliance.

Model 2: District Exchange, determination of Eligibility remains with IMA.

This includes both MAGI and non-MAGI eligibility determination and enrollment into a qualified health and/or human services program. This requires IMA/DHS to assume responsibility for administrating all DC HIX eligibility and enrollment activities, including those for commercial and SHOP.

Model 2 *This model is not an option for federally facilitated or federal/state partnerships* *This model is a valid option for a District DC HIX*	
Exchange	**Other District Agencies**
• DC HIX contracts with IMA to conduct eligibility determinations for insurance affordability programs.	• IMA determines eligibility for insurance affordability programs. • Requires that the agency develop an IT system that meets all the federal requirements in the Center for Medicare and Medicaid Services (CMS) Blueprint for Eligibility and Enrollment. • IMA determines eligibility for non-MAGI individuals. • DHCF facilitates enrollment in Medicaid health plans. • Enrollment broker could be utilized. • IMA determines eligibility for other public assistance programs, (e.g., TANF, SNAP).

Model 3: District Exchange, responsibility for Medicaid/CHIP Eligibility determination is assumed by DHCF.

Under this model, DHCF assumes all responsibility for MAGI-based eligibility determination (or the DC HIX governance contracts with an agency within DHCF to perform this function). Again, the MAGI calculations and Medicaid/CHIP eligibility processing is part of the DC HIX. This model is also applicable with a District Exchange as most vendors are moving toward this model in developing their Exchange platforms. In this model, IMA performs non-MAGI eligibility determination.

Model 3 *This model is not an option for federally facilitated or federal/state partnerships* *This model is a valid option for a District DC HIX*	
Exchange	**Other District Agencies**
• DC HIX contracts with either DHCF or a new DC HIX agency under DHCF to conduct eligibility determinations for insurance affordability programs. • DC HIX conducts eligibility determination and enrollment for QHPs.	• DHCF determines eligibility for insurance affordability programs. • Requires that the agency develop an IT system that can meet all the federal requirements in the CMS Blueprint for Eligibility and Enrollment. • DHCF facilitates enrollment in Medicaid Health Plans, possibly through continued use of the enrollment broker. Transactions (834/836) can also be sent directly to MCOs. • IMA determines eligibility non-MAGI individuals.[7] • IMA determines eligibility for other public assistance programs, (e.g,. TANF, SNAP).

Findings

Because of the complexity of Program Integration, the findings are presented to individually to address each requirement for Program Integration.

a. The current public health care programs available in DC, including corresponding eligibility, covered benefits, and operations;

A review of the District's DHCF budget underscores the number and variety of public health care safety-net programs available to District residents, providing them with public insurance coverage for medical expenses. Similar to other states, eligibility for these programs is categorical and focused on distinct segments of the local population. The programs are coupled through CMS-approved State Medicaid plans, amendments to these plans and waivers to established federal requirements. Often, states offer local public insurance as part of the overall safety-net for those who do not otherwise qualify for Medicaid — the principal insurance of last resort.

The following is a brief summary of Mercer's findings regarding both District-funded and federal programs providing coverage to low-income Aged, Blind and Disabled (ABD) individuals in the District.

[7] Under this model, DHCF could perform eligibility determinations for non-MAGI instead of IMA. However, it this function were moved from IMA to an in-house function at DHCF, a DHCF IT eligibility system would have to be built or a current DHCF system be significantly modified.

DC Health Programs

Program	Eligibility	Benefits	DC HIX Integration Issues
Medicaid MCO Health Plans: Chartered, Unison	Low-income children, pregnant women, parents are eligible. MCO enrollment is confined to non-disabled population except as noted below. Due to recent changes under national health reform, childless adults are now also eligible for the first time. Recipients must meet income guidelines and some must meet asset limits: • Recipients must be US citizens or have been legal permanent residents for more than five years. • Children (0-18) and pregnant women are eligible up to 300% FPL — $67,050 for a family of four (in 2011). • Youth (19-20), parents of enrolled children and childless adults are eligible up to 200% FPL — $44,700 for a family of four.	State Plan mandatory benefits Certain optional benefits include: • Inpatient • Outpatient services • Day treatment • ICF/MR • Residential treatment • Dental • Optometry • Podiatry • DME • Hospice • Rehab • Mental health • Sterilization • Home health • Pharmacy	The District offers generous coverage and alignment with the DC HIX should not pose a barrier in terms of eligibility or benefits. Citizenship or legal residency is required. Federal Medicaid requirements: • Medicaid eligibility is expanded to include all individuals and families with incomes up to 133% FPL along with a simplified CHIP enrollment process. • Low-income persons and families above the Medicaid level and up to 400% FPL will receive federal subsidies on a sliding scale if they choose to purchase insurance via an DC HIX (persons at 150% FPL would be subsidized such that their premium cost would be of 2% of income or $50 a month for a family of four). The above federal Medicaid requirements could result in the transition of eligible District residents into DC HIX health plans from their current MCO health plans in the event current Medicaid MCOs either elect not to participate in the DC HIX or fail to meet either federal or state requirements.
Medicaid Fee-for-service (FFS)	Aged, Blind and Disabled (ABD).		Eligibility requirements for the ABD population will be the same as the federal Medicaid requirements stated above. This population segment generally qualifies for Medicare as well as Medicaid. This will necessitate a coordination of benefits for dual-eligibles.

Program	Eligibility	Benefits	DC HIX Integration Issues
			Given the requirement for "Guaranteed Issue" (no exclusion for preexisting conditions) FFS Medicaid members may elect to seek coverage through the DC HIX assuming favorable health plans are offered. Given Freedom of Choice requirements, access to DC HIX health plans other than current District MCOs may have to be accommodated.
CHIP Health Plans: Chartered, Unison	Integrated into the Medicaid program.		Once determined eligible, members exercising their freedom of choice could elect to participate in QHP by the DC HIX or BHP offered outside the DC HIX or remain in their current MCO. This will require QHPs offering Medicaid coverage to negotiate contracts with the DHCF. The need for an Enrollment Broker is questionable and the DC HIX may operate to assign PCPs in order to maintain a seamless experience. This would also require a reexamination of MCO network provider contracts and rates.

Program	Eligibility	Benefits	DC HIX Integration Issues
Alliance	Low-income residents not eligible for Medicaid.	Benefits include: • Inpatient hospital • Outpatient medical (including preventive care) • Emergency services • Urgent care • Prescription drugs • Rehabilitative services • Home health care • Dental services • Specialty care • Wellness programs that include mother and baby care.	The Alliance program is designed to provide medical assistance to needy District residents who are not eligible for federally financed Medicaid benefits. This includes non-disabled childless adults, non-qualified aliens and some individuals who are over income for Medicaid. The Alliance program provides comprehensive health services, including preventative; primary; acute; and chronic care services such as clinic services, emergency care, immunizations, inpatient and outpatient hospital care, physician services, and prescription drugs. Offered through MCOs, coverage is managed by a PCP and subject to the same care management and quality and cost oversight as Medicaid recipients. In the event that the District were to include a BHP (applicable to ineligible Medicaid recipients) integration into the DC HIX would be limited to adults between 133%-200% FPL and lawfully present immigrants below 133% FPL who are ineligible for Medicaid (e.g., legalized within the last five years). The challenge will be documenting income data. Enrollment in the Alliance is currently 32,710 individuals, although, the District may impose an enrollment cap of 18,750 in 2012. Currently about 47% of these Alliance members report no income, yet 94% are between the ages of 18-64.

Program	Eligibility	Benefits	DC HIX Integration Issues
			Consequently, there is a need for "face to face" eligibility determinations and verification of employment status or income.
Mental Health/ Non-MCO coverage	Medicaid eligibility.	Benefits include: • Adult and children individual, group and family counseling • Diagnostic assessment • Medication management • Community support and crisis response • The Department of Mental Health (DMH) also operates a psycho-educational program for children who require an integration of clinical services in day care or a school environment. Inpatient and ambulatory services	Current DMH services agencies may remain outside the DC HIX; however, DMH MCO coverage would have to be aligned with the DC HIX in a similar manner to other Medicaid covered services offered through a health plan.
Other District Coverage Programs	Must satisfy Medicaid eligibility requirements.	COBRA Benefits Medicare Benefits	COBRA payments paid by the District; Medicare buy-in; Presumably these coverage programs would be aligned with the DC HIX for individuals to continue coverage uninterrupted during unemployment or transition to Medicare health plans.
MCO Insurer Participation	Complies with all District Health Management Organization (HMO) laws and under contract to DHCF.	All Medicaid required benefits established by contract.	Business operations process issues: • Insurer engagement MCO contracting issues related to integration into the Exchange • If current MCOs do not participate in the Exchange,

Program	Eligibility	Benefits	DC HIX Integration Issues
			there would be need to transfer Medicaid if QHP seek to offer Medicaid health plans as well. • There are disincentives for MCO participation in the Exchange — very heavy reporting requirements may scare insurers from offering essential benefits in exchanges. • Quality assurance, rating issues, underwriting, IT Issues, how many benefit designs, actuarial issues and reinsurance possibilities need to be examined • Need to ensure ongoing quality requirements including local District laws for HMOs. Current Medicaid MCOs are fully National Committee for Quality Assurance (NCQA) Accredited. May also have to comply with additional federal requirements. • Provider reimbursement levels need to be aligned as well. Medicaid FFS, MCO and MCO provider networks, OOP member payments, provider incentive payment programs for Medicaid and Alliance programs, buy-in programs will need to be reconciled. • Alignment of oversight for respective programs (auditors for state and federal governance) for Medicare/Medicaid and state local programs such as the Alliance.

b. The impact on Exchange implementation to the eligibility levels and operations of existing health care programs, including Medicaid, CHIP and the Alliance

The following table outlines the changes in District health care program eligibility levels with the implementation of Health Care Reform in 2014.

Coverage Gaps in 2014

Issues Presented	Analysis
• Expiration of District Expansions enacted in 2010: – SPA expires 2014 – 1115 Waiver generally expires in 3-5 years	In 2010, the District transitioned approximately 32,700 childless adults from the locally funded Alliance program to the Medicaid program through a combination of CMS approved program expansions authorized in a SPA (<133% FPL; impacting 30,000 adult members) and a new 1115 Waiver (>134% <200% FPL; impacting 2,700 adult members). Acting early to adopt requirements in the ACA, the District may receive enhanced federal funding (FMAP) beyond 2014 to support this population. As a result, the District's Medicaid program presently covers the following eligible categories: • Families with Children — 200% FPL • Children (0-18) — 300% FPL • Pregnant Women — 300% FPL • Childless Adults — 200% FPL ***(Source: DHCF Budget Review — 2011)***
• District income thresholds exceed FPL for expansion populations: – Possible cutbacks in coverage for some parents; guardians, etc. – Childless adults Maintenance of Effort requirements for CHIP populations may preclude any reduction in Medicaid coverage for them; however, a rollback in Medicaid coverage for some parents and childless adults could occur where incomes exceed 133% FPL. This may be limited to the 2,700 adult members enrolled in Medicaid through the 1115 Waiver expanding coverage to 200% FPL.	The federal law, to take effect in 2014, extends Medicaid eligibility to individuals who are otherwise qualified (citizens and legal immigrants), under the age of 65 and not eligible for Medicare. The major categories include children, pregnant woman, parents and childless adults with incomes up to 133% FPL. All eligible Medicaid adults can obtain Medicaid coverage through an essential benefit health plan offered through the DC HIX.
• Limited subsidies available to those individuals for DC HIX coverage between 133% and 400% FPL in 2014	DC HIX subsidies for premiums and cost sharing are based on sliding income scale.

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- Offering a BHP could make it more affordable
  - If a BHP is offered outside the DC HIX, the District still must assure that those covered are qualified and eligible as well as assure the BHP meets federal requirements for premium subsidy and cost sharing.
  - New eligibility system would need to address these calculations

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Income Eligible	Premium Subsidy	Cost Sharing Subsidy
Up to 133% FPL	2% of Income	
100%-150% FPL		94%
133%-150% FPL	3%-4%	
150%-200% FPL	4%-6.3%	87%
200%-250% FPL	6.3%-8.05%	73%
250%-300% FPL	8.05%-9.5%	70%
300%-400% FPL	9.5%	70%

<u>Federal Requirements for BHP</u>

The BHP is a possible option for individuals who:

- Are ineligible for Medicaid
- Have incomes at or below 200% of the FPL
- Lack affordable access to comprehensive employer-based coverage, as defined by the ACA

In other words, two groups:

- Adults between 133% and 200% FPL
- Lawfully present immigrants below 133% FPL who are ineligible for Medicaid (e.g., legalized within the last five years)

A BHP offered outside the DC HIX must provide EHBs and not charge premiums exceeding similar coverage offered through the DC HIX and that cost sharing requirements do not exceed that of Platinum plan for individuals at 150% FPL or a Gold plan for those above 150%-200% FPL.

States receive 95% of the funds for premiums and cost sharing for BHP enrollees.

This approach contrasts sharply for Alliance members who currently qualify for Alliance at 200% FPL financed entirely by local District appropriations.

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- Alliance Coverage:
  - Undocumented immigrants will not qualify for the DC HIX coverage and

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The Alliance presently covers over 30,000 individuals who do not qualify for Medicaid despite recent expansions; nor will they qualify for subsidies offered through the exchange; however, BHP provides

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subsidies – The District needs to explore if BHP may be a solution to address immigrant issue	coverage outside the DC HIX. Thus, BHP coverage does not require the same stringent immigrant eligibility requirements as does Medicaid eligibility or DC HIX eligibility. Thus, the annual recertification process for Alliance recipients earning less than 200% FPL may offer an opportunity to continue to transition new members into BHP. Undocumented immigrants are not eligible for coverage within the DC HIX. The District needs to determine how if these individuals will still receive benefits under the Alliance.

c. Models for Medicaid screening under the new Medicaid eligibility guidelines, including maintaining eligibility in IMA/DHS, transferring the function to DHCF, transferring function to new Exchange entity (if any), or others models;

Model 1: Federal Government Oversees MAGI Eligibility and IMA Oversees non-MAGI[8]

As discussed above, this model is required if the determination of Medicaid/CHIP eligibility becomes a federal responsibility. In this model, the DC HIX performs the MAGI calculations, determination of commercial or Medicaid eligibility, verifies the citizenship, income level, incarceration status and social security number of the applicant.

- Medicaid/CHIP eligibility determination is part of the federal DC HIX.
- Applicant screening information is passed to IMA for non-MAGI eligibility and enrollment.
- DC HIX can pass enrollment transactions to Medicaid MCOs and QHPs.

Under this scenario, IMA no longer processes Medicaid/CHIP MAGI eligibility. IMA must have the ability to accept standard eligibility and enrollment transactions from the federal/state partnership solution through the state Data Hub. This is the same as is required of commercial health plans.

Advantages

- Streamlines MAGI and simplified eligibility processing in the DC HIX. Allows the DC HIX to focus on medical eligibility determination for all citizens and enrollment in accordance with income levels.
- Allows IMA to focus on non-MAGI population and social/welfare eligibility.
- Social/welfare eligibility can still be integrated into the “one-stop” eligibility portal within the DC HIX after January 1, 2014.
- Required under both federally facilitated and state/federal partnership options.
- Supports national direction for simplified Medicaid/CHIP rules processing.

[8] This option is mandatory under Federal or State/Federal Partnership Models

Disadvantages

- Separates medical and social/welfare eligibility determination.
- Impacts HHS cost sharing of Medicaid funds to support social/welfare eligibility determination.
- Potentially impacts IMA employment; however, some jobs/positions may shift to support Medicaid/CHIP eligibility processing within the DC HIX.

Model 2: District DC HIX, maintaining current Eligibility determination with IMA/DHS
Under this model, the DC HIX itself must be a District DC HIX (not a federal/state or regional partnership). Under this scenario, IMA would continue to provide the integrated Medicaid/CHIP eligibility determination, as well as SNAP, TANF and other social welfare program eligibility determination and enrollment functions. In this model, the DC HIX performs the MAGI calculations, determination of commercial or Medicaid eligibility, verifies the citizenship, income level, incarceration status and social security number of the applicant. However, under this model the “one-stop” shopping portal is built and administered by IMA, as proposed in the IMA APD for procurement of an eligibility solution. The advantages and disadvantages of Model 2 are discussed below.

Advantages
The District has successfully developed an integrated eligibility system operated by the DHS to verify eligibility for income support programs and health care programs for low-income residents. This horizontal look at safety net programs is “applicant centric” maximizing the successful outcomes for applicant enrollment into safety net programs:

- DHS is positioned to further build upon its current system and introduce electronic capabilities and technologies to more efficiently conduct its eligibility operations across all District safety net programs and improve its ability to verify applicant requirements.
- This existing infrastructure supports electronic collection and manual enrollment processes needed to verify applicant data and provide a streamlined entry point for applicants among the variety of programs available for both income support and health care delivery. Removing manual support services could be a problem for consumers.
- Integration of eligibility into the DC HIX would undermine the current infrastructure built out over time and could jeopardize DHS’ ability to coordinate applicant entry into the variety of support programs available to them.
- Separating out eligibility for health programs from social service programs and placing them into the DC HIX could jeopardize the DHS ability to subsidize its eligibility and enrollment operations for non-Medicaid related programs received through Medicaid financial support. It is unclear what the impact of that would be on the District’s local budget since the social service eligibility would need to continue.

Disadvantages
The narrow focus on safety net programs in the business processes may lead to fragmentation unless IMA assumes full responsibility for implementation of the DC HIX and its related operational processes.

The determining factor for the focus of eligibility is the population that is driving the processes and the objectives of the ACA. Medicaid eligibility is set <133% FPL. The complexity arises with the Alliance population, (childless adults) about 30,000 who are either above the threshold and not otherwise qualified for Medicaid (not here long enough – 5 years). They may be employed from time to time and at any one time, about 20% are working. Therefore, the need for an annual assessment coupled with calculating premium and out of pocket subsidy, as well as enrolling them into an appropriate health plan (private sector), and possibly later enrolling them back to the Alliance etc. is so complex that integration into the DC HIX is needed.

Added to this complexity is that the focus of the ACA and its implementation is on the low-income working people (<400% FPL) and no longer exclusively on the poor. This change in focus alone necessitates that IMA not be the focus of eligibility. The DC HIX can pass information to them to determine qualification for social service income support programs like food stamps, etc. IMA becomes one of several agencies interacting with the DC HIX.

IMA will be in the midst of a major system procurement and implementation at this time, which is a risk that should be considered as part of this evaluation:

- IMA is in the process of major systems procurement for the new eligibility system for both medical and welfare programs.
- The IMA timelines for the IMA procurement show development of the web portal through summer of 2013, which is six months after the certification period for the DC HIX, begins. In accordance with Section 1321 of the ACA and recent CCIIO guidelines, the certification period begins on January 1, 2013.
- While IMA has considerable experience with the Medicaid population, they are not experienced in working with individuals and small employers to assist them with their benefit selection, fulfillment, and enrollment. IMA would need to assume responsibility for not only the low-income population but also the commercial population passing through the “one-stop” portal of the DC HIX.

Model 3: District DC HIX, transferring responsibility to DHCF and/or a new DC HIX Entity
Under this model, the DC HIX itself must be a District DC HIX (not a federal/state or regional partnership). Under this scenario, DHCF (or a new DC HIX entity) would assume the responsibility for Medicaid/CHIP eligibility determination. IMA would retain the responsibility for determination of social/welfare eligibility (SNAP/TANF). In this model, as with the other two models, the DC HIX performs the MAGI calculations, determination of commercial or Medicaid eligibility, verifies the citizenship, income level, incarceration status and social security number of the applicant.

Advantages

Integrating health care eligibility and enrollment into the DC HIX complies with the new federal requirements and maximizes the District's ability to create a seamless process for all health care insurance consumers including Medicaid recipients across the city.

- The focus of eligibility is no longer limited exclusively to qualifying the poor for the related safety net programs. Under the ACA, the program focus is expanded to address the needs of the low-income workers and directing them to affordable health coverage. Accomplishing this objective efficiently and accurately requires consolidating of public and private sector programs across the city.
- The complexity of the eligibility process due to the frequency (annually) that it will be required to be performed and the expanded population that will undergo the eligibility process (everyone <400% FPL) coupled with income and subsidy calculations underscores the need for the DC HIX to be the focus of eligibility and enrollment.
- No other agency in the city has the depth and breadth of experience needed to manage the required DC HIX related functions.
- DHCF has the experience contracting with health plans, conducting enrollment in health plans, undertaking regulatory oversight for health plans, coordinating audits as well as fraud and abuse oversight, consumer assistance and related plan navigation, coordinating plan benefits, payments and interaction with federal regulators.
- This breadth of experience will be needed to manage an integration of public and private programs as is required by the ACA through DC HIX implementation.
- Allows the District 100% federal funding to design and build DC HIX operations benefiting all District residents; it also allows continued federal financial support for DC HIX operations to the extent that Medicaid operations are consolidated into the DC HIX and the DC HIX is embedded in the DHCF (the District receives FMAP well over $1 billion annually to support its Medicaid operations and leverage other District programs related to serving Medicaid, such as the DMH).
- Allows the District the flexibility to decide how best to maximize federal revenues by deciding which programs and/or which portions of programs should remain outside the DC HIX. Allows the District the opportunity to develop new programs that would support small businesses desiring to offer employees subsidized health coverage through the DC HIX health plans and aid in job creation in the District by employers who have been reluctant to add employees due to high health costs or adverse financial impacts on their current health insurance.
- It would be possible to have the DC HIX eligibility system provide IMA with the required information needed to determine eligibility for the social programs without any disruption in social service support.

Disadvantages

- DHCF does not have current experience with handling Medicaid/CHIP eligibility determination. However, under the new federal guidelines the rules for Medicaid/CHIP eligibility will be greatly simplified, which will mitigate part or all of this risk. Additionally, the

business processes and rules for the determination would be housed in a rules-engine in the DC HIX. CCIIO is defining the business processes for Eligibility Verification and Enrollment blueprint that could help mitigate this risk.

- A new DC HIX entity would have to be put in place prior to the start of January 1, 2013 to help govern certification testing and integration with the IMA or Medicaid MCOs for applicant enrollment. This risk could be mitigated by establishing the DC HIX responsibility directly within DHCF.

d. The transition of individuals from the Pre-Existing Condition Insurance Plan to the Exchange

The ACA enables citizens that have been denied benefits because of pre-existing health conditions to receive affordable health insurance. The District is one of 29 states to establish a PCIP. To be eligible to be enrolled in the PCIP, a person must:

1. Be a US citizen or lawfully present in the US as determined in accordance with Section 1411 of the ACA.
2. Have been denied health care coverage due to a pre-existing condition.
3. Have been uninsured for the past six months.

The PCIP was established as a key part of the ACA. Historically, public policy has addressed the challenges of people with pre-existing conditions through inclusion of this population in high-risk pools or through health insurance reform. High-risk pools are generally the coverage of last resort for these individuals. These individuals have been denied coverage in the individual market and are unable to obtain coverage at reasonable rates. Additionally, these individuals are not eligible for public health coverage (Medicaid or Medicare). Thus, these individuals, many of whom are working class individuals, must seek insurance in the high-risk pools.

Section 1101 of the Patient Protection and Affordable Care Act (PPACA) requires a temporary high-risk pool be created to provide access to coverage to US citizens with pre-existing conditions. This temporary high-risk coverage, now known as the PCIP, is intended to provide coverage for these individuals until the establishment of the DC HIX on January 1, 2014.

In accordance with the data provided from statehealthfacts.org, the District currently has 36 individuals enrolled in the PCIP at a cost of $9 million per year.

e. The transition of members of Congress and Congressional personal office staff from their current insurance plans to the Exchange

Members of Congress and their staff are currently enrolled in the FEHBP. The FEHBP is currently the largest employer-sponsored health insurance program in the US. Currently, those eligible to participate in this program include all federal employees, members of Congress, Congressional staff and the President. It has been hailed by President Obama as a model for health care reform. This, however, leads to a dilemma moving forward. Part of the intention of

the Health Care Reform legislation is to provide access to health care coverage that is as "good as what congress has".[9] The ACA also permits citizens to keep insurance plans they like, and with over 300 plans currently available, the FEHBP offers much to like. However, it is unclear if members of Congress and their staff will be able to retain this coverage if the plans in the FEHBP do not become part of the DC HIX.

Analysis of section 1312(d)(3)(D) of Pub. L. No. 111-148 of the PPACA by the CRS has identified several apparent "drafting issues" with this portion of the legislation that will need to be resolved. The key issues identified by the CRS include:

1. Lack of specific date for the transition of Congress and staff from the current FEHBP.
2. The absence of a named administrative or implementing authority for members of Congress and covered staff.
3. Lack of specificity in the definition of "members of Congress" and whether this includes non-voting delegates, Resident Commissioner from Puerto Rico.

Section 1321(d)(3)(D) of the ACA states that the only health plans that will be made available to members of Congress and their staff:

- *Are created as part of the ACA (or an amendment of this act); and*
- *Are offered by an Exchange as part of this act (or an amendment of this act).*[10]

However, the legislation, as currently written, leaves a number of questions unanswered that must be resolved by Congress before the transition of members of Congress and their staff to state Exchanges can be planned for. These questions are based in the language of the legislation, resulting in ambiguity regarding several key aspects of Section 1321(d)(3)(D). The ambiguity includes not specifying the effective date of the termination of the current FEHBP and an apparent contradiction between sections of the legislation regarding "grandfathered" health plans.

The current legislation in Section 1321 does not specify the effective date of the law pertaining to when the transition of Congress and their staff becomes effective. Section 1321(d)(3)(D) specifies that this Bullet becomes effective "after the effective date of this subtitle (Subtitle D of Title I of PPACA). However, as there is no effective date applicable to the subtitle, it is unclear and uncertain as to when this provision takes effect. "Because of a possible "drafting error," the

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[9] Baffled by Health Plan? So are some lawmakers". http://www.nytimes.com/2010/04/13/us/politics/13health.html, April 2011

[10] Congressional Research Service http://fleming.house.gov/UploadedFiles/Member_of_Congress_Health_Care_Memo.pdf, April 2011

CRS report says, Congress did not specify an effective date for the Bullet, excluding lawmakers from the existing program."[11]

Another problem that must be clarified by Congress is if members of Congress that are currently participating in the FEHBP will be able to retain this coverage as a "grandfathered plan". The language in Section of 1251 does not specify if the FEHBP will be considered a "grandfathered" plan. Section 1251 (a) states that:

"Nothing in this Act (or amendment to this Act) shall be construed to require that an individual terminate coverage under a group health plan or health insurance coverage in which such individual was enrolled on the date of this enactment of this Act".

Based on this, Acts 1321 (d)(3)(D) and 1251 are in contradiction, which will have to be resolved by the legal system or clarified by Congress.

According to the New York Times article, despite "painstaking analysis" by the CRS, the impact and effect of the new law on Congress and Congressional staff is difficult to ascertain. "The strictures of the new law will apply to staff members who work in the personal office of a member of Congress. But they may or may not apply to people who work on the staff of Congressional committees and in "leadership offices," like those of the House speaker and the Democratic and Republican leaders and whips in the two chambers."[10]

Thus, the impact of the ACA on Congress and Congressional Staff is unclear at this point. Congress may have to enact additional legislation to resolve the issues or choose to resolve this internally. Firm guidelines for the transition of Congressional members and their staff cannot be established until these issues within the legislation are clarified.

f. The transition of employees from current coverage to Employer Sponsored Insurance purchased through the Exchange.

Based on the direction from the HRIC, the Individual Health Benefit Exchange (HBE) and the SHOP will be combined in the DC HIX. Employees will need to transition from their current employer sponsored insurance coverage to purchasing coverage in the DC HIX environment. Operational procedures will need to be developed in the next phases of the project to describe how small employers will register with the SHOP function of the DC HIX. These procedures will need to outline the transition steps for small employers to register their employees for the DC HIX and the process for employees to choose health benefits, such as:

- Notifying the DC HIX they want to enroll their employees.
- Working with an insurance agent to enroll in the DC HIX.

[11] Baffled by Health Plan? So are some lawmakers". http://www.nytimes.com/2010/04/13/us/politics/13health.html, April 2011

- The employer must have between 2-50 employees to be qualified.
- Must be a licensed small business within the borders of the District.
- Once registered, the employees of the company are notified they are eligible for benefits selection through the DC HIX.
- Once notified, employees will complete an online Eligibility and Enrollment application through the "one-stop" web portal.
- Employees will have the ability to make benefit selections using the DC HIX during the open enrollment period.

The transition of small employers and their employees to the DC HIX is one of the key components of the ACA. According to the 2008 Employee Benefit Research Institute study, nearly 23 million of the 47 million uninsured Americans are small business owners, employees or dependents.[12] This means roughly 50% of uninsured Americans are directly related to the small business market, underscoring the necessity for their inclusion in the SHOP DC HIX. Additionally, the over the past decade, health care costs for small businesses have risen 133%.[13]

The dramatic rise in insurance costs has contributed to a decline in the number of small business and employees that currently have health insurance coverage. Since 2009, the percentage of small businesses offering coverage to their employees has fallen from 69% in 2000 to 54% by 2009. Of those remaining businesses offering coverage to their employees, only 63% of small business employees choose to apply for health benefits through their small business employers[14]. This trend will result in economic consequences for small businesses. According to recent studies by MIT, at the current rates:

- Nationally, small businesses with fewer than 100 employees will pay almost $2.4 trillion in health insurance costs over the next 10 years.
- Small businesses typically do not have the margin or cash flow to sustain or absorb this increased cost of health coverage. Based on the current rates it is estimated that this will lead to 178,000 lost jobs in the small business market, $834 billion in wages, and $52.1 billion in profits.[13]

Effectively transitioning the District's small businesses to the DC HIX requires designing the SHOP component to provide competitive, high value, low-cost options for the District's small business community. Key design considerations for the SHOP DC HIX need to address:

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[12] "Statistics about Business Size (including Small Business)," Table 2a, available at http://www.census.gov/econ/smallbus.html

[13] The Kaiser Family Foundation and Health Research & Educational Trust, "Employer Health Benefits: 2010 Annual Survey" (2010), available at http://ehbs.kff.org/pdf/2010/8085.pdf.

[14] Jon Gabel and others, "Generosity And Adjusted Premiums In Job-Based Insurance: Hawaii Is Up, Wyoming Is Down," Health Affairs 25 (3) (2006), available at http://content.healthaffairs.org/content/25/3/832.full.

- Will the DC HIX be an active or passive purchaser?
- What role will agents and brokers play?
- Should employers or employees pick their own plans?

In designing the SHOP component of the DC HIX, the District needs to address these considerations. The overall goal should be to maximize enrollment of small business. To effectively compete against options outside of the DC HIX and drive enrollment, the DC HIX will need to offer plans at competitive premium rates. Achieving this requires attracting a wide base of employees to adequately spread risk and offer a range of competitive plans. To maximize enrollment, the District needs to market the DC HIX aggressively to the small business market:

- Promote a successful launch and drive early adoption of small businesses in the market place.[15]
- Promote the financial incentives for small employers. Beginning in 2014, small business tax credit increases from 35% of premiums to 50% of premiums for for-profit employers and from 25% of premiums to 35% of premiums for non-profit employers. This tax credit is only available to employers who purchase health benefits through the DC HIX.
- Promote Wellness. Small employers can be incentivized with premium discounts for wellness. Several existing state DC HIXs, including the Massachusetts Health Connector, have offered wellness incentives to small employers as a means of increasing small business enrollment in the DC HIX.

Role of the Brokers or Navigators

One of the key aspects to transitioning small employers and their employees to the DC HIX is engaging the broker community. Small businesses have traditionally relied heavily on brokers to help them with insurance choices. Brokers play a key role in guiding and influencing the choice of purchasing coverage small business inside or outside of the DC HIX, thus ultimately influencing the viability of the DC HIX itself.

The Brokers also serve the role of providing outreach, education and communication for the DC HIX, helping to link commercial carriers, small business and the DC HIX. Brokers can assist the DC HIX in the following manner:

- Providing outreach to small business employers.
- Educating small business employers on the use and navigation of the DC HIX.
- Educating small business employees on the benefit choices offered within the DC HIX.
- Influencing small employers and businesses to purchase coverage through the DC HIX.

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[15] Utah Health Policy Project, "Utah's DC HIX at the Crossroads: Time to Bring Utah's Health DC HIX up to Federal Standards" (2010), available at http://www.healthpolicyproject.org/Publications_files/State/UtahExchangeAtCrossroads10-18-10.pdf

One of the key design aspects of the DC HIX for the District is to define the role and compensation package for brokers. Brokers provide vital aspects for recruiting and transitioning small employers to the DC HIX and ultimately helping to establish the viability of DC HIX.

District Decisions Regarding Program Integration

The District must still explore the optimum relationships for successful Program Integration. Mercer's understanding is that no formal decisions have been published regarding Program Integration.

Mercer Recommendations and Next Steps

As there are multiple areas that require more analysis and decision making regarding Program Integration, the summary of recommendations and considerations are presented to individually address A through F of the RFP requirements for Program Integration. Based on the available data, the following conclusions can be drawn:

- Compared to national averages, the District has a relatively low uninsured population (11% compared to the national average of 17%).
- The percentage of Medicaid recipients (based on current Medicaid eligibility rules) is relatively high (21% compared to the national average of 16%).
- The percentage of employer sponsored (although this statistic is not specific as to size of employer) and individual coverage is slighter higher than the national averages.
- Approximately 33,000 individuals are covered under individual health insurance coverage within the District.
- Currently only 36 individuals are enrolled in the PCIP.

The following offers a brief summary of the specific issues for each requirement under The Program Integration Summary Memo.

a. The current public health care programs available in DC, including corresponding eligibility, covered benefits and operations

1. Recent Medicaid expansions up to 133% FPL and CHIP Maintenance of Effort requirements will lessen the impact on integrating Medicaid coverage operations including eligibility determinations into the DC HIX environment.
2. Some parents and guardians, youth above 18 years and childless adults whose incomes exceed the 133% FPL will no longer be Medicaid eligible in 2014 when the SPA and Waiver are set to expire. They would seek coverage through the DC HIX and receive federally subsidized premiums and out of pocket costs. An estimated 30,000 individuals (between 133% and 150% FPL) previously enrolled in Medicaid, would be treated in the same manner as other low-income workers between 133% and 400% FPL.
3. The enactment of a BHP, financed in large part by the Federal Government, could help low-income immigrant workers under 150% FPL who otherwise are not Medicaid or DC HIX eligible due to questionable legal status.

4. Those individuals currently in the Alliance, about 32,710 people (or 18,750 if a cap is imposed in 2012) who remain undocumented (an estimated 52% or about 17,000 individuals) must remain outside the DC HIX and require annual eligibility assessments to verify their continued eligibility for the Alliance.
5. Those individuals currently in the Alliance (<200% FPL) earning above 133%-200% FPL and those residents earning up to 400% FPL, will require annual assessments to determine if their incomes continue to qualify them for the Alliance or federal subsidies through the DC HIX.

b. The impact on Exchange implementation to the eligibility levels and operations of existing health care programs, including Medicaid, CHIP and the Alliance

A single point of entry for insurance consumers is designed to support consumers in the complex eligibility processes envisioned in the ACA. Merging Medicaid and Alliance business rules with the many contingencies available necessitates a consolidation of the business rules into an integrated environment within the DC HIX.

The very fact that eligibility is an annual requirement and involves large segments of the District's population including for the first time workers who are continuously moving above or below the poverty levels as they find or lose work adds a layer of complexity that requires close coordination of public programs and private health coverage not previously administered by the District's agencies.

1. The focus for eligibility determinations is no longer limited to the District's safety net programs. Under the ACA, the focus shifts to assessing the near-poor and low-income workers for their eligibility for federal subsidy and access to private insurance coverage, not public programs.
2. Large segments of the District's population will remain low income, but continue not to be eligible for Medicaid coverage in 2014. Seeking affordable health coverage will require them to enter the DC HIX where assessments and guidance can assure their access to affordable coverage.
3. Clearly, the impact to the District's Medicaid program is not an obstacle for those individuals who will continue to qualify for Medicaid support given recent expansions. On the other hand, the Alliance population raises significant issues and opportunities to direct significant portions of this population to receive federally subsidized coverage in the DC HIX or in a BHP. To accomplish this efficiently and accurately, the DC HIX environment is the most appropriate place to conduct an assessment of the many complex variables that need to be considered in making the "one-stop" eligibility determination and directing them (enrollment) to the most appropriate private insurance coverage.
4. Given the changing focus of eligibility determination and the more complex analysis required, our recommendation is that the MAGI and simplified Medicaid/CHIP eligibility

should be integrated into the DC HIX through a consolidated rules engine that can support a seamless eligibility verification and enrollment process.

Further, our recommendation is that careful thought should be given to locating the determination of Medicaid/CHIP eligibility in the Department of Health Care Finance, which already has direct experience in administering health plan contracting (Medicaid Managed Care Organizations), enrolling recipients and consumer support among other experience. Culturally, the Department of Health Care Finance is best positioned to view the program city-wide and in a manner that will permit the full integration of both public and private sector interests.

c. Models for Medicaid screening under the new Medicaid eligibility guidelines, including maintaining eligibility in IMA/DHS, transferring the function to DHCF, transferring function to new Exchange entity (if any), or others models

1. The decision process must include the possibility of a federal/state partnership that would result in the determination of Medicaid/CHIP eligibility becoming a federal function.
2. IMA is currently in the process of a major systems procurement and replacement. This introduces significant implementation and timeline risk.
3. The processes for the determination of Medicaid/CHIP eligibility are required to be integrated into the DC HIX. This includes MAGI calculation and simplified Medicaid Eligibility determination. As part of the creation of the blueprint of the DC HIX, the business rules that are required to support these processes should be identified and included in the DC HIX.
4. The “one-stop” shopping eligibility and enrollment application will be a function of the DC HIX. As described above, the business rules Medicaid/CHIP eligibility will be integrated into the DC HIX. Transactions can be produced from the DC HIX for eligibility verification and enrollment, similar to a QHP in the commercial market.
5. The DHCF is best positioned to manage the integration of Medicaid/CHIP eligibility within the DC HIX. DHCF offers the most experience in managing the array of business processes related to insurance coverage and regulatory oversight of health plans; it offers an inclusive perspective for the expanded population being served which will now include low-income wage earners under 400% FPL. The need to serve all of the citizens needs in a single eligibility application should be of the main goals of the District.

In conclusion, regardless of the creation of a quasi governmental entity or direct agency management, the DHCF is the most appropriate agency within the District to manage ACA implementation including integration of Medicaid/CHIP eligibility into the DC HIX.

d. The transition of individuals from the PCIP to the Exchange;

1. The District PCIP enrollment is currently 36 individuals.
2. Wait for additional guidance from HHS as to how the close-out of the PCIP program and transition of the current enrollees to the DC HIXs will occur.

3. Conduct outreach to PCIP members to inform them of the forthcoming opportunity to participate in the DC HIX. Outreach program should include information on how to access and enroll in the DC HIX and ability to leverage Consumer Assistance Programs (through the District Ombudsman office). Given the low number of enrollees (36), this should be achievable for each member.
4. Work to obtain data from the current PCIP that not only identifies the current 36 program enrollees, but can be used to ensure a smooth transition into the DC HIX. Identifying the enrollees' current providers, specialists and/or PCP would allow for continuity of care for these enrollees'. Additionally, information about their current diagnosis, and medications would permit these enrollees to locate providers and plans that allow patients to continue with their same treatment plans as well as permit an understanding their OOP costs.

e. The transition of members of Congress and Congressional personal office staff from their current insurance plans to the Exchange

1. Continue to monitor the situation and wait for Congress to enact amended legislation to correct the "drafting" errors noted by the CRS.
2. Await clarification as to the effective date of the new legislation for Congress and staff members.
3. Await clarification as to whether the FEHBP will be considered a "grandfathered" plan or if all plans in the FEHBP will move to the DC HIX.
4. Await clarification as to whether the new laws apply to all 535 members of Congress and their Congressional Staffers.
5. Await clarification on if Congressional staffers have the right to enroll in their home state Exchange or will they be required to enroll in the DC HIX.
6. Once clarification is received, members of Congress and their staff should be treated like small businesses. Each State should enroll their Congressional members and staff into the DC HIX in the same manner that a small business entity would register. Once registered, Congressional members and staffers would receive notification from the DC HIX that they are eligible to make benefit selections from the DC HIX. If the Federal Government elects to make a "defined" contribution or premium subsidy, this would be applied to each member or staffers premium calculation, similar to an employee of a small business within the DC HIX. Additionally, having each state enroll their Congressional members and staff would afford the District the opportunity to manage the transition of Congressional members and staffers enrolling and dis-enrolling from the DC HIX.

f. The transition of employees from current coverage to Employer Sponsored Insurance purchased through the Exchange.

In summary, a well-designed SHOP program will facilitate a smoother transition of small employers into the DC HIX and allow it to survive against other external markets. In the design of the SHOP environment, the District needs strategies for how to attract and retain small businesses within the DC HIX. The District must engage brokers and provide incentives for brokers to enroll small businesses into the DC HIX. The District should also offer incentives for

wellness and preventive care (such as weight loss and smoking cessation) that not only help small businesses lower their overall risk and premiums, but lead to improved quality of life for individuals, and ultimately lower health care costs. The following highlights some of the key factors and recommendations that will make the DC HIX attractive and viable for small businesses, thus facilitating a smoother transition:

- Focus on providing high-value, low-cost health care benefit options to attract small businesses to the DC HIX marketplace.
- Maximize participation to create a successful and sustainable SHOP environment.
- Develop an aggressive outreach program to market the DC HIX to the broker community and to small businesses.
- In designing the SHOP portion of the DC HIX, the District should look to the examples provided by other states, such as Massachusetts, New York and Connecticut.
- Determine if the District is going to use a “defined contribution” model.
- The DC HIX must be designed to compete with external markets and should not only provide cost and value, but also promote and reward wellness on the part of employees. To create a smooth transition for employers and employees to the DC HIX, it is incumbent upon the District to design the SHOP program to offer advantages (such as premium discounts) that cannot be obtained by small employers in the outside market.
- Engage the Broker community. This is one of the key lessons of the early DC HIXs (particularly Utah). The Brokers serve the role of providing outreach, education and communication for the DC HIX, helping to link commercial carriers, small business and DC HIX. Brokers can assist the District in the following manner:
  - Provide outreach to Small business employers.
  - Educate small business employers on the use and navigation of the DC HIX.
  - Educate small business employees on the benefit choices offered within the DC HIX.
  - Influence small employers and businesses to purchase coverage through the DC HIX.
- Define the role and compensation package for Brokers. Brokers provide vital aspects for recruiting and transitioning small employers to the DC HIX and ultimately helping to establish the viability of the DC HIX.

4

Technical Infrastructure

C.3.3.1.3.3 Technical Infrastructure

The Contractor shall assess and describe the required technical infrastructure components required to compliment the Business Operations (C.3.3.1.3.1) to support the District's Exchange vision and objectives. The Contractor shall provide a summary of the findings in a Technical Infrastructure Summary Memo. The Technical Infrastructure Summary Memo shall address or provide for at a minimum the following:

a. A web portal for consumers to apply for and evaluate health care options offered in the Exchange;
b. A process for eligibility determination to screen applicants for programs offered by the Exchange, including DC Medicaid and other District insurance programs;
c. A secure database management system to store and manage applicant and member information;
d. A process for secure exchange of data between the Exchange and at a minimum the following entities:
    1. DC Medicaid agency
    2. DC Department of Human Services, Income Maintenance Administration
    3. Internal Revenue Service
    4. Social Security Administration (SSA)
    5. US Department of Homeland Security
    6. Any other relevant local, state, and federal agencies
e. A process for collecting and publicizing Exchange health plan policies and options;
f. A process for assigning and collecting premiums from members;
g. A process for eligible businesses to evaluate and purchase insurance coverage through the Exchange; and[16]
h. A call center to assist residents seeking information on or who have experienced problems with the Exchange[17]*.*

The following sections describe the DC HIX options and decisions, and requirements and findings having a direct impact on the supporting technical infrastructure, followed by our recommendations.

[16] No District decisions have been formally published

[17] This decision was not included in the Planning Phase

Options

In accordance with the law, each state and the District must implement an operational Health Insurance Exchange by January 1, 2014. Additionally, in accordance with Section 1321 of the ACA, the District must apply for certification on January 1, 2013. However, there are a number of key questions that each state must answer that impact the technical design and operations of the DC HIX. These questions include:

1. Will the DC HIX be operated locally or by the Federal Government?
2. If the federal option is selected will this be a federally facilitated or state/federal partnership model?
3. Will the individual and SHOP DC HIXs be combined in a single DC HIX environment?
4. Will the District join a regional DC HIX?

These are the key questions that have been explored as part of the discussions by the HRIC as part of the December 15th, 2010 meeting:

- Exchange model (federal, regional, district) — Each state and the District has the option to participate in multi-state insurance pools or establish their own Exchange. The District has determined that they will pursue their own Exchange. The December 15th, 2010 meeting of the HRIC determined this direction.
- One DC HIX or two (individual Health Benefit Exchange (HBE)/SHOP)? — This is a fundamental question each state Exchange must address; whether the SHOP should be combined or separate from the individual HBE. As many of the same functions and workflow are needed to support both the HBE for individual consumers and for employees of the SHOP Exchange, having separate systems would result in duplicate costs and components across the two Exchanges. Having a single DC HIX will support the one-stop" shopping experience of the consumer, as well as individual employees, without duplicating components and costs. The result will be lower development costs and project risks for the District.
- Understanding how to interface with District eligibility & enrollment — As part of the planning process, we have assessed the technical capabilities of the IMA to determine how the Medicaid and CHIP eligibility programs will integrate with the DC HIX.
- Interface with federal agencies: CMS is developing a standardized federal interface for the Exchanges that will allow states to communicate using standards-based protocols to verify information provided by the consumer during their application. Required functionality of the federal Data Hub is to provide connectivity to the Internal Revenue Service, Homeland Security, Department of Corrections and the SSA. As CMS makes the details of the federal Data Hub available they must be incorporated into the DC HIX.

There are numerous other additional policy, technology and business decisions surrounding the development and operations of the DC HIX that must be addressed in the detailed design phase of the project. CMS, through the CCIIO, is developing guidelines, principles and blueprints for how the Exchanges will be architected, designed and operated.

Findings

The following assumptions and discussion items are the basis for the recommendations:

- The current options must consider the possibility of a federal solution. At this time, there are two federal options being offered to states (federally facilitated or state/federal partnership). Under the state/federal partnership model, the District has the option has the option of operating either the communication management or plan management sections of the DC HIX, or both. Under both, the federally facilitated and state/federal models, the eligibility verification and enrollment is part of the “one-stop” shopping within the federal components of the DC HIX. This also means that under this option, the District must be able to process standard HIPAA transactions for the verification of Medicaid/CHIP eligibility and enrollment of recipients into the selected MCO.
- The federal (and many vendor solutions) will be interoperable with any state eligibility systems using standard HIPAA transactions.
- In accordance with The Guidance for Exchange and Medicaid IT Systems (May 2011), state Exchanges should be designed and implemented using a MITA-based approach that fully defines the business, information and technical architecture layers of the solution. MITA is a CMS business initiative in cooperation with state programs, initially intended to stimulate an integrated business and technological transformation of the Medicaid enterprise in all states. The MITA Framework 2.01 consolidates principles, business and technical models. MITA principles are not confined to designing Medicaid applications; this process can be leveraged to clearly define and implement the business processes, sub-processes, standardized processes and interface definitions throughout the DC HIX.
- Although not specifically required, the system must comply with the CMS Seven Conditions and Standards, published in April 2011. This publication supports many of the DC HIX architectural recommendations made throughout the Mercer Technical Infrastructure Memo.
- Given the tight time frames and the need to be ready for certification on October 1, 2013, undertaking the development of the DC HIX or components of the DC HIX is not a realistic option. The District desires a COTS-based solution that minimizes development risks and allows “best of breed” components to be assembled for the solution.
- It is recommended that the District require an Exchange that is modular, with a SOA built on a common ESB, offered as a SaaS Cloud-based system.
- The District is one of the few states nationwide that incorporates both medical and welfare program eligibility determination in a single application. Current CMS/CCIIO direction is for the DC HIX to include Medicaid/CHIP eligibility determination in the “seamless” interoperability. Based on recent HHS direction, SNAP/TANF can be integrated into the DC HIX “one-stop” eligibility on January 1, 2014.
- The DC HIX framework must include the flexibility to allow the District the opportunity to add additional programs and capabilities in the future, including additional social and welfare programs.

District Decisions Regarding Technical Infrastructure

The District has not yet published any formal decisions regarding Technical Infrastructure. The following outlines the decisions that must be made in order to finalize the planning for Technical Infrastructure.

The required components of the Health Insurance DC HIX are clearly documented in the CMS Funding Opportunity Announcement. Additionally, CCIIO is defining the blueprint for the DC HIX, including the blueprints for the functionality of each area and component of the DC HIX. The following table provides a high-level overview of each component and links the component to the appropriate DC HIX functional area, as currently defined by CCIIO.

The following components are addressed, in order, within the table below:

a. *A web portal for consumers to apply for and evaluate health care options offered in the Exchange;*
b. *A process for eligibility determination to screen applicants for programs offered by the Exchange, including DC Medicaid and other District insurance programs;*
c. *A secure database management system to store and manage applicant and member information;*
d. *A process for secure exchange of data between the Exchange and at a minimum the following entities:*
    1. *DC Medicaid agency*
    2. *DC Department of Human Services, Income Maintenance Administration*
    3. *Internal Revenue Service*
    4. *SSA*
    5. *US Department of Homeland Security*
    6. *Any other relevant local, state, and federal agencies*
e. *A process for collecting and publicizing Exchange health plan policies and options;*
f. *A process for assigning and collecting premiums from members;*
g. *A process for eligible businesses to evaluate and purchase insurance coverage through the Exchange; and*[18]
h. *A call center to assist residents seeking information on or who have experienced problems with the Exchange*[19]*.*

[18] No District decisions have been formally published

[19] This decision was not included in the Planning Phase

Component	RFP Requirement	Description/Purpose	Key Requirements
a. Web Portal	a. A web portal for consumers to apply for and evaluate health care options offered in the DC HIX	The DC HIX requires a centralized web portal that is accessible by all stakeholders, including HIX administrators, consumers and health plans. The portal provides the integrated "one stop" shopping gateway for all consumers to determine eligibility and enroll them into the appropriate public or private health plan. The portal will provide overview to applicants of the eligibility, plan offerings and selection and enrollment process, including appeals and grievances, and links to customer call center. Can include visual aids such as tutorials, videos, live chat and links to health and education sites.	Web portal must support: • SaaS. • The ability to integrate multiple portal applications and enhancements overtime. • Any state-specific requirements Support Single-Sign on, Security Assertion Markup Language (could provide basis for linking to social/welfare eligibility programs). • Ease of use, navigation. • Access for individuals with disabilities. • Must be 508 compliant. • Must include modules and applications for individual HBE and SHOP comparison and selection.

Component	RFP Requirement	Description/Purpose	Key Requirements
b. Eligibility Determination Module	b. A process for eligibility determination to screen applicants for programs offered by the DC HIX, including Medicaid and other District insurance programs.	This module is based on the eligibility verification and enrollment functional area. This is one of the six major MITA functional areas for the DC HIX that has been defined by CCIIO. The business processes are defined by the EE BA Supplement v1.0 2011-05-03. This is the blueprint for the "one-stop" eligibility application and enrollment. Provides the "seamless" determination of eligibility for all applicants, including commercial and low-income applicants.	Application must support: • ANSI X12 270/271 eligibility request and response transactions. • Connectivity to commercial/public health insurers using 270/271 for eligibility determination. • Includes the capabilities to communicate with the federal Data Hub. This includes electronic links to SSA, IRS, and the National Information Exchange Model (NIEM) for obtaining additional applicant data. • 834/836 transaction set for enrollment into Medicaid/commercial insurance as appropriate.
c. Database Management System	c. A secure database management system to store and manage applicant and member information.	The Data Vault is part of the core technologies of the DC HIX. The Data Vault is supported by a database management system capable of real-time capture and retrieval of applicant information. The full requirements and rules surrounding the capture and use of application data have not yet been defined by CCIIO. The potential use of Personal Health Information (PHI) is governed by HIPAA rules and standards.	The database management system must support: • Capture of application data for eligibility, verification and enrollment. • Data for appeals and grievances. • Must still be determined what data will be allowed to be persisted (stored) within the system versus that which is only needed for during the online application processing. • Data required for reporting is still undetermined by CCIIO.

Component	RFP Requirement	Description/Purpose	Key Requirements
d. Communication with federal and state Data Hubs	d. A process for secure exchange of data between the DC HIX and at a minimum the following entities: • District Medicaid agency • DHS IMA • IRS • SSA • US Department of Homeland Security • Any other relevant local, state and federal agencies	The DC HIX and income maintenance eligibility and enrollment systems will need to support interfaces for the "seamless" determination of eligibility and enrollment with the appropriate plan. Within the DC HIX, the "one-stop" application must collect the information required by CCIIO for the verification of US citizenship, incarceration status, employment and income and employment status. Within the DC HIX, the web portal (either vendor provided or as part of the state/federal partnership) will link to the federal Data Hub for verification of citizenship, income, incarceration status and employment status. The DC HIX will also make initial MAGI and FPL determination, and then pass the application information via a standard HIPAA transaction to IMA for eligibility verification and enrollment into the appropriate Medicaid Managed Care plan. The requirements of this process are defined as part of the eligibility verification and enrollment functional area. The business processes for this area are contained within the EE BA Supplement v1.0 2011-05-03. This is the blueprint for the "one-stop" eligibility application and enrollment.	The DC HIX will connect to the federal Data Hub to processes the verification of citizenship, income, incarceration status and employment status. The business processes and business rules for MAGI determination and Medicaid/CHIP eligibility will be housed within the DC HIX. Analysis is required to determine which Medicaid/CHIP eligibility rules would need to remain with IMA. IMA will support real-time standard transactions to process eligibility verification and enrollment. This is within the definition of "seamless" integration of Medicaid/CHIP eligibility into the DC HIX.

Component	RFP Requirement	Description/Purpose	Key Requirements
e. Plan Benefit Selector	e. A process for collecting and publicizing DC HIX health plan policies and options.	The web portal must contain an application that facilitates "transparency" in the plan selection process. The plan navigator portal must provide the information necessary for consumers to make informed choices in selecting coverage and foster an understanding of premiums, deductibles, cost sharing and potential tax credits (for groups). It should be noted that there are currently no national standards for the collection of plan and benefit file information from private insurers. The requirements of this process are defined as part of the plan management functional area. The blueprint for this Functional Area is not yet fully defined.	The plan selector must: • Provide ability to perform real-time side-by-side plan comparison costs, premiums and benefits. • Provide a cost calculator for applicants to understand the full OOP expenses. Plus will be for systems which can utilize patient claims experience to help applicants understand past cost and calculate potential future costs. • Must have ability for applicant to enroll separately in medical, dental, vision and drug plans, if offered. • Should provide transparency into access to care, providers and provider locations.
f. Premium Billing System	f. A process for assigning and collecting premiums from members.	This is a support component to the DC HIX that provides a system for managing financial transactions with subscribers for commercial programs that uses standard-based, real-time interfaces with insurers and supports robust reporting. This component includes e-pay functionality and report writing. The requirements of this process are defined as part of the financial management functional area. The blueprint for this Functional Area is not yet fully defined.	The premium billing system must: • Support real-time payment transaction processing across the DC HIX. • Allow online premium payments for consumers. • Potential for lower consumer premium for those who opt for online monthly payments. • Improve plan cash-flow and premium collection process.

Component	RFP Requirement	Description/Purpose	Key Requirements
g. SHOP DC HIX Functions	g. A process for eligible businesses to evaluate and purchase insurance coverage through the DC HIX.	The SHOP DC HIX provides the online capability for small businesses to register their employees with the DC HIX to be able to compare, evaluate and select employer sponsored health benefit options through the DC HIX, just as individuals do. The SHOP may be integrated into the individual HBE. The IT framework needed to support the DC HIX is the same as is required for the individual HBE. Thus, is a single-framework can support both SHOP and individual HBE. This results in lower risk and IT cost for the District.	• Must support employer enrollment and benefit selections. • Allow employers to submit “rosters” of eligible employees to the DC HIX. • Notify employees that the small business employer has enrolled in the DC HIX and that the employee is now eligible to make benefit selections. • Should the District elect, the SHOP function within the DC HIX should support “defined employer contributions” as a means for allowing employees greater flexibility in selecting plans.
h. Call Center Functions	h. A call center to assist residents seeking information on or who have experienced problems with the DC HIX.	The DC HIX requires a call center to handle calls for all applicants. The call center will function as a “knowledge” center for applicants, navigators and brokers interacting with the DC HIX to apply for and purchase health insurance. The call center must support and integrate the needs of the Ombudsman and Navigator Customer Assistance functions into the call center.	• Call center must support appropriate technologies (automated call distribution, interactive chat, etc.). • Must support 24*7 capabilities. • Web-based account management tools for call reps and customers. • Reporting systems that measure effectiveness (e.g., abandonment rate, average wait time, average length of call, etc.)

Mercer Recommendations and Next Steps

The following series of options and recommendations are based on analysis by the Mercer Planning team to-date, and current federal guidance and direction for the establishment of an DC HIX.

Procurement Options

The District should seek a SI vendor that can manage and oversee the implementation of the DC HIX, as well as ensure the seamless integration of eligibility and enrollment components into the DC HIX. Ideally, the SI could take on the administrative burden of procuring the solution modules based on the District's requirements. The SI will be required to fill different roles in the establishment of the DC HIX — with the roles changing along with the continuing development and timeline of the DC HIX — from pre-implementation to ongoing operations and maintenance. The following are required for the DC HIX SI role:

2. Create the DC HIX architectural blueprint. These are steps that should be completed as part of the establishment of the DC HIX, which is part of the Level 1 Grant. The blueprint for the DC HIX will be in line with CCIIO guidelines, requirements and blueprints. The following deliverables should be created in this step:
   A. The DC HIX Concept of Operations
   B. The Logical Conceptual Model
   C. High-level Business Architecture and Business Requirements
3. Based on the completed blueprint, the second step of the process will be to create RFIs for system demonstrations. The SI will have the responsibility of creating the vendor RFI, scheduling the vendor demonstrations and assisting the District in evaluating the vendor demonstrations. During the course of the demonstrations, it will be critical to understand several key components of the vendors offering:
   D. Major functions, modules and capabilities the vendor offers and how these align with or complete the DC HIX blueprint.
   E. Vendor adherence to open standards — including the recommendations listed above — and allowing for an understanding of the vendors ability to integrate functionality, major functional areas, modules and the District's eligibility programs into the ESB of the vendor for the DC HIX.
   F. Cost of the vendor system, procurement options (including SaaS) or Cloud-based options for solution implementation.
5. The DC HIX system vendor(s) will need to be selected as part of this process. The District will have the option of determining the role of the SI in the evaluation and recommendation process, including bringing the entire solution. Some SI roles for the MMIS now include the option of the SI assisting in the evaluation process or bringing forth the entire systems solution. This will be a contracting option for the District.
6. As no one system will have all of the required modules and functionality, one of the primary functions of the SI is to identify options for obtaining any incomplete or missing functionality. The SI will have a number of options for obtaining various components, modules or

capabilities, which will result in a “hybrid” solution. The following table outlines the options for functionality with a “hybrid” solution:

Hybrid Solution Implementation Options

Option	Description
Reuse	Reuse functional or technical components from existing DC IT assets.
Build	Develop the DC HIX solution using application development tools and supporting technology components (e.g., SQL Server, Oracle, .NET, Java, etc.).
Configure	Acquire, configure and integrate one or more Commercial Off-the-shelf (COTS) packages to build the DC HIX solution.
Leverage	Leverage solutions from Early Innovator states or the Federal Government; acquired systems would be configured and customized to meet the needs of the District.
Hybrid	This option could involve any of the above options. The SI will need to have the capability to select “best of breed” modules from available open source, early innovator, federal or private vendor solutions.

The resulting “hybrid” solution that combines leveraging of product-based vendor components with available federal, private or custom modules to complete the full functionality outlined in the blueprint of the DC HIX. The role of the SI is then defined as providing the steps, skills and expertise necessary to define, procure, establish, implement and potentially govern the DC HIX.

The role of the SI would evolve during the course of the project. As the procurement and implementation process (described above) is completed, the SI role changes to one of governance and oversight. The SI provides the monitoring and governance of the interface definitions and works to ensure the independence of modules within the DC HIX architecture. This ensures maximum flexibility for the District over time, allowing the District to replace individual modules of the DC HIX without impacting the functionality or interface requirements of other modules. The result is that the District is not “tethered” to any one solution vendor, technology or software. Over time, modules within the DC HIX (and MITA) will become commodities, allowing the District the freedom to procure and replace components of the solution down to the individual module level. This mitigates the risk of a single solution vendor, as well as minimizing risk for replacement or re-procurement of the system.

A summary of SI responsibilities include the following:

- Function as SI manager responsible for architecting the DC HIX, implementing the DC HIX solution framework, defining all interfaces and integrating all modular products.
- Develop the RFIs/RFPs for the solicitation of vendors and procurement of the hybrid system.

- At the District's discretion, evaluate vendors during the procurement process. Additionally or alternatively, the SI can be asked to provide the solution (and vendors) to the District.
- Procure and coordinate the implementation of all of the required components for the system. The SI will evaluate vendor solutions versus the DC HIX blueprint, identify any gaps in functionality or missing components, then develop a plan to procure or develop (as necessary) the additional functionality.
- Ensure that all module interfaces are open and follow the defined Information Architecture of the system. The SI is responsible for the creation and maintenance of the ICD.
- Provide the PMO/IV&V functions during the course of implementation of the system.
- Integrate the Ombudsman and Navigator Customer Assistance functions into the DC HIX call Center functionality.
- Provide the management of the systems framework that meets all District and federal security standards and requirements, including:
  - BRMS that provides for the separation of business rules from core programming and the availability of business rules in both human and machine-readable formats
  - Workflow Management System and Orchestration Process
  - Single sign-on infrastructure
  - System Interfaces (internal and external) based on the use of open interfaces and exposed application programming interfaces
  - Rules Engine Oversight/Configuration Management
  - Technical Integration
  - Single Sign-on Capability
  - SOA Infrastructure and Governance

5

Financial Sustainability

C.3.3.1.3.4 Financial Sustainability

The Contractor shall develop a business plan enabling financial sustainability for governance and operation for the District's Exchange, to be summarized in a Financial Sustainability Summary Memo. The Financial Sustainability Plan shall be capable of supporting Exchange governance and operations beyond any initial planning or implementation funding provided by HHS, with the goal of complete self-sustainability by January 1, 2015. The Financial Sustainability Plan shall include, but is not limited to:

a. Development of projected operating budgets for the pre-launch, launch, and 2 post-launch years of operations. This shall include, but is not limited to, all component expenditures, such as personnel services, contracted services, IT and equipment, rent/overhead;
b. Identification of financing models for the Exchange which reflect limited to no reliance on local public funding; and
c. Liabilities and advantages associated with each model.

Options

The Financial Sustainability Summary Memorandum was the combination of three separate memorandums: the Financial Sustainability Summary Memorandum — Revenue Sources, dated August 26, 2011; the Financial Sustainability Summary Memorandum — Administration and Reserves, dated September 27, 2011; and the Financial Sustainability Summary Memorandum — Summary and Conclusions, dated October 11, 2011 (a combination of two previously released memorandums). The information contained within the three memorandums assisted the District in making decisions in the DC HIX design, based upon various alternatives for funding its administrative costs and reserves to help ensure the DC HIX remains viable.

Mercer has prepared these projections exclusively for the District to estimate the range of expenditures to allow the District to determine its revenue requirements for the DC HIX. 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 PPACA and Health Care Education and Reconciliation Act 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 PPACA and Health Care Education and Reconciliation Act. 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.

District-only HIX

The administration and reserves memorandum identified potential additional expenses (operating budgets) within the District associated with the DC HIX. A summary of those additional expenses by administrative cost category are provided in the following tables. (Details for the assumptions and sources for the below cost categories and expenditures are available are provided in the Financial Sustainability Summary Memorandum — Administration and Reserves.)

Low cost estimate	2013	2014	2015	2016
Staffing	$1,350,000.00	$2,250,000.00	$3,600,000.00	$3,600,000.00
Consulting	$5,000,000.00	$5,000,000.00	$3,000,000.00	$3,000,000.00
Outsourced services	$4,320,000.00	$4,320,000.00	$4,320,000.00	$4,320,000.00
IT maintenance	$2,000,000.00	$2,000,000.00	$2,000,000.00	$2,000,000.00
Website maintenance	$750,000.00	$750,000.00	$750,000.00	$750,000.00
Comm. & outreach	$3,000,000.00	$3,000,000.00	$3,000,000.00	$3,000,000.00
Navigator	$750,000.00	$1,500,000.00	$2,000,000.00	$2,000,000.00
Facility & other admin.	$1,000,000.00	$1,250,000.00	$1,500,000.00	$1,500,000.00
Reserve build-up	$1,500,000.00	$1,500,000.00	$1,500,000.00	$1,500,000.00
Total	**$19,670,000.00**	**$21,570,000.00**	**$21,670,000.00**	**$21,670,000.00**

High cost estimate	2013	2014	2015	2016
Staffing	$2,500,000.00	$4,500,000.00	$6,000,000.00	$6,000,000.00
Consulting	$6,000,000.00	$6,000,000.00	$4,000,000.00	$4,000,000.00
Outsourced services	$8,400,000.00	$8,400,000.00	$8,400,000.00	$8,400,000.00
IT maintenance	$2,500,000.00	$2,500,000.00	$2,500,000.00	$2,500,000.00
Website maintenance	$1,000,000.00	$1,000,000.00	$1,000,000.00	$1,000,000.00
Comm. & outreach	$4,000,000.00	$4,000,000.00	$4,000,000.00	$4,000,000.00
Navigator	$1,000,000.00	$2,000,000.00	$2,250,000.00	$2,250,000.00
Facility & other admin.	$1,250,000.00	$1,500,000.00	$1,750,000.00	$1,750,000.00
Reserve build-up	$3,000,000.00	$3,000,000.00	$3,000,000.00	$3,000,000.00
Total	**$29,650,000.00**	**$32,900,000.00**	**$32,900,000.00**	**$32,900,000.00**

The cost estimates were based upon the following assumptions and observations:

- The low cost estimate is based upon 60,000 DC HIX enrollees and the high cost estimate is based upon 100,000 DC HIX enrollees.
- Cost estimate focus is on ongoing operations only (IT system build and infrastructure are not included in the costs).
- Fixed costs are estimated to be 40%-50% of the DC HIX costs. If DC HIX enrollment is 60,000 or 100,000, approximately 40%-50% of the costs will be incurred regardless of other assumptions/decisions. For these two enrollment scenarios, (60,000 and 100,000) estimated fixed costs may range from approximately $11.00-$15.00 per member per month (PMPM) for 2015. However, if enrollment is only 20,000 members the fixed cost PMPM would be much higher.
- Staffing estimates increase from 15-25 in 2013 to 40-60 in 2016 and is largely depended on the use of consultants and higher use of consultants at start-up may be needed.
- Outsourcing premium billing, customer service/call center and eligibility/enrollment services at approximately $6.00-$7.00 PMPM (staffing would greatly increase if brought “in-house”).

The following table provides a PMPM estimate of the cost to run the DC HIX based upon the cost estimates previously provided and the 60,000 (low) and 100,000 (high) DC HIX enrollees.

Low cost low enrollment	2013	2014	2015	2016
Total cost	$19,670,000.00	$21,570,000.00	$21,670,000.00	$21,670,000.00
PMPM $ amount	$27.32	$29.96	$30.10	$30.10

High cost high enrollment	2013	2014	2015	2016
Total cost	$29,650,000.00	$32,900,000.00	$32,900,000.00	$32,900,000.00
PMPM $ amount	$24.71	$27.42	$27.42	$27.42

Based upon the illustration above, the PMPM dollar amount for the low cost/low enrollment model is approximately $27.32 PMPM (2013), $29.96 PMPM (2014) and $30.10 (2015 and 2016) and the high cost/high enrollment model is $24.71 PMPM (2013), $27.42 PMPM (2014, 2015 and 2016). The Medicaid component of cost savings and cost shifting are above the scope of this memorandum and will need to be considered by the District after final decisions have been made regarding the DC HIX design. These decisions will likely take place during Level 1 and Level 2 Establishment Grant stages.

Federal-District partnership HIX

On September 19 and 20, 2011, the HHS, CMS and CCIIO provided potential options for a federal-state partnership at the DC HIX Grantee Meeting. Under the proposed partnership, the District may choose to operate under the following options:

- Option 1: Plan management functions including, but not limited to, plan selection; collection and analysis of plan rate and benefit package information; ongoing issuer account management; and plan monitoring, oversight, data collection and analysis for quality.
- Option 2: Selected consumer assistance functions, including in-person assistance; Navigator management; and outreach and education.
- Option 3: Both selected consumer assistance functions and plan management functions.

Given the late notice of this option, the District requested Mercer provide a high-level estimate of the cost ranges for these partnership options. Given that the Federal Government has not provided specifics on the actual operations and roles of these partnership options, the following potential costs and statistics were provided to the District for illustrative purposes. Given the lack of guidance by the Federal Government, these estimates should not be used for ultimate decision making purposes.

It should be noted that it is unknown how the Federal Government anticipates maintaining its DC HIX sustainability. The Federal Government may assess charges to the states that participate in the partnership, charges to carriers that offer plans in the partnership or charges to enrollees that enroll through the partnership. The cost estimate ranges presented below are the District-only cost estimates for partnership options for 2015, based upon low enrollment estimates of 60,000 DC HIX enrollees and high estimates of 100,000 DC HIX enrollees. The potential federal costs and charges are not known and are not included in the analysis.

- Option 1: Plan management functions: $6.25-$6.75 PMPM, 10-15 staff, $4.5-$8.0 million total estimated expense.
- Option 2: Selected consumer assistance functions: $10.00-$11.50 PMPM, 10-18 staff, $8.0-$12.5 million total estimated expense.
- Option 3: Both Option 1 and Option 2: $11.50-$13.50 PMPM, 15-25 staff, $9.5-$14.5 million total estimated expenses.
- These estimates are presented as compared to District-run DC HIX at $27.42-$30.10 PMPM for 2015, 40-60 staff, $21.6-$32.9 million total estimated expenses.

Financing models

To finance these projected HIX costs, the Financial Sustainability Summary Memorandum — Revenue Sources identified the available financing sources for the DC HIX below. Advantages and disadvantages of each method follow.

- DC HIX fees charged to the DC HIX carriers
  - Inside the DC HIX carriers (percentage of premium, PMPM fee or flat carrier fee)
  - Inside and outside the DC HIX carriers (percentage of premium, PMPM fee or flat carrier fee)
- Service fees charged to the DC HIX consumers (enrollment charge or transaction fee)
- Insurer fees charged to all DC HIX carriers (percentage of premium fee, PMPM fee or flat carrier fee)
- District appropriations
- Other available sources (provider taxes, DC HIX advertising, consumer taxes, donations, administrative and ancillary services or investment income)
- Combination of sources

DC HIX fees charged to the DC HIX carriers

This option results in those carriers offering coverage through the DC HIX paying for the DC HIX. Advantages and disadvantages of this option are highlighted below.

Advantages

- These options would be simple for the DC HIX implementation and operation.
- Revenue would be consistent with the volume and, presumably, funding need of the DC HIX; however, fixed costs may not be covered if participation is low.
- Costs are exclusively covered by those offering and accessing coverage through the DC HIX.
- Under the participation fee option, available revenue would be relatively predictable, assisting financial modeling for sustainability. However, if small carriers find they are not getting sufficient market share to cover costs, they may decide to opt-out instead of paying the fees.
- Under the PMPM fee option, those carriers with more market share would subsequently pay more of the DC HIX's administrative costs.
- If the DC HIX can ensure sufficient insurance carrier participation, this source of funding would be stable from year to year.

Disadvantages

- The ACA requires carriers to price identical insurance products similarly on and off the DC HIX. The existence of this assessment for the DC HIX products only would make off-DC HIX coverage more attractive to carriers. This issue is largely negated by the federal subsidies to lower and middle income purchasers and the requirement that they enroll within the DC HIX to receive such subsidies.

- These options would likely make the DC HIX coverage less price-competitive with similar products offered outside the DC HIX. Insurers who do not participate in the DC HIX could potentially offer the same coverage at a lower cost, and insurers who do participate in the DC HIX could offer similar, but not identical, coverage off DC HIX at a lower cost. This issue is minimized by the federal subsidies to lower and middle income purchasers and the requirement that they enroll within the DC HIX to receive such subsidies.
- Under the percentage of premium option, consumers with greater health care needs will likely purchase more comprehensive coverage and will be responsible for a higher fee.
- Under the PMPM fee option, carriers writing lower-cost coverage would have to pay as much for each policy as carriers writing higher-cost coverage.
- These options may create barriers for carriers to provide coverage through the DC HIX if the fees are too high.
- These options may result in excessive deficits if the participation in the DC HIX does not meet budgeted expectations.
- These options may result in smaller carriers avoiding the DC HIX if the participation fee is too large for the carrier to operate profitably.

Service fees charged to HIX consumers
This option results in those consumers purchasing coverage through the DC HIX paying for the DC HIX. Advantages and disadvantages of this option are highlighted below.

Advantages
- Consumer user fees place the administration burden of the DC HIX on those people that utilize the services of the DC HIX and can be viewed as a fair method of funding.
- A single fixed fee or monthly transaction fee is easy to implement and administer by the DC HIX.
- The consumer fee option could increase participation by carriers, and therefore competition within the DC HIX, since the carriers are not paying the fees.

Disadvantages
- Revenue available to the DC HIX would fluctuate and could cause issues with budgeting, especially during the early years of the DC HIX.
- If the fees charged are the only source of revenue, the fee may need to be too large to ensure competitive prices within the DC HIX. The impact of this would be largely offset by the ability of lower and middle income consumers to access federal subsidies, and the requirement that they enroll in the DC HIX to receive such subsidies.
- Subsidy-eligible individuals would have to pay this fee OOP (i.e., federal subsidies would not cover the cost of these fees) as HHS may not allow the DC HIX to charge an “access fee” in order to obtain access to federal subsidies.

Insurer fees charged to all District carriers
This option results in those carriers offering coverage throughout the entire District paying for the DC HIX. Advantages and disadvantages of this option are highlighted below.

Advantages

- A fee could be imposed upon insurance carriers on an annual basis.
- Available revenue to the DC HIX would be stable and predictable since it is not tied to DC HIX participation levels, assisting financial and program planning for each year.
- This option allocates costs of running the DC HIX across all carriers, which results in lower fees on a per policy basis.
- The means to collect the premium tax are already operational and can be leveraged for this purpose.

Disadvantages

- The fee is not directly tied to those utilizing and benefiting from the DC HIX.

Funding through District appropriations

This option results in all District residents paying for the DC HIX. Advantages and disadvantages of this option are highlighted below.

Advantages

- Direct appropriations may be an appropriate instrument to overcome possible cash flow problems for the DC HIX in 2015. The DC HIX will be forced to fund costs in 2015 against a growing caseload that may not provide sufficient revenue to support operations. Also, certain start-up costs (such as Navigators) cannot be covered with federal funds.
- Existence of a District funding mechanism may provide a more direct level of accountability between the DC HIX and voters/taxpayers.

Disadvantages

- Direct appropriations could be difficult to win District support through a budget process and would make the DC HIX vulnerable to future budget cuts.
- This option could create negative public perception of the DC HIX, as individuals who do not purchase coverage through the DC HIX would be paying for its costs.
- Since this funding option is not tied directly to the DC HIX operations/volume, it may make the DC HIX's financial sustainability more vulnerable to increases in the DC HIX volume, as additional staffing/costs would be required to meet the increased needs of the DC HIX.

Other available sources

There are many other available financing sources that are listed here for potential discussion points, but for which a detailed listing of potential advantages and disadvantages are not provided. These other sources can be items such as:

- Provider taxes — This would be an additional tax charged to health care providers, such as a hospital tax.
- DC HIX advertising or traffic fees — The District could set up health care-related banners on the DC HIX to generate revenue.

- Tobacco, alcohol, soft drink or other similar taxes — Current or additional taxes could be utilized to generate additional revenue for the DC HIX.
- Donations — The DC HIX could seek donations through corporate sponsorships or other related alternatives.
- Ancillary benefits — The DC HIX could provide ancillary benefits such as dental, vision, life, etc., and get paid a broker fee for selling them. In this scenario, the HIX could aggregate premium across these different coverages (and likely carriers) and send the individual/employer one bill, then distribute to the carriers so the broker fee they receive would have to exceed the cost of this additional administration in order to generate net revenue.
- Administrative services — The DC HIX could provide additional administrative-type services such as COBRA administration, health savings account administration or Section 125 plan administration and collect an administrative fee on these services. Similar to providing ancillary benefits, the fee would need to take into account the cost of providing these services to ensure net revenue is generated.
- Investment income — DC HIX reserves and positive cash flow will allow investment of excess cash to earn investment (most likely interest) income to offset the DC HIX administrative costs.

Using a combination of sources
If a combination of sources is utilized, the District should select a primary source (insurer fees charged to the DC HIX carriers, service fees charged to the DC HIX consumers or insurer fees charged to all DC HIX carriers) for generating revenue to ensure sustainability and then utilize other sources to generate additional revenue. If a primary source is not selected, the District may find that the DC HIX can not remain financially sustainable. The advantages and disadvantages of this combination approach are presented below.

Advantages
- A combination of sources can lower the fee charged to a specific source.
- The advantages of the revenue sources utilized (as previously discussed) are also pertinent in the combination of sources approach.

Disadvantages
- Implementation and collection of a combination of sources may be administrative burdensome to the DC HIX and to the DC HIX carriers/members.
- The disadvantages of the revenue sources utilized (as previously discussed) are also pertinent in the combination of sources approach.

Findings
Applying the District-only PMPM cost estimates (previously discussed) to the premium estimates from the actuarial modeling, the table below illustrates the estimated percentage of premium required to cover the estimated administration and reserve requirements if the premium is charged within the DC HIX only.

	2013	2014	2015	2016
Low cost low enrollment % of premium	5.86%	5.84%	5.33%	4.89%
High cost high enrollment % of premium	5.30%	5.34%	4.85%	4.46%

It should be noted that if actual enrollment falls below the illustrated 60,000 enrollees for this analysis, the percentages illustrated in the previous table will not cover the estimated administration and reserves. For purposes of reference and comparison, the Massachusetts Connector Exchange charges an administrative fee to percentage of premium within the Connector Exchange. This administrative fee to finance the Exchange started at approximately 4.5% of premium and decreased to approximately 3.5% of premium for fiscal year 2011.

Another option for financing the DC HIX is applying an insurer fee to all DC HIX carriers across all premiums. This insurer fee could be based upon a percentage of total premiums (large group, small group and individual coverage). Based upon results of the actuarial modeling and the costs outlined above, the expected percentage would need to be 0.9%-1.2%. This assumption is based upon an estimated total premium in the District of $2.5 billion in 2015.

It should be noted that it is unknown how the Federal Government anticipates maintaining its DC HIX sustainability. The Federal Government may assess charges to the states that participate in the partnership, charges to carriers that offer plans in the partnership or charges to enrollees that enroll through the partnership. The guidance provided at the September 19 and 20, 2011, State Grantee Meeting states that the partnership option allows for easier transitions to state-based Exchanges in future years. However, it should be noted that to the extent a state moves to a state-based Exchange, there may not be federal grants available past January 1, 2015, for system build and establishment that are currently available to a states.

The District evaluated the importance of DC HIX control with the additional cost. This is due to the fact that a District-run DC HIX will give the District more control, but with the added cost and financial risk. The federal-District partnership would give up control of numerous aspects of the DC HIX, but would come at potential cost savings and less financial risk. This is due to the fact that the Federal Government will be performing and funding many of the DC HIX functions.

Based upon the uncertainty surrounding the federal-District partnership discussed above, the District decided to operate a District-run Exchange. However, the District is still in the process of determining the appropriate mechanism to fund the DC HIX.

District Decisions Regarding Financial Sustainability

The District has not formalized any decisions regarding options for Financial Sustainability.

Mercer Recommendations and Next Steps

It is recommended to charge insurer fees of 0.9%-1.2%, to all DC HIX carriers and all premiums (large group, small group and individual). This is due to the estimated DC HIX-only charge inside

the District is 4.85%-5.33%, resulting in too high a percentage of premiums. In addition, if actual enrollment falls well below the projections, the costs of the DC HIX may not be covered by the available revenue. The main advantage of charging a percentage across all premiums is that if enrollment in the DC HIX falls well below projections, the District is able to cover the costs of the DC HIX given that the fees will be collected regardless of enrollment. Advantages and disadvantages of this option are highlighted below.

Advantages

- Fee could be imposed upon insurance carriers on an annual basis.
- Available revenue to the DC HIX would be stable and predictable since it is not tied to participation levels, assisting financial and program planning for each year.
- This option allocates costs of running the DC HIX across all carriers, which results in lower fees on a per policy basis.
- The means to collect the premium tax are already operational and can be leveraged for this purpose.

Disadvantages

- The fee is not directly tied to those utilizing and benefiting from the DC HIX.
- The fee may require legislative action to implement.
- The perception of a new tax may result in difficult implementation.

The next steps for the District would be to finalize the method to fund the DC HIX. In addition, the District should assess the availability and use of existing District agencies to support functions of the DC HIX. This assessment should quantify the fiscal efficiencies generated by use of current District agencies and functions being consolidated into the DC HIX. The availability of federal matching funds for Medicaid functions performed in the DC HIX should also be considered.

6

Legal and Policy

C.3.3.1.3.5 Legal and Policy

C.3.3.1.3.5.1 The Contractor shall provide legal and policy analysis regarding the Exchange's key policy framework, establishment and authorization vehicles, and policies and procedures, to be summarized in a Legal and Policy Summary Memo. The Legal and Policy Summary Memo analysis shall include at a minimum the following:

a. A review of existing statutes and regulations that may impact , either positively or negatively, the implementation of the Exchange;
b. Establishment vehicles including an analysis of all legislative and regulatory actions necessary for the establishment of the Exchange entity, including all short and long term authorities and legal charges, and privacy practices and policies; and
c. Identification and development of policies and procedures to address all administrative and operational aspects of the Exchange.

Options

Not applicable.

Findings

Mercer delivered the Legal and Policy Summary Memo in two parts. The first part (Part I) summarizes the findings of a "gap" analysis of the market reforms in the ACA, and the second part (Part II) reviews existing DC Code provisions that might impact establishment of the DC HIX. As agreed to by District, Part I and Part II in the Legal and Policy Summary Memo focus on existing statutes and do not address regulations or policies and procedures.

Findings Regarding Market Reforms

The following summarizes the findings of Part I regarding market reforms:

1. Through a preemption provision in the ACA, the market reforms apply regardless of any action by the state, and the HHS has the regulatory authority to enforce the reforms.
2. In order to retain regulatory authority, a state needs to issue guidance or rules in support of the market reforms and/or enact legislation to implement the ACA provisions.
3. The DISB, relying on the general and licensing authority of the Commissioner, issued a Bulletin on August 16, 2010 describing compliance procedures for the market reforms that became effective September 23, 2010. DISB intends to issue a similar bulletin for the market reforms that become effective in 2014.

4. DISB plans to submit general authority legislation to require compliance with all applicable provisions of the ACA.
5. At the request of the Mayor, a bill has been introduced to enact the ACA requirements regarding grievances and appeals, including establishing an external review process that meets HHS' standards.
6. Through the actions described in bullets #3 to #5 above, the District has/will have regulatory authority to enforce all of the market reforms specified in the ACA.
7. In order to avoid confusion, the District should amend or repeal DC Code provisions that might not be consistent with ACA requirements. These provisions are identified in Part I of the Legal and Policy Summary Memo.

Findings Regarding DC Code Provisions

The following summarizes the findings of Part II regarding DC Code provisions that might impact the DC HIX:

1. The District should consider the potential impact of various provisions in the DC Code on the DC HIX. Specifically, the District should consider the impact of DC Code provisions related to the following topics:
   A. Board appointments
   B. Open meetings
   C. Agency reorganization
   D. Promulgation of rules
   E. Procurement
   F. Budget and financial management
   G. Audits
   H. Fees and revenues
   I. Hiring and compensation
2. In reviewing provisions of the DC Code related to the foregoing topics, the District should determine:
   A. Whether the provision would apply to the DC HIX as an existing agency Exchange (within an existing District agency) and/or independent agency Exchange
   B. Whether the provision may negatively impact implementation of the DC HIX
   C. Whether the enabling legislation for the DC HIX could limit or expand the application of the provision to the DC HIX
   D. Whether the enabling legislation should limit or expand the application of the provision
   E. How, if appropriate, to limit or expand application of the provision
3. In general, an independent agency Exchange will have more flexibility than an existing agency Exchange in limiting the application of DC Code provisions to the DC HIX.
4. Regarding Board appointments, without enabling legislation explicitly stating otherwise, the Mayor would be permitted to nominate Board members without consulting the Council.
5. Unless the enabling legislation provides otherwise, the meetings of the Board of Directors of an independent agency Exchange and of the public bodies governing an existing agency Exchange would be subject to certain open meeting provisions in the DC Code. If the District

were to limit open meeting and open record provisions' application to the DC HIX, the District may not be in compliance both with the ACA and with stakeholder direction.

6. To the extent necessary, the Mayor has the authority to provide a reorganization plan to transfer, consolidate or abolish functions between or among agencies in order to promote the effective management of District agencies and functions, reduction of administrative waste and elimination of duplicative efforts.
7. Unless the enabling legislation provides otherwise, the DC HIX would be required to establish administrative and rulemaking procedures.
8. Unless stated otherwise in the enabling legislation, all contracts entered into by the DC HIX must comply with the procurement procedures described in the DC Code. To the extent the DC HIX is subject to the procurement procedures described in the DC Code, this could impact the timing associated with establishing the DC HIX.
9. Unless provided otherwise in the enabling legislation, to the extent the DC HIX receives operating funds from the District; the DC HIX would be subject to provisions in the DC Code regarding budget and financial management.
10. While the DC HIX's enabling legislation could limit the scope of the Districts audit requirements as they apply to the DC HIX, the enabling legislation could not change the federal audit requirement in the ACA. Moreover, any attempt by the DC HIX to limit its financial accountability conflicts with the requirement that the DC HIX maintain transparency and remain subject to public input.
11. All District revenues, including taxes, fees and charges, must be directed to the General Fund, unless the Council has established special accounts for certain receipts and expenditures. It will likely be necessary for the enabling legislation to establish a special account for the DC HIX.
12. The hiring and compensation requirements in the DC Code may impact the District's ability to attract qualified candidates to staff the DC HIX.

District Decisions Regarding Legal and Policy

On October 18, 2011, the HRIC submitted a report to the Mayor containing the HRIC's recommendations related to the DC HIX governance and structure. None of the HRIC recommendations addresses market reforms (Part I of the Legal and Policy Summary Memo); however, the report included HRIC recommendations relevant to Part II of the Legal and Policy Summary Memo regarding DC Code provisions.

The HRIC recommendations relevant to legal and policy include the following:

1. [T]he DC HIX be established as a quasi-governmental or independent District agency, with an appointed board and an executive director…, and that is exempt from the personnel and procurement laws.
2. [T]he Executive Board is to be comprised of 15 members: five members appointed by the Executive; four appointed by Council; and six non-voting ex-officio executive agency officials representing the relevant District agencies.

3. [T]he majority of the appointed Executive Board members, excluding ex-officio members, be District residents and be in compliance with District residency requirements at the time of appointment and through the duration of the appointment.
4. [The] Executive Director [shall be] a District resident and shall have the authority to hire additional DC HIX staff, to administer the day-to-day operations of the DC HIX.
5. [T]he DC HIX Executive Board be granted rulemaking authority to implement the enabling legislation and the relevant provisions of the ACA.
6. [A]n independent, non-lapsing DC HIX fund be established and used to support the operations of the DC HIX, and that the DC HIX be authorized to charge assessments and user fees to fund its operations.

Mercer Recommendations and Next Steps

Mercer recommends that the District take the following steps related to Legal and Policy:

1. Develop and pass legislation to provide DISB with general regulatory authority to enforce the market reform provisions of the ACA.
2. Develop and pass legislation to enact the ACA requirements regarding grievances and appeals, including establishing an external review process that meets HHS' standards.
3. Develop and pass legislation to amend or repeal DC Code provisions that might not be consistent with ACA requirements, including provisions identified in Part I of the Legal and Policy Summary Memo.
4. Prior to the January 1, 2014, the effective date of the "future" market reforms, issue a Bulletin to insurers describing compliance procedures.
5. Develop and pass legislation authorizing the DC HIX that addresses the application of provisions of the DC Code in the areas identified in Part II of the Legal and Policy Summary Memo.

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Exchange Insurance Market

C.3.3.1.3.6 Exchange Insurance Market

The Contractor shall provide analyses and recommendations regarding guidelines for the insurance market in the Exchange, to be summarized in an Exchange Insurance Market Summary Memo. The Exchange Insurance Market Summary Memo shall include, but is not limited to:

a. Models, and associated benefits, for certification of QHPs, including active purchasing, passive certification, and other approaches;
b. Options and corresponding modeling and actuarial analyses of health plans to be offered in the Exchange, including insurance standards, benefit design, and cost-sharing models for each actuarial level permissible by the ACA;
c. Actuarial analysis and fiscal impact to the District of including benefits and services in addition to federally mandated benefits to Exchange plans;
d. Options and corresponding actuarial analyses for insurance standards and eligibility criteria for Exchange options for small businesses;
e. Actuarial analysis of merging the individual and small-group markets in the Exchange;
f. Options and corresponding actuarial analysis of adopting Exchange insurance standards for individual and group markets outside of the Exchange; and
g. Modeling and analysis of potential adverse selection, and recommendations for minimizing adverse selection in the Exchange.

Options

In planning for its DC HIX, there are several decisions the District will need to make related to how the DC HIX functions and the rules under which the post-reform insurance marketplace will operate. Actions must be taken to ensure a competitive marketplace is maintained and efforts are actively undertaken to maximize participation in the DC HIXs. First and foremost, carriers must participate in the DC HIX, as without carrier participation, the DC HIX will not exist. Carriers must be assured that controls are in place to limit adverse selection; carriers who perceive they will be selected against inside the DC HIX may choose not participate unless mandated to do so as a condition of writing business in the District. It will also be important to ensure that an adequate mix of affordable plan choices be made available within the DC HIX. A balance must be struck between rates in the individual and small group markets, if they are not merged, so that affordable rates exist in both and one market is not selected against. In order to incentivize individuals and small groups who are not eligible for subsidies to participate in the DC HIX, the choice of plans cannot be significantly limited relative to the outside market. If broad choices at

affordable rates cannot be found in the DC HIX, these individuals and small groups will look to the outside market.

Mercer, along with its sister company Oliver Wyman Actuarial Consulting, Inc. as a subcontractor, studied several of these key decisions that the District will have to make related to the structure and rules of its new insurance marketplace, each of which are discussed in turn.

Active versus Passive Purchaser

The District will need to decide the type of model that it will employ related to the certification of QHPs inside the DC HIX. The DC HIX can play various roles in developing a fair insurance market for consumers, depending on the philosophy, the insurance environment and the goals of the DC HIX. The model the District selects can range from that of a passive market organizer/aggregator to a more active purchaser, or a hybrid of the two. Each model will have different effects on the market, all of which should be considered carefully.

Adverse Selection and Mitigation Techniques

Whenever individuals and small groups have choice, there is the potential for adverse selection. Adverse selection can occur when the average risk profile of the individuals enrolled in a product is higher than the risk profile embedded (or assumed) in that product's rates. Whenever individuals and employers have choices among health insurance options (including the option to forgo insurance altogether), there is potential for this type of selection to occur. Unlike other types of insurance, such as automobile or homeowner's coverage, the upcoming year's health care expenditures are relatively predictable for most people. Unrestrained risk selection can produce an unstable marketplace, so striking a balance between preserving choice and mitigating the potential for adverse selection is a key challenge for states implementing Exchanges.

There are three primary types of adverse selection that have the potential to influence the District's individual and small group health insurance marketplace in the reformed environment that will exist beginning in 2014:

- Adverse selection against the market: If healthier individuals and groups choose not to participate in the fully insured market, either by going uninsured or self insuring
- Adverse selection against the DC HIX: If its design causes the DC HIX to be more attractive to higher-risk populations while healthier populations stay in the outside market
- Selection among carriers and products offered inside the DC HIX

The ACA includes a number of provisions designed to discourage adverse selection, but many sources of selection remain. The District will need to consider these sources, the impact that they could have on its market, and put in place measures to control them.

DC HIX Enrollment

In order to prepare and develop a plan for financial sustainability, the District must understand the level of enrollment anticipated in its individual and small group DC HIXs. The anticipated enrollment will affect many decisions such as how to design the DC HIX, staffing levels and perhaps market rules.

Merging the Individual and Small Group Pools

Under the ACA, the District has the option of merging the individual and small group markets, or retaining two separate risk pools as they have today. Merging the individual and small group insurance markets would have the effect of spreading risk across a wider pool of participants and potentially provide greater rate stability for all. Unless the pools have the same underlying morbidity today, a merger will work to increase the rates for one pool while decreasing it for the other. The impact that a merger would have on the number of people that enroll in a merged market will depend upon the impact that the merger has on the rates for each.

Expanding the Definition of Small Group to 100 in 2014

The ACA defines small group market as groups with 100 or fewer employees beginning in 2016 and does not apply the new rating provisions until that time. However, the District has the option to adopt this new definition in 2014, in which case all of the provisions in the ACA that apply to small groups would also apply to groups 51-100 in 2014. Disruption for group sizes 51-100 is likely to occur once these groups must be rated on an adjusted community rated basis. Today, many of these groups are, in part, rated on their own experience. Groups with 51-100 employees are less likely to participate in the SHOP DC HIX unless significant administrative savings exist. Groups with good experience may see a significant increase in rates as a result of community rating and these groups will be more likely to self insure. Without concerted effort to provide either value-added services for larger small employers or significantly lower premiums, the DC HIX may not be able to attract those consumers.

Covering services beyond federally mandated benefits

According to the ACA, the District will be required to cover the cost of any benefits that are required to be provided by a QHP inside the Individual and SHOP DC HIXs that are not included in the EHB package. So, for those policies sold inside the DC HIX, the District will bear the cost for those benefits mandated by the District that are not included in the EHB package. The District must decide whether to continue requiring coverage for or repealing current District mandates that are not part of the EHB package.

Maximizing Participation in the SHOP DC HIX

In order to have a viable DC HIX, the District must undertake efforts to ensure that a critical mass of individuals and small groups enroll so that the DC HIX will be financially sustainable. It will be important that an adequate mix of affordable plan choices be made available within the DC HIX in order to incentivize individuals and small groups who are not eligible for subsidies to participate. If broad choices at affordable rates cannot be found in the DC HIX, these individuals and small groups will look to additional options made available in the outside market.

While premium and cost-sharing subsidies will draw many into the individual DC HIX, there are no comparable financial incentives to draw small groups into the SHOP DC HIX, with the exception of small business tax credits, which are temporary and only apply to a small number of groups. The District must consider efforts beyond just attracting small employers. Benefits and other options will also be needed to attract employees; the engagement of brokers will also be critical. Attracting carriers to participate in the DC HIX will be a necessity for both the individual and SHOP DC HIXs.

Findings

Adverse Selection and Mitigation Techniques

There are many sources of potential adverse selection that could impact the District's individual and small group markets. These sources cannot be eliminated and many cannot be directly controlled, such as the federal mandate that all coverage be issued on a guaranteed issue basis. However, there are ways to mitigate the impact that these sources have on the market. Some of the sources of adverse selection that the DC HIX faces where action could be taken to mitigate risk include:

Product Offerings

The ACA does not require that all products offered inside the DC HIX also be offered outside the DC HIX. Likewise, some products may be offered only outside the DC HIX. While there is a requirement that carriers operating in the DC HIX offer at least Silver and Gold product levels, no such requirement exists for carriers operating outside the DC HIX. Therefore, carriers could choose to offer only Bronze plans in the outside market, which would be most attractive to relatively healthy populations.

Network Design

The ACA places requirements regarding provider network access standards on products sold within the DC HIX. Lack of these same requirements outside the DC HIX can drive adverse selection. Network design could be used by carriers to avoid enrollment of members with certain chronic conditions. Minimum standards of network adequacy and quality should also apply outside the DC HIX to avoid wide disparities between networks inside and outside the DC HIX.

Grandfathered Plans

The presence of grandfathered plans outside the DC HIX also has the potential to cause adverse selection inside the DC HIX. Maintaining grandfathered status will be most valuable to young, healthy individuals and groups, since carriers will be allowed to continue using pre-ACA rating rules for these plans. This provision could allow lower age factors and underwriting discounts for these grandfathered groups and individuals. In turn, it could produce lower rates than are available inside the DC HIX for these individuals. The exclusion of these plans from the risk pool will affect risk-sharing mechanisms such as risk adjustment and risk corridors set by the ACA for addressing adverse selection.

Self Funded Multiple Employer Welfare Arrangements
Multiple employer welfare associations (MEWAs) provide health and welfare benefits to employees of two or more unrelated employers who are not parties to bona fide collective bargaining agreements.[20] An example of a MEWA would be a plan sponsored by a trade association for its members. MEWAs can be fully insured or self insured. Fully insured MEWAs covering small employers will be subject to the same rating rules that will govern the small employer market in general in 2014 and beyond, (e.g., 3:1 rate bands for age and premiums based on experience pooled across the entire small group market). However, self-insured MEWAs would be able to have the cost of their benefits be based on the experience of the MEWA. This would be attractive to those groups that expect their health care claims to be lower than the small group pool as a whole. The ACA includes several provisions related to MEWAs, including giving the Secretary of Labor the authority to make a MEWA subject to state regulatory jurisdiction.[21] The District may want to consider a means for monitoring the extent to which MEWAs are selecting against in the DC HIX, or the small group market in general, and may want to begin developing options for addressing the situation should it begin to occur.

DC HIX Fees
If DC HIX fees are assessed only inside the DC HIX and some carriers sell only outside the DC HIX, this could lead to adverse selection. This adverse selection would occur when carriers outside the DC HIX are able to avoid the fees and offer comparable products at a lower price. Carriers that sell inside and outside the DC HIX would be assessed these fees against all of their products. Since these carriers are required to charge the same premium for a plan sold both inside and outside the DC HIX, the fees assessed against their policies sold inside the DC HIX would essentially be spread across their policies outside the DC HIX as well.

Employee Contributions
Employers could set employee contributions at a level high enough so that the contribution for single coverage exceeds 9.5% of the employee's household income. At this point, the coverage would be deemed unaffordable and if the employee's household income is less than 400% FPL, the employee would be eligible to enroll in the DC HIX and receive premium subsidies. Employers could take this action in order to avoid covering low-wage individuals with health conditions while still continuing coverage for other employees. This approach could lead to adverse selection against the DC HIX.

There are several measures that the District could take to address the various sources of adverse selection against the DC HIX. While each of the options presented below has the potential for mitigating adverse selection, they should be studied with care and considered alongside other design aspects of the DC HIX as they may have unexpected ramifications on

[20] 29 U.S.C. 1002(40)

[21] PPACA Sec. 6604.

the broader insurance market in the District. Possible actions the District could take to mitigate these sources of adverse selection include:

- Eliminate the outside market
- Extend some or all QHP requirements to the outside market
- Require carriers to participate in the DC HIX
- Require carriers participating only in the outside market to offer Gold and Silver products
- Require carriers participating in the DC HIX to offer Bronze products
- Control the minimum level for specific and aggregate stop-loss
- Take actions to increase enrollment in the DC HIX
- Place restrictions on plan designs offered outside the DC HIX
- Do not allow employees in the SHOP DC HIX to select from all products

Several of these options could have material repercussions on the individual and small group markets in the District. It is important to balance the need to discourage adverse selection with the need to retain choice, flexibility and innovation in the marketplace. There are important provisions established by the ACA that may be successful at managing some selection; however, many sources for selection remain.

DC HIX Enrollment

To understand how certain design scenarios could impact enrollment and premiums in the District's individual and SHOP DC HIXs, Oliver Wyman's Health Care Reform Micro-simulation Model was used to project anticipated enrollment. A vast amount of information was used for this modeling and many assumptions underlie the modeling which are too numerous to describe in this memorandum. These assumptions are outlined in great detail in our report titled "District of Columbia Exchange Insurance Marketplace" and any decisions must take into consideration all of those assumptions. The key underlying assumptions include, but are not limited to:

- A steady state population is assumed. While the population ages and grows, and incomes increase over time, the underlying mix of the population does not change with respect to most other variables. The distribution of the District's overall population by income, gender, health status, occupation, family size and other variables is assumed to remain relatively constant over the projection period.
- All major carriers participating in the District's individual and small group markets during the base period continue to participate in 2014 and beyond.
- No new carriers enter the market and obtain significant market share.
- All carriers participate in both the inside and outside DC HIX markets.
- Products offered inside the individual and SHOP DC HIXs are similar to products offered outside the individual and SHOP DC HIXs and premium rates are the same inside and outside the DC HIXs for the same benefit package.
- Individuals currently enrolled in Medicaid, CHIP and the Alliance will remain in those programs.

- Large employers with 101 or more employees are assumed to continue to offer coverage at the same rate they did in 2010.
- Small employers not offering coverage in 2010 will not begin offering coverage in 2014.
- Individuals and families receiving employer sponsored coverage through a government employer will not enroll in the DC HIX, with the exception of members of Congress and their staff.
- The will be no individuals or small groups with grandfathered policies in 2014.
- Small groups will not self insure. (We note that with the rate shock that will occur in 2014, some groups are likely to self insure.)
- The model does not consider the impact that private DC HIXs may have on enrollment in the District's individual and SHOP DC HIXs.
- The model assumes undocumented workers are not included in the underlying AC Survey data.
- Based on discussion with the District, 50% of all non-subsidy residents enrolling in individual coverage will do so through the individual DC HIX.
- 10% of all District small employers offering coverage will do so through the SHOP DC HIX.
- The District will extend its 138% up to 200% FPL Waiver program (if approved) or establish a BHP. As a result, individuals with incomes between 138% and 200% FPL were not modeled as being eligible to enroll in the individual DC HIX.

The following tables provide the results of our baseline modeling*:

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	14,500	$4,710	$68,341,000	37,500	$5,440	$204,143,000	52,000	$5,240	$272,484,000
2015	14,000	$4,900	$68,559,000	38,000	$5,620	$213,457,000	52,000	$5,420	$282,016,000
2016	17,500	$5,320	$93,117,000	39,000	$5,980	$233,135,000	56,500	$5,770	$326,252,000
2017	17,000	$5,620	$95,540,000	41,000	$6,470	$265,429,000	58,000	$6,220	$360,969,000
2018	16,750	$5,870	$98,301,000	42,500	$6,880	$292,508,000	59,250	$6,600	$390,809,000

	External Markets								
	Small Employer Coverage			Individual Coverage			Total External Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	65,750	$4,510	$296,722,000	23,750	$5,230	$124,159,000	89,500	$4,700	$420,881,000
2015	64,250	$4,740	$304,481,000	24,250	$5,210	$126,421,000	88,500	$4,870	$430,902,000
2016	101,500	$5,160	$523,387,000	25,000	$5,620	$140,578,000	126,500	$5,250	$663,965,000
2017	99,250	$5,460	$541,818,000	25,000	$6,140	$153,424,000	124,250	$5,600	$695,242,000
2018	98,000	$5,770	$565,073,000	26,000	$6,480	$168,524,000	124,000	$5,920	$733,597,000

	District Total Individual and Small Group Insurance Markets								
	Small Employer Coverage			Individual Coverage			Total Market		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	80,250	$4,550	$365,063,000	61,250	$5,360	$328,302,000	141,500	$4,900	$693,365,000
2015	78,250	$4,770	$373,040,000	62,250	$5,460	$339,878,000	140,500	$5,070	$712,918,000
2016	119,000	$5,180	$616,504,000	64,000	$5,840	$373,713,000	183,000	$5,410	$990,217,000
2017	116,250	$5,480	$637,358,000	66,000	$6,350	$418,853,000	182,250	$5,800	$1,056,211,000
2018	114,750	$5,780	$663,374,000	68,500	$6,730	$461,032,000	183,250	$6,140	$1,124,406,000

Covered lives are rounded to the nearest 250; Annual average premium are rounded to the nearest $10; Total premium are rounded to the nearest

Key observations for calendar year 2014 (as compared to 2010) when employing the assumptions previously described include:

1. Enrollment in the District's total individual market is projected to more than triple, from roughly 20,000 members in 2010 to 61,250 members in 2014 (not shown), with 61% of covered individuals enrolled in the individual DC HIX.
2. Of the individuals that enroll in the individual DC HIX, 22% will receive premium subsidies.
3. Average premium on a per capita basis in the individual market, prior to application of premium subsidies, is projected to increase by 45% from 2013 to 2014. The EHB package (i.e., required coverage for EHBs and the required increase to an actuarial value of at least 0.60) accounts for roughly 25% of the increase.
4. Individual premiums are projected to be 15% higher than small group premiums in 2014. This compares to premiums in the individual market today that are 25% lower than in the small group market.
5. Enrollment in the District's small group market is projected to decline by approximately 13% in 2014, with roughly 18% of individuals receiving coverage through their small group employer enrolled in the SHOP DC HIX.
6. Enrollment in the SHOP DC HIX increases by roughly 3,500 members in 2016 when the definition of small group expands to include businesses with up to 100 employees.
7. Average premiums on a per capita basis in the small group market are projected to increase by only 6% from 2010 to 2014. This reflects significant rate decreases (averaging 12.2%), which results from carriers' efforts to comply with minimum loss ratio requirements starting in 2011. It also reflects a recent significant rate decrease by one major carrier.
8. Enrollment in Medicaid/CHIP (based on coverage up to 200% FPL) is projected to increase by roughly 9,500 lives from 2010 to 2014.
9. The uninsured population in 2014 is projected to be roughly half of the 2009 level,[22] decreasing to roughly 21,000 individuals, or approximately 3.5% of the District's population.

[22] The current uninsured rate is based on the 2009 American Community Survey data that was used for the background research. As of the time this analysis was completed 2010 American Community Survey data was not available to update this statistic.

Underlying this estimate is an underlying assumption that 20% of those currently eligible for Medicaid, but uninsured, would enroll by 2014.[23]

Merging the Individual and Small Group Pools

The District's current individual insurance market is significantly smaller than the small employer market in terms of covered lives. However, based on information from the Census Bureau, the average morbidity of the two pools is not significantly different today (the average morbidity of the current individual pool is roughly 2% lower than the average morbidity of the current small group pool) and a market merger of the District's current individual and small group pools would appear more of a merger of equals.

However, the entrance of those who are currently uninsured into the individual pool will have the effect of increasing the average morbidity of the current individual market to levels above that of the current small group pool. Without a merger, the average morbidity of the individual pool would be roughly 7% higher than the average morbidity of the small group pool after the uninsured enter the pool. A merger would provide a moderate amount of premium relief to the individual market at a small cost to the small group market. The results of our modeling revealed the following key effects of a market merger:

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	13,750	$4,760	$65,447,000	38,500	$5,210	$200,690,000	52,250	$5,090	$266,137,000
2015	12,750	$5,100	$64,981,000	39,500	$5,410	$213,686,000	52,250	$5,330	$278,667,000
2016	17,250	$5,250	$90,548,000	39,750	$5,780	$229,676,000	57,000	$5,620	$320,224,000
2017	16,750	$5,550	$92,907,000	41,750	$6,250	$260,863,000	58,500	$6,050	$353,770,000
2018	16,250	$5,910	$96,040,000	43,250	$6,650	$287,798,000	59,500	$6,450	$383,838,000

1. Premium levels do differ as a result of the market merger; however, the variance is not so extreme that take-up patterns are markedly different.
2. Premiums in the individual market are 3.5% lower in 2014 in a merged market, relative to the baseline scenario.
3. Premiums in the small group markets are 3.6% higher in 2014 in a merged market, relative to the baseline scenario.
4. The average enrollment in the combined individual and SHOP DC HIXs is not anticipated to be significantly different than if the markets are not merged.

[23] Note: not all individuals eligible for Medicaid but not currently enrolled are uninsured. Many of these individuals currently have employer sponsored coverage.

In addition to the direct financial impact that merging the individual and small group pools may have on the rates for each market, there are other considerations when making the decision of whether or not to merge the pools. Some additional advantages and disadvantages to merging the pools include:

Advantages to Merging the Pools

- Merging of the two markets would result in a larger risk pool, and perhaps more rate stability.
- If the markets are kept separate, individual and small group rates may be materially different for identically suited people.
- Carriers' administrative expenses may be lower in a merged market due to consistent product portfolios, a reduced number of rate flings, etc. These savings should theoretically be passed along to District residents and businesses.
- Individuals leaving groups, or in groups that no longer offer coverage, would be able to continue their coverage at their current level of benefits.
- Theoretically, a single pool could prompt the highest number of carrier options, since it could conceivably require carriers operating only in the existing individual market as well as carriers operating only in the existing small group market to participate in both markets, resulting in more competition and choice for consumers. The dominance of one carrier in each of these markets today may make this particular consideration for the District less important than in some other states.
- If more employers move toward a defined contribution approach, the small employer market would function more like the individual market. Even if employers do not adopt a defined contribution approach, the fact that the SHOP DC HIX must allow individual choice among a given metallic level of coverage means that a merged market that is based on an individual rather than group rating structure may be more conducive to these arrangements.
- Some managed care entities that, until now, have focused only on those markets that did not require underwriting expertise (e.g., Medicaid or Medicare Advantage markets) may perceive a combined market as a greater business opportunity than separate markets and may be more willing to assume the risk of expanding into the commercial sector.

Disadvantages to Merging the Pools

- Merging the markets could lead to even more market disruption than that which will occur from the rate shock resulting from the required changes under the ACA (e.g., adjusted community rating, guarantee issue), and the markets can always be merged at a later date.
- A single pool could result in fewer total carriers and less competition if those carriers that specialize in only one of the existing separate markets choose not to participate in the new combined market.
- A merged market might limit the DC HIX's flexibility to address the differing needs of individuals and small groups.
- Products in the individual market could potentially look very different from those in the small group market, unless restricted by the District. This could require benefit changes for these individuals migrating from small group coverage to individual coverage.

- In the District, we expect that merging the markets will raise premiums for small groups and reduce premiums for individuals. Higher small group rates in a merged market could lead to more groups dropping coverage. If more small employers drop coverage, the costs to taxpayers will increase as more individuals become eligible for subsidies.
- Upward pressure on small group rates, resulting from merging the markets, could cause more small groups to consider self-insuring, which could in turn result in healthier risks leaving the market.
- Merging the markets could complicate the DC HIX's operations. As an example, the DC HIX would have to enforce one set of open enrollment rules for individuals and another set for small groups.
- While our modeling results do not show tremendous disruption from merging the markets, we would note that there is more uncertainty surrounding premiums in the small group market after 2014 due to the difficulty in estimating the costs associated with covering those who were previously uninsured.
- For this reason, the District may want to keep the markets separate initially.

Expanding the Definition of Small Group to 100 in 2014

Defining small group in the District to include employers with up to 100 employees in 2014 and 2015 may enlarge and strengthen the small group risk pool in the near term, but it does not produce significantly higher levels of DC HIX enrollment in the long term. This is because the current 51-100 market is roughly half the size of the current small group market and group sizes 51-100 will not be eligible for small business tax credits, which is projected to attract a fair number of small groups into the DC HIX.

The results of our modeling revealed the following key effects of expanding the definition of small group to 100 beginning in 2014:

	Exchanges								
	Small Employer Coverage			Individual Coverage			Total Exchange		
Year	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars	Covered Lives	Average Annual Premium	Total Premium Dollars
2014	18,750	$4,810	$90,095,000	37,500	$5,450	$204,550,000	56,250	$5,240	$294,645,000
2015	18,250	$5,000	$91,309,000	38,000	$5,630	$213,883,000	56,250	$5,430	$305,192,000
2016	18,000	$5,260	$94,769,000	38,500	$6,010	$231,453,000	56,500	$5,770	$326,222,000
2017	17,500	$5,600	$98,018,000	40,500	$6,480	$262,436,000	58,000	$6,210	$360,454,000
2018	17,250	$5,870	$101,316,000	42,000	$6,900	$289,919,000	59,250	$6,600	$391,235,000

- An additional 4,250 members are projected to enroll in the SHOP DC HIX in 2014 due to inclusion of the 51-100 population in the small group pool.
- The early entrance of the 51-100 life groups into the small group pool has the impact of slightly increasing premiums in the expanded small group market. This is due to differences

in demographics and benefits of these two sub-populations (the under 50 population and the 51-100 population).
- The early expansion of the small group market has almost no impact on either premiums or enrollment in the individual market.

A key factor that our modeling did not consider, but that could significantly impact the results, is the scenario where a large number of small groups decide to self insure. If healthy small groups are able to self insure, their removal from the risk pool will put upward pressure on rates as the remainder of the risk will have higher than average morbidity.

Covering services beyond federally mandated benefits

The long awaited (and recently released) report from the Institute of Medicine (IOM) did not include recommendations for specific services in the EHB package. The report indicates that the committee was not tasked with recommending specific services for the EHB package; further, the report suggests that HHS should establish its initial draft of the EHB package by May 2012. With this uncertainty around the EHB package, it is not clear at this time what services that are currently mandated by District will be excluded from the EHB. Ultimately, we were unable to perform a complete analysis of the potential cost to the District to cover these benefits at this time.

We did, however, perform a high-level analysis, relying on information from the IOM Report, services explicitly included through the ACA and the frequency of certain mandated benefits from a report published by the Council for Affordable Health Insurance. Based on this information, there are four current District mandates that have a reasonable chance of not being included in the EHB package. Those mandates, and our estimate of the costs, are:

- Autism: $0.70 to $1.00 PMPM
- Habilitative Services for Congenital/Genetic Defects: $0.20 PMPM
- Hormone Replacement Therapy: $0.14 PMPM
- Speech and Hearing Therapy: $0.03 PMPM

These costs total $1.07 to $1.37 PMPM. In total, these estimates suggest that under the baseline modeling scenario performed, the District would have to pay approximately $650,000 to $850,000 in 2014, increasing to $750,000 to $950,000 in 2018, to cover these benefits. This range assumes that the District's other mandated benefits are included in the EHB package. It also assumes that the scope of the District's coverage (e.g., age limits, annual visits, etc.) is consistent between the District and those states for which the estimates were prepared.

Maximizing Participation in the SHOP DC HIX

There are a number of items we found that the District should consider when designing its SHOP DC HIX to help increase participation. These items are discussed below.

Attract a Sufficient Number of Carriers
In order to have a viable DC HIX and ensure affordable rates, participation in the DC HIX must be attractive to carriers. Participation by a number of carriers will mean more choices for individuals and small groups and a greater chance that they will purchase coverage through the DC HIX. Greater carrier participation will also likely mean more competition for a fixed pool of individuals, which may help keep rates affordable. In order to encourage carriers to participate though, the DC HIX must be able to demonstrate that they have “rules” in place to control adverse selection; carriers who perceive they will be selected against inside the DC HIX may choose not participate. At the extreme, the District could require that all carriers that wish to do business in the District participate in the DC HIX; however, this option must be explored with caution, as it could lead carriers that planned to participate only in the outside market to exit the District altogether.

Ensure a Broad Selection of Product Choices
Having a number of carriers participate in the DC HIX increases the chances that offerings inside the DC HIX will provide a wide variety of deductibles, coinsurance and providers from which individuals and small employers may choose. A wide variety of products is needed to ensure enough choice to attract individuals and small groups; it is also needed to create robust competition among carriers. If the choices inside the DC HIX are more limited than those available in the outside market, participation by non-subsidized individuals and small groups could be reduced. Options are available to the DC HIX to limit or standardize the benefit offerings; however, if this same restriction is not applied to the outside market, these restrictions may also hinder enrollment. Therefore, if the District does decide to standardize benefits, a balance must be struck to ensure a variety of deductible and coinsurance options are available at each metallic level.

While choice will be important, the District should also take care to ensure the DC HIX does not overwhelm individuals and small employers with so many options that the process of selecting a plan becomes overly complicated. The standardized benefit form that will be required for all products sold inside the DC HIX will assist individuals and small groups when comparing plans. Different plans offered by the same carrier should be meaningfully different.

Ensure Easy Access to Information
Individuals and small group carriers must be able to access carrier and benefit information with relative ease. The process should be no more cumbersome than obtaining this same information from the market outside of the DC HIX. Exchanges are required to contract with Navigators to assist with providing information to consumers, which could lead to greater enrollment in the DC HIX. One of the roles of the Navigator is to facilitate the distribution of information about plans in a culturally and linguistically appropriate manner. Given the District’s diverse population, the Navigator’s role will be particularly important. To the extent that the outside market does not meet these diverse needs at the same level, the DC HIX may have an advantage.
Some of the functions related to facilitation of information might include:

- Information related to price and quality should be easily accessible through the Navigator program in a single location.
- Provide small groups with a summary of each employee's benefit plan choice, coverage tier and premium to facilitate employee premium contribution calculations.
- Provide small employers with estimated small business tax credits.

Engage Brokers and Agents
Brokers and agents play a significant role in the current market. They advise individuals and small businesses of the most appropriate coverage for them and they help them shop among different carriers. While the Navigator will perform these functions, brokers and agents provide additional advisory services and many small businesses rely heavily on their brokers for this advice. The DC HIX must recognize the need to rely on brokers and agents to help them build their market and ensure affordable rates. To protect against a scenario where agents and brokers are not as active within the DC HIX as they are in the outside market, the DC HIX should ensure that navigators are able to assist agents with their functions. At the same time, rules must be in place to ensure agents are not incentivized to steer small groups comprised of unhealthy individuals into the DC HIX while steering healthy groups only to the outside market.

Consider Offering Value-added Services and Benefits inside the DC HIX
Many small businesses do not have human resource departments and the small business owner fills this role. This takes time that they could otherwise spend focusing on their business. If the DC HIX could provide business services, it might be especially appealing to a small group. Additional services the SHOP DC HIX could consider providing include:

- New employee education and enrollment facilitation
- COBRA administration
- Flexible spending account administration
- HSA administration
- Payroll services
- Human resource reference desk
- Business counseling

A successful SHOP DC HIX would not only draw small employers into the SHOP, but maintain them. While the initial "sale" is primarily targeted at the employer, employees play a role in retention. If the employees do not like the plan or service they receive from the DC HIX, they will likely complain to their employer. In addition to value-added services, the District may want to explore the option of providing value-added benefits. Many of these benefits are directed more toward the employees than the employer, and they may work to increase employee satisfaction with the DC HIX. Some examples of additional benefits that could be attractive to SHOP enrollees if they could be made available at little or not cost include:

- Discounts programs for employees (e.g., health club memberships, vision hardware)
- Discount programs for employers (e.g., printing and shipping services)

- Nurse advice lines
- Health appraisals and lifestyle coaching
- Employee assistance programs
- One stop shopping for ancillary insurance products (e.g., life, dental, vision, auto, homeowner's)
- Assistance helping employees understand explanation of benefits forms
- Negotiating with providers on employee's behalf to reduce OOP cost sharing

Benefit Plan Offerings Anticipated in the DC HIX

Actuarial values associated with a particular product option can change over time, especially for product options with fixed dollar cost sharing elements such as deductibles or service specific copayments. For example, as the general level of health care expense increases, a given deductible (or copayment) value represents a lower proportion of expected service cost, and thus it will produce a higher actuarial value. The presence of coinsurance can mitigate that leveraging effect, because it moves proportionately with health care expense levels until an OOP maximum is reached. Thus, between 2010 and 2014 when the coverage tiers become effective, a particular product option that is now modeled as Bronze may require cost sharing changes to remain at the Bronze level.

Starting with the underlying 2010 cost of coverage in the District, Mercer projected these costs forward to 2014. We then calibrated Oliver Wyman's Benefit Rating Model to this 2014 cost and developed benefit design and cost-sharing options that would meet each of the actuarial levels permissible under the ACA. A wide range of deductibles, coinsurance, copayments and OOP limit combinations are offered in the market today, leading to almost an endless number of possible benefit combinations. Even with the restricted actuarial values in the future, we anticipate variation in benefit design within each metallic level.

For simplicity and ease of comparison, we developed plans where all services are subject to an overall deductible, coinsurance and OOP maximum. In reality, plans offered will likely include copayment for various services as they do in many cases today. We restricted the deductible and OOP maximum to meet the requirements of the EHB package and limited the single deductible to no more than $2,000, as required in the ACA. The following table presents likely benefit offerings at each metallic level in 2014.

Coverage Level	Deductible	Coinsurance	OOP Max
Platinum	$200	90%	$1,000
	$50	100%	$1,000
Gold	$250	70%	$2,500
	$500	80%	$2,500
	$750	90%	$2,500

Coverage Level	Deductible	Coinsurance	OOP Max
Silver	$500	65%	$5,500
	$750	70%	$5,000
	$1,000	80%	$5,950
	$1,500	85%	$3,500
Bronze	$1,500	60%	$6,000
	$2,000	70%	$6,000
	$2,500*	80%	$5,000
	$3,000*	90%	$5,000

*Not available in the Small Group market

District Decisions Regarding DC HIX Insurance Market

The District has not yet formalized any decisions regarding DC HIX Insurance Market.

Mercer Recommendations and Next Steps

There are many considerations that must go into the decisions that need to be made related to the structure and rules of the District's new insurance marketplace, and the information and findings above are just one of many pieces. One would be remiss to make decisions based on this information alone. These results and findings should be brought together with the results from other efforts undertaken by the District such as public meetings and focus groups held with consumers, small businesses and insurers. I

Market Risk Pools

Given the fact that the District will be required to ultimately change its current definition of small group to 1-100, it may seem on the surface to appear easier to make the change along with the host of other changes that will occur in 2014. However, if carriers are allowed to continue rating groups size 51-100 using current methods until 2016, it may postpone the number of groups that decide to self insure or drop coverage. Much of the market disruption that will occur in 2014 will have worked through the system and postponing the small group expansion until 2016 will allow these groups time to understand the new system. Given the above, Mercer recommends that the District not expand its definition of small group until 2016.

Further, a delay in expanding the definition will give the District more time to implement programs such as value-added benefit and services which could work to draw more groups into the SHOP DC HIX; groups size 51-100 may see value in these benefits and services as well. By delaying the expansion of the definition, additional information should also be available related to the prevalence at which small groups decide to self insure. These new self insured products are currently emerging in the market and if the District finds that they become attractive to small groups, delaying the point in time at which the 51-100 groups are brought into the market would allow the District more time to study the expected impact that these products will have on the

fully insured risk pool, and allow time for making decisions and any changes to the rules for these products, such as requiring minimum specific and aggregate stop-loss attachment points to control for this potential adverse selection. For these reasons, we recommend the District not expand its definition of small group to 100 until 2014.

There are also many considerations that should go into the decisions of whether to merge the individual and small group markets beyond the modeled impact that these options would have on premium rates and DC HIX participation. The results of our modeling revealed that a market merger would have little impact on both rates and enrollment. Therefore, it is important that the District include other additional factors in its decision of whether to merge the market, and not base it on the results of this analysis alone.

Adverse Selection and Mitigation Techniques

As described above, there are several measures that the District could take to address the various sources of adverse selection that could occur against the DC HIX. While each of the options presented has the potential for mitigating adverse selection, they should be studied with care and considered alongside other design aspects of the DC HIX as they may have unexpected ramifications on the broader insurance market in the District.

We recommend the District study further these possible sources of selection. We recommend a study that examines the implications of requiring carriers to offer the same plans inside and outside the DC HIXs, implications of the standardization of plan benefit offerings, the incentive/disincentives available in the market for small employers to self insure, the implications of the penalties for non-enrollment, and whether those penalties can and/or should be strengthened.

Perform a Detailed Analysis of Mandated Benefit not Included in the EHB Package

We recommend that once the EHB package is announced, the District perform an updated and in depth study of the costs that the District would be anticipated to incur if they were to keep in place current mandates for benefits beyond those included in the EHB package. The District must understand the social, medical and financial effects of maintaining or eliminating mandated benefits. As a result, we recommend the District study the costs that they would incur in covering these mandated benefits and make decisions around whether or not to continue each mandate. The District should study how often those services are utilized, the cost of providing those services and how the covered service impacts the overall health of District residents. It is important that this analysis include the collection of meaningful and timely feedback from those District residents that would be directly affected by the elimination of any benefit not included in the EHB package. This feedback could be collected through various means such as town halls, group interviews, and web-based and other forms of open comment periods.

Cost Benefit Analysis of Value Added Services and Benefits in the SHOP DC HIX

A successful DC HIX is highly dependent upon the level of participation and the spread of risks that enroll. In order to gain this success, the District must be pro-active in attracting small employers to purchase coverage through the SHOP DC HIX. We recommend the District consider conducting a detailed analysis of various value added services and benefits that the DC HIX could offer that may be attractive to small employers. In particular, services that the DC HIX can offer at a lower cost, through purchasing power that would come with a larger pool of purchasers of those services, could lead to the DC HIX offering services at a lower cost than similar services could be offered in the outside market. This could lead to greater participation in the SHOP DC HIX by small employers. We recommend the District gather information on the cost of providing these services and compare those costs with the anticipated benefits that would come with greater enrollment. To perform a robust analysis, information should also be gathered by holding focus groups of small employers to understand those services and benefits that would be most attractive to them.

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Appendix D

Additional Resources

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ADVERSE SELECTION ISSUES AND HEALTH INSURANCE EXCHANGES UNDER THE AFFORDABLE CARE ACT

Background

Adverse selection is a phenomenon that is endemic to insurance of any kind, including health insurance. It occurs whenever insureds or applicants for insurance make decisions relative to the purchase of insurance based upon their own unique knowledge of their insurability or likelihood of making a claim on the insurance coverage in question.

Health insurance may be particularly susceptible to adverse selection. In the absence of underwriting or regulatory impediments, the public can and will make decisions on when, whether and what to purchase based upon knowledge of their own personal health. Adverse selection can take place between insurers, benefit plans and between markets. In an environment that allows adverse selection to occur unchecked, the insurance buying public will in large part delay the decision to purchase health insurance until, in their estimation, coverage is needed (while my house is on fire, I call to get a home owner's policy). Therefore, instead of a large number of individuals purchasing and paying for health insurance to cover the claims of those that incur health care costs, far fewer individuals are paying premiums to cover those same health insurance contingencies, thereby raising the unit cost of health insurance considerably. It is imperative to minimize adverse selection in order for health insurance to remain a financially viable product.

Today's Marketplace

Just as a consumer will act in their own financial self interest, insurers will as well, utilizing a variety of tools to lessen their susceptibility to high risk individuals. In the individual market today applicants can be underwritten to determine their insurability. In the event of an intentional misstatement of a material fact, that policy can be rescinded by the insurer. Insurers also apply preexisting condition waiting periods during which no coverage is provided for those preexisting conditions. Insurers also use waiting periods in policies during which there is coverage only for accidents and no coverage for costs incurred due to sicknesses. In the absence of regulation designed to create more balanced risk pools, these tools lessen the risk for insurers, and depending on the age and health status of the consumer, may lower or raise their premium rate accordingly. In employer group health insurance adverse selection is minimized because employees often sign up for coverage regardless of health status due to insurer participation requirements and employer contributions. Large employers in particular are able to get a more balanced risk profile because of this. Small employers, however, do not have the critical mass of enrollees to shelter them if an employee gets sick.

Adverse Selection Issues and Exchanges

As mentioned above, adverse selection can take place between insurers, benefit plans, and between markets. With the establishment of health insurance exchanges, adverse selection can take place in all these ways. The federal Patient Protection and Affordable Care Act (the "Affordable Care Act," or ACA) puts in place a number of mechanisms or tools to minimize the risk of adverse selection. These are outlined later in the paper. The following are examples of where adverse selection may have an undesirable effect in a marketplace that includes Exchanges if unchecked:

1. The existence of two markets, the Exchange and a traditional health insurance market outside the Exchanges, must be crafted carefully to avoid one from becoming the equivalent of a state high risk pool. This would likely happen if one market is able to offer stripped down plan designs while the other is required to offer more robust options. Ultimately, the more healthy population will select a lower priced plan option while the less healthy will choose the more comprehensive plan. The ACA includes some provisions to address the adverse selection issues between these markets, however the ACA also allows insurers to offer less comprehensive plans—provided they meet the essential health benefit package in the external market. To participate in the Exchange, however, an insurer must offer at least one silver plan and one gold plan, ensuring that those who choose to offer coverage in the Exchange must offer more comprehensive plans that they will be required to offer in the external market.

2. Exchange network adequacy requirements, if they vary from those outside the exchange could be a potential source of adverse selection. The federal Department of Health and Human Services (HHS) is required under the ACA to develop standards to ensure that there is a sufficient choice of providers and that essential community providers, such as community health centers, are included in an exchange plans' networks. The insurance buying public frequently makes purchasing decisions based upon the availability of their chosen medical providers within the insurer's network. A younger, healthier consumer may be less concerned about the availability of specific providers

than an older consumer with pre-existing conditions. Therefore if a more robust network exists for Exchange plans than for those offered outside of the Exchange, it is probable that consumers seeking specific health care services will choose to purchase coverage inside the Exchange.

3. If permitted, a differential in pricing between insurers' products inside and outside the Exchange could result in adverse selection. Although there is a requirement that plans offered in the Exchange must receive the same pricing if sold outside the Exchange, it is not clear if this is limited to benefits that are exactly the same or substantially similar.

4. As mentioned later in the paper, the ACA requires insurers to pool all non-grandfathered individual plans, regardless of where offered into one risk pool. The same requirement holds true for the small group market. This will greatly assist with minimizing adverse selection. The ACA, however, prohibits the states from including grandfathered plans in either of those risk pools. Although the number of participants in grandfathered plans may be minimal by 2014, the removal of these members from the risk pool may also result in adverse selection.

5. Differentials in insurance producer commissions or user/insurer fees inside and outside the Exchange can result in producers steering consumers into the market that best compensates their services.

6. SHOP Exchanges, either as a stand-alone Exchange or as part of a single state Exchange, may experience adverse selection based upon employers' decisions to retain grandfathered status, self-insure or purchase insurance through the Exchange. Employers with favorable risk demographics may have an incentive to self-insure while those with less desirable risks would tend to opt for fully insured plans either through the exchange or in the outside market. The likelihood of this type of adverse selection occurring increases as the size of an employer increases as self-insuring is much more prevalent in large group plans.

7. Exchanges may be designed to introduce individual choice for employees of small groups. Typically a small employer will choose one plan for its employees. The only choice for employees is whether or not to enroll. In the ACA, small employers choose a tier—bronze, silver, gold, or platinum and the employee may choose any plan within that tier. This can result in adverse selection between insurers and plans within the Exchange. If employers decide to move to a defined contribution arrangement within the Exchange, allowing the employee to make the additional choice of tier, the greater the possibility of adverse selection taking place between insurers and plans. These scenarios are recognized by the ACA and will be lessened through the risk spreading mechanism provided for in the ACA.

8. Benefit design can be used to attract or deter enrollment by consumers. While the ACA addresses the adverse selection risks of benefit design in a number of ways, such as requiring the inclusion of the essential health benefits in all plans; and the requirement that plans meet actuarial values based on tier, opportunities will still exist for insurers to attract healthier consumers while deterring sicker ones. A number of studies document that through benefit design, even with similar safeguards as those in the ACA, certain Medicare Advantage plans were able to draw healthier enrollees into their plans, while discouraging those with greater health problems from enrolling.

Key ACA Provisions Addressing Adverse Selection

Several sections of the Affordable Care Act ("ACA") address the issues of adverse selection. Such provisions and potential effects are summarized below.

- **Requirement to maintain minimum essential coverage, §5000A.** Designed to bring a more balanced risk profile to the entire marketplace, the purchase mandate is perhaps one of the most important checks on adverse selection in the ACA. Although challenged legally by many states regarding its constitutionality, the individual responsibility requirement is considered by health policy experts across the spectrum as a strong tool to minimize adverse selection. In order for this tool to work, individuals must decide that purchasing coverage is a better value for them as opposed to remaining uninsured and paying a penalty. Many have criticized the penalties as being too low to fully realize the intent of the individual mandate.

- **Financial assistance with purchasing coverage. §1401.** Individual premium tax credits and small business tax credits will be available only for coverage purchased through the Exchange. This may invite a broader pool of participants and small businesses into the exchange. While the individual premium tax credits are permanent, the small business tax credits are not and are offered until 2016.

- **Same plan, same premium. §1301(a)(1)(C)(iii).** The premium rate for qualified health plans must be the same without regard to whether it is sold through the Exchange or whether the plan is offered directly from the insurer or through an agent.

- **The same rating rules apply, regardless of market. §1252.** Non-grandfathered plans inside and outside the Exchanges must use the same rating factors, which are limited to age (3:1 ratio), geography, family size and tobacco use.

- **Organizing coverage levels by tier, §1302(d); and requiring all non-grandfathered small group and individual plans to include the "essential health benefit package." §1302**. As mentioned earlier, by requiring all plans in the same metallic tier to offer benefits with the same actuarial value; and by requiring all plans to include the essential health benefits, the ACA will not only assist consumers with purchasing decisions, it will also help to minimize adverse selection. Concerns remain however that this safeguard does not sufficiently deal with adverse selection. An insurer would still be able to, within the same actuarial value, use cost sharing levels and the addition or limitation of certain benefits to differentiate their plans in order to entice or deter certain consumers from enrolling in their plan. State policy makers should also be cognizant that large groups and self-insured plans need to meet the minimum essential coverage requirements as opposed to the essential health benefits standard required of individual and small group plans. This could result in older or sicker employees finding their employer-sponsored coverage no longer adequate and choosing to purchase coverage in the individual market where a richer level of coverage, and, perhaps subsidies may be available. The large group, whether fully or self-insured becomes a healthier pool, and the individual market becomes a sicker one. The ACA does anticipate the potential for "employer dumping" of risk and assesses a penalty on large employers whose employee(s) seek subsidized coverage through the Exchange. If the employee seeks coverage without the help of a subsidy, either inside or outside the Exchange, there is no employer penalty.

- **The creation of single risk pools. §1312(c).** The ACA mandates single risk pools. This means that a health insurance issuer must combine the experience of all of its individual plans into one risk pool; and do the same for all of its small group plans, regardless of whether they are offered on the Exchange. Grandfathered plans are expressly prohibited from inclusion in either risk pool, §1312(c)(4).

- **Marketing requirements. §1311(c)(1)(A).** The ACA requires qualified health plans to meet certain marketing requirements. They are not allowed to use marketing practices or activities that may encourage healthier consumers to enroll and discourage those with health conditions from enrolling.

- **Exchange market participation requirements. §1301(a)(1)(C)(ii).** Health insurance issuers must offer at least one silver and one gold level plan in order to participate in the Exchange. This provision is designed to minimize adverse selection by insurers who might otherwise offer only bronze or catastrophic coverage in the Exchange in an effort to enroll primarily young and healthy consumers. It should be noted, however that there is no similar requirement for insurers in the external market. This could lead to significant adverse selection happening between the markets, as insurers would be allowed to offer higher deductible plans outside the Exchange and not be required to participate inside the Exchange at all. Potential state policy solutions are addressed later in the paper.

- **Expanding the definition of small group. §1304(b).** In 2016, the definition of small employer will be expanded to include firms with 100 employees or less, thereby expanding the risk pool for states that had previously defined small employer as a group of 50 employees or less. However, a larger pool does not necessarily mean a more stable pool. This provision may offer other problems with adverse selection, such as more newly defined small employers deciding to self-insure based on their perceived risk pool.

- **Level playing field §1324.** Health insurance plans cannot be made subject to many state or federal laws unless Consumer Operated and Oriented Plans (Co-op plans) and Multi-State plans are required to meet them. These include guaranteed renewal, preexisting conditions, non-discrimination, quality improvement and reporting, solvency and financial requirements, market conduct, appeals and grievances, licensure, and benefit plan material or information. Multi-State plans may have different medical loss ratios, profit margins or premiums based upon the standards that are set by the Director of the Office of Personnel Management (OPM). §1334(c)(5). If, however, a state has an age rating requirement lower than 3:1 that state may require a Multi-State plan offered through the Exchange to meet the state's standard. §1334(a)(4).

- **Risk spreading mechanisms,** such as interim reinsurance, temporary risk corridors, and risk adjustment. These three mechanisms are designed to make the new marketplace more predictable, stable and less risky for insurers, encouraging them to participate with business models that compete based on quality, service and price and not on risk selection.
    - **Interim reinsurance program. §1341.** All health insurance issuers and group health plans (through their third party administrators) will be required to participate in an interim reinsurance program for the individual market to address high risk individuals. This provision may allow implementation of a gradual phasing out of state high risk pools instead of an immediate transition of all high risk pool members into the Exchange. However, there may be a potential conflict with the federal high risk pools pursuant to § 1101(g)(3).
    - **Temporary risk corridors. §1342.** All qualified health plans in the individual and small group markets will be required to participate in a risk corridor mechanism. This may increase plan participation in the Exchange by reducing risk to insurers.
    - **Risk adjustment mechanisms. §1343.** All health plans and health insurance issuers in the individual and small group markets, whether offering plans through the Exchange or not, will be required to participate in a state's risk adjustment mechanisms. The goal is to share risk among insurers offering coverage within the exchange. Large group, self-insured and grandfathered plans are not required to participate. Insurers may be inclined to avoid the individual and small group markets in order escape assessments.

While there are a number of identifiable shortcomings or gaps, the ACA lays out a number of provisions designed to minimize adverse selection and its impact on consumers and insurers. However, many of these important protections are only effective if state regulators play a prominent role in monitoring and enforcing them.

State Options to Minimize Adverse Selection Effects

The ACA allows state flexibility to consider additional policies beyond those described above. States should consider the goals of their Exchange when weighing their policy options. Whether a state views its Exchange as a clearinghouse, organized marketplace or active purchaser, will shape the state's decisions concerning implementing adverse selection policies.

Many of the options listed below could also be phased in; either in advance of 2014 or some number of years after the Exchange is up and running in order to mitigate any market disruption or rate impact.

Market Participation Rules

The most important thing that states can do is to help facilitate a level playing field between participants inside and outside of the Exchange. The ACA does not require insurers to participate in the Exchange; and plans offered by insurers outside the Exchange do not have to meet all of the same Exchange plan standards. States may choose otherwise.

Allowing some variance between the marketplaces allows insurers to design and innovate plans in order to meet consumer needs. However, the more choices a market provides, the greater the opportunity for adverse selection, either directly or indirectly. If allowed, both consumers and insurers will follow their own economic interests: consumers will purchase based on the benefits they need or perceive they will need; and insurers will market to those they perceive to have a lower risk.

States may consider a number of policy options to address these challenges. For example, insurers could be required to operate in both markets and/or compelled to offer products at certain levels in order to operate in a particular market. States may require plans sold outside the exchange to meet the same standards as those offered inside the exchange.

Consumer Choice

Determining a manageable level of coverage options that provide consumers with a robust yet easy to understand shopping experience should be the goal of policymakers. Too few options is undesirable, and too many can lead to choice that is counterproductive and confusing for consumers in addition to opening the door to adverse selection. State policymakers will need to decide the level of appropriate standardization both inside and outside of the Exchange. For example, state policymakers could decide to create a minimum level of benefits that is standard across all plans and coverage levels similar to standardized Medicare supplemental coverage plans. It is incumbent upon states to analyze their current insurance market, their citizens who are currently uninsured and the overall goals of the Exchange in order to tailor their policies to serve their populous.

State Mandated Benefits

Many states currently require that plans include particular benefits. The ACA allows states to continue doing so. Under the ACA, if a state decides to require certain benefits that are above and beyond the essential health benefits, then the state may require qualified health plans operating in the Exchange to include some or all of those benefits. In doing so, however, the ACA requires states to pay the additional cost of those benefits. In order to create a level playing field between the markets, state policymakers should consider making the requirements around mandated benefits, whether to include them or not, the same inside and outside of the Exchange.

Qualified Health Plan Designation

The ACA identifies minimum requirements that all plans will need to meet beginning in 2014 regardless of whether they are sold inside the Exchange or in the external market. In order to be sold through the Exchange, a plan must be certified as a qualified health plan and must also meet any additional federal or state requirements, which could make these plans more expensive than plans offered outside of the Exchange and drive enrollment away from the Exchange. Additional requirements may also hinder competition and/or inhibit new insurers from entering a state's Exchange or health insurance marketplace. State policymakers should consider this dynamic when further defining a qualified health plan and determining what plans must do to sell their products, both inside and outside of the Exchange.

Participation Requirement Consistency

As expressed earlier on in the paper, one advantage large employers have is the ability to create a more balanced risk pool. This happens in part due to insurer participation requirements—the insurer will offer the product(s) only if a certain percentage of employees enroll. Currently, insurers typically require between 50% and 75% of all employees be enrolled for coverage. If there are different participation requirements between insurers inside or outside the Exchange, those employers with low participation (usually the less healthy) will certainly move to the market with the lower participation requirement.

Producer Commissions/Navigators

The compensation structure for both producers and navigators inside and outside of the Exchange could have a significant effect on the market. States should consider the effect of different commission structures inside and outside the Exchange and how that could impact the market. The effects may vary between the individual and small group markets. States may choose to minimize these effects by regulating how compensation is structured both in and out of the Exchanges, including consideration of whether or not navigators should be salaried employees of the Exchange.

Exchange administrative fees

State Exchanges must be financially self sufficient beginning in 2015. States have flexibility in determining what mechanisms they want to use. If the addition of administrative fees increases the cost of coverage and exists only on Exchange offered plans, consumers may be more inclined to purchase in the outside market. To ensure the financial sustainability of the Exchange, states will need to enroll enough participants to make the operations of the Exchange worthwhile. The basic principle of a level playing field applies here as well—if a state decides to charge an administrative fee to cover the costs of the Exchange, it should also consider charging the same fee on products sold outside the Exchange. This would ensure that neither market would have an advantage over the other and broaden the assessed population making the fees lower overall.

Structured Enrollment Periods

Significant adverse selection will take place in a guaranteed issue market that prohibits discrimination based on health status by individuals purchasing when they need coverage and dropping it when they do not. The individual responsibility mandate will address some of this concern. States, however, may want to consider additional policies. Outside of special enrollment periods, as required in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), states could allow individuals to purchase coverage, both inside and outside of the Exchange only during a specific time period each year. In considering this option, states will need to weigh the impact it would have on the market and consumer access to coverage. States could also institute a penalty for late enrollment or limit the number of times a person can change coverage to once a year to limit the adverse selection due to a consumer "buying up" once faced with a health problem. When considering these policy options, state policymakers should recognize that if an individual can only purchase or change coverage during a

limited period of time each year, an aggressive outreach and education should be in place so that consumers are informed about their choices and the consequences of their decisions.

Conclusion

The success of an Exchange is directly linked with its ability to attract a sufficient cross section of risk to balance high and low cost consumers. If the market outside of the Exchange is perceived as more attractive to younger and healthier people, the Exchange could become a "risk magnet" and will ultimately fail due to adverse selection. Adverse selection can take place between insurers, plans and between markets. Just addressing potential adverse selection between the Exchange and the outside market is not sufficient to foster a healthy marketplace. States need to recognize and address the potential for adverse selection between insurers and plans as well.

There are numerous options states may use to facilitate a level playing field between the markets inside and outside of the Exchange. Many of these options may be phased in; either in advance of 2014 or some number of years after the Exchange is operational in order to mitigate any market disruption or significant rate impact. The stated goals and intentions of each state's Exchange should determine the manner and degree of involvement state policymakers engage in when establishing market rules aimed at minimizing adverse selection. Because market response may vary across the states, as well as each state's goals for the Exchange, flexibility and continual review may be the best tools for a state to facilitate and sustain the success of its Exchange.

Draft: 11/22/10
A new model
As adopted by the Health Insurance and Managed Care (B) Committee, Nov. 22, 2010

AMERICAN HEALTH BENEFIT EXCHANGE MODEL ACT

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Section 1. Title

This Act shall be known and may be cited as the American Health Benefit Exchange Act.

Section 2. Purpose and Intent

The purpose of this Act is to provide for the establishment of an American Health Benefit Exchange to facilitate the purchase and sale of qualified health plans in the individual market in this State and to provide for the establishment of a Small Business Health Options Program (SHOP Exchange) to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans offered in the small group market. The intent of the Exchange is to reduce the number of uninsured, provide a transparent marketplace and consumer education and assist individuals with access to programs, premium assistance tax credits and cost-sharing reductions.

Drafting Note: States expanding the definition of "qualified employer" to include large employers, as permitted beginning in 2017 under the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152) (Federal Act), should remove the references to "small" employers and the "small" group market.

Section 3. Definitions

For purposes of this Act:

A. "Commissioner" means the Commissioner of Insurance.

Drafting Note: Use the title of the chief insurance regulatory official wherever the term "commissioner" appears. If the jurisdiction of certain health carriers, such as health maintenance organizations, lies with some state agency other than the insurance department, or if there is dual regulation, a state should add language referencing that agency to ensure the appropriate coordination of responsibilities.

B. "Educated health care consumer" means an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical and scientific matters.

C. "Exchange" means the [insert name of State Exchange] established pursuant to section 4 of this Act.

D. "Federal Act" means the federal Patient Protection and Affordable Care Act (Public Law 111-148), as amended by the federal Health Care and Education Reconciliation Act of 2010 (Public Law 111-152), and any amendments thereto, or regulations or guidance issued under, those Acts.

E. (1) "Health benefit plan" means a policy, contract, certificate or agreement offered or issued by a health carrier to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

Drafting Note: The Federal Act uses the terms "health plan" and "health insurance coverage." "Health benefit plan," as defined above, is intended to be consistent with the definition of "health insurance coverage" contained in Title XXVII of the Public Health Service Act, as enacted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and amended by the Federal Act.

(2) "Health benefit plan" does not include:

(a) Coverage only for accident, or disability income insurance, or any combination thereof;

(b) Coverage issued as a supplement to liability insurance;

(c) Liability insurance, including general liability insurance and automobile liability insurance;

(d) Workers' compensation or similar insurance;

(e) Automobile medical payment insurance;

(f) Credit-only insurance;

(g) Coverage for on-site medical clinics; or

(h) Other similar insurance coverage, specified in federal regulations issued pursuant to Pub. L. No. 104-191, under which benefits for health care services are secondary or incidental to other insurance benefits.

(3) "Health benefit plan" does not include the following benefits if they are provided under a separate policy, certificate or contract of insurance or are otherwise not an integral part of the plan:

(a) Limited scope dental or vision benefits;

(b) Benefits for long-term care, nursing home care, home health care, community-based care, or any combination thereof; or

(c) Other similar, limited benefits specified in federal regulations issued pursuant to Pub. L. No. 104-191.

(4) "Health benefit plan" does not include the following benefits if the benefits are provided under a separate policy, certificate or contract of insurance, there is no coordination between the provision of the benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor, and the benefits are paid with respect to an event without regard to whether benefits are provided with respect to such an event under any group health plan maintained by the same plan sponsor:

(a) Coverage only for a specified disease or illness; or

(b) Hospital indemnity or other fixed indemnity insurance.

(5) "Health benefit plan" does not include the following if offered as a separate policy, certificate or contract of insurance:

(a) Medicare supplemental health insurance as defined under section 1882(g)(1) of the Social Security Act;

(b) Coverage supplemental to the coverage provided under chapter 55 of title 10, United States Code (Civilian Health and Medical Program of the Uniformed Services (CHAMPUS)); or

(c) Similar supplemental coverage provided to coverage under a group health plan.

F. "Health carrier" or "carrier" means an entity subject to the insurance laws and regulations of this state, or subject to the jurisdiction of the commissioner, that contracts or offers to contract to provide, deliver, arrange for, pay for, or reimburse any of the costs of health care services, including a sickness and accident insurance company, a health maintenance organization, a nonprofit hospital and health service corporation, or any other entity providing a plan of health insurance, health benefits or health services.

G. "Qualified dental plan" means a limited scope dental plan that has been certified in accordance with section 7E of this Act.

H. "Qualified employer" means a small employer that elects to make its full-time employees eligible for one or more qualified health plans offered through the SHOP Exchange, and at the option of the employer, some or all of its part-time employees, provided that the employer:

(1) Has its principal place of business in this State and elects to provide coverage through the SHOP Exchange to all of its eligible employees, wherever employed; or

(2) Elects to provide coverage through the SHOP Exchange to all of its eligible employees who are principally employed in this State.

Drafting Note: Beginning in 2017, the Federal Act permits States to expand eligibility for Exchange participation beyond small employers. States that do so should amend subsection H accordingly.

I. "Qualified health plan" means a health benefit plan that has in effect a certification that the plan meets the criteria for certification described in section 1311(c) of the Federal Act and section 7 of this Act.

J. "Qualified individual" means an individual, including a minor, who:

(1) Is seeking to enroll in a qualified health plan offered to individuals through the Exchange;

(2) Resides in this State;

(3) At the time of enrollment, is not incarcerated, other than incarceration pending the disposition of charges; and

(4) Is, and is reasonably expected to be, for the entire period for which enrollment is sought, a citizen or national of the United States or an alien lawfully present in the United States.

K. "Secretary" means the Secretary of the federal Department of Health and Human Services.

L. "SHOP Exchange" means the Small Business Health Options Program established under section 6 of this Act.

M. (1) "Small employer" means an employer that employed an average of not more than 100 employees during the preceding calendar year.

Drafting Note: The Federal Act permits States to define "small employers" as employers with one to 50 employees for plan years beginning before Jan. 1, 2016.

(2) For purposes of this subsection:

(a) All persons treated as a single employer under subsection (b), (c), (m) or (o) of section 414 of the Internal Revenue Code of 1986 shall be treated as a single employer;

(b) An employer and any predecessor employer shall be treated as a single employer;

(c) All employees shall be counted, including part-time employees and employees who are not eligible for coverage through the employer;

Drafting Note: This issue is discussed in HHS Bulletin 99-03 (Group Size Issues Under Title XXVII of the Public Health Service Act). States with different legal standards for counting employer size should review their definitions for consistency with federal law and substitute their existing definitions when appropriate. States should also consider the adverse selection issues that arise if different definitions of "small employer" are used within the Exchange and outside the Exchange.

(d) If an employer was not in existence throughout the preceding calendar year, the determination of whether that employer is a small employer shall be based on the average number of employees that is reasonably expected that employer will employ on business days in the current calendar year; and

(e) An employer that makes enrollment in qualified health plans available to its employees through the SHOP Exchange, and would cease to be a small employer by reason of an increase in the number of its employees, shall continue to be treated as a small employer for purposes of this Act as long as it continuously makes enrollment through the SHOP Exchange available to its employees.

Section 4. Establishment of Exchange

A. The [insert official title of the Exchange] is hereby established as a [insert description and governance provisions here, either establishing the Exchange as a governmental agency or establishing the Exchange as a nonprofit entity].

Drafting Note: States have different options to consider when establishing the Exchange. This Act does not include any specific option for governance. Section 1311(d) of the Federal Act, requires that any Exchange established must be a governmental agency or nonprofit entity. As such, the Exchange could be located at a new or existing State agency. Some possible advantages to having the Exchange within a State agency include having a direct link to the State administration and a more direct ability to coordinate with other key State agencies, such as the State Medicaid agency and the State insurance department. Some possible disadvantages include the risk of the Exchange's decision-making and operations being politicized and the possible difficulty for the Exchange to be nimble in hiring and contracting practices, given most States' personnel and procurement rules. The Exchange could also be established as an independent public agency, or a quasi-governmental agency, with an appointed board or commission responsible for decision-making and day-to-day operations. Some possible advantages to establishing the Exchange as an independent public agency, or a quasi-governmental agency, include possible exemption from State personnel and procurement laws and more independence from existing State agencies, which could result in less of a possibility of the Exchange being politicized. The Exchange's enabling legislation would specify how the Board members would be appointed, including its size, composition and terms. The Board would also select the Exchange's Executive Director. Some possible disadvantages include the possible difficulty for the Exchange to coordinate health care purchasing strategies and initiatives with key State agencies, such as the State Medicaid agency and the State insurance department and their employees because the Exchange would not be located at a State agency (unless those decisions are subject to the approval of a State official, such as the State insurance commissioner or the Governor). The Exchange also could be established by creating a non-profit entity. This means that most likely it would not be directly accountable to State government or subject to State government oversight nor would it most likely be subject to State personnel and procurement laws. Some possible advantages of establishing the Exchange as a non-profit include flexibility in decision making and less of a chance for those decisions being politicized and some possible disadvantages include isolation from State policymakers and key State agency staff and the potential for decreased public accountability. In addition, States can establish an Exchange using a combination of the options described above. The NAIC, through the Exchanges (B) Subgroup, intends to review the options for governance above and others related to establishing Exchanges and develop an issues paper on the topic to assist States in this area.

Drafting Note: States should be aware that when establishing the Exchange they will have to include additional sections in this Act relating to governance and operations, including sections that set out:

- The appointment process, powers, duties and other responsibilities of any board, committee or other entity that will have day-to-day responsibility for carrying out the duties and responsibilities of the Exchange, as provided in this Act;
- Authority and procedures for hiring staff and procurement resources; and
- Responsibilities of State agencies coordinating activities with the Exchange.

Drafting Note: States should be aware that section 1311(f) of the Federal Act permits States, with the approval of the Secretary of the federal Department of Health and Human Services, to establish regional or interstate Exchanges. This Act does not specify how to establish these Exchanges or how they would operate. The NAIC, through the Exchanges (B) Subgroup, intends to review those issues and others related to establishing regional or interstate exchanges and develop an issues paper on the topic to assist those states that wish to establish such exchanges. States participating in interstate Exchanges or establishing regional Exchanges should modify the relevant portions of this Act accordingly.

Drafting Note: Depending on how a State establishes its Exchange, a State may need to consider whether the Exchange should be exempt from the State's insurance producer or consultant licensing requirements or whether the Exchange or its employees need to obtain such a license.

B. The Exchange shall:

(1) Facilitate the purchase and sale of qualified health plans;

(2) Provide for the establishment of a SHOP Exchange to assist qualified small employers in this State in facilitating the enrollment of their employees in qualified health plans; and

(3) Meet the requirements of this Act and any regulations implemented under this Act.

C. The Exchange may contract with an eligible entity for any of its functions described in this Act. An eligible entity includes, but is not limited to, the [insert name of State Medicaid agency] or an entity that has experience in individual and small group health insurance, benefit administration or other experience relevant to the responsibilities to be assumed by the entity, but a health carrier or an affiliate of a health carrier is not an eligible entity.

Drafting Note: States should be aware that the Federal Act does not refer to "affiliate" as referenced in subsection C above. Section 1311(f)(3)(B) of the Federal Act, as related to a health insurance issuer, defines "eligible entity" as a person: 1) incorporated under, and subject to the laws of, one or more States; 2) has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and 3) that is not a health insurance issuer or that is treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer.

D. The Exchange may enter into information-sharing agreements with federal and State agencies and other State Exchanges to carry out its responsibilities under this Act provided such agreements include adequate protections with respect to the confidentiality of the information to be shared and comply with all State and federal laws and regulations.

Section 5. General Requirements

A. The Exchange shall make qualified health plans available to qualified individuals and qualified employers beginning with effective dates on or before January 1, 2014.

B. (1) The Exchange shall not make available any health benefit plan that is not a qualified health plan.

(2) The Exchange shall allow a health carrier to offer a plan that provides limited scope dental benefits meeting the requirements of section 9832(c)(2)(A) of the Internal Revenue Code of 1986 through the Exchange, either separately or in conjunction with a qualified health plan, if the plan provides pediatric dental benefits meeting the requirements of section 1302(b)(1)(J) of the Federal Act.

C. Neither the Exchange nor a carrier offering health benefit plans through the Exchange may charge an individual a fee or penalty for termination of coverage if the individual enrolls in another type of minimum essential coverage because the individual has become newly eligible for that coverage or because the individual's employer-sponsored coverage has become affordable under the standards of section 36B(c)(2)(C) of the Internal Revenue Code of 1986.

Section 6. Duties of Exchange

Drafting Note: The provisions in this section are the minimum requirements of the Federal Act. States are encouraged to consider assigning additional duties, consistent with the Federal Act, to the extent appropriate to the State's market conditions and policy goals. The NAIC, through the Exchanges (B) Subgroup, intends to develop an issues paper on the topic to assist States in evaluating options in this area.

The Exchange shall:

A. Implement procedures for the certification, recertification and decertification, consistent with guidelines developed by the Secretary under section 1311(c) of the Federal Act and section 7 of this Act, of health benefit plans as qualified health plans;

B. Provide for the operation of a toll-free telephone hotline to respond to requests for assistance;

C. Provide for enrollment periods, as provided under section 1311(c)(6) of the Federal Act;

D. Maintain an Internet website through which enrollees and prospective enrollees of qualified health plans may obtain standardized comparative information on such plans;

E. Assign a rating to each qualified health plan offered through the Exchange in accordance with the criteria developed by the Secretary under section 1311(c)(3) of the Federal Act, and determine each qualified health plan's level of coverage in accordance with regulations issued by the Secretary under section 1302(d)(2)(A) of the Federal Act;

F. Use a standardized format for presenting health benefit options in the Exchange, including the use of the uniform outline of coverage established under section 2715 of the PHSA;

G. In accordance with section 1413 of the Federal Act, inform individuals of eligibility requirements for the Medicaid program under title XIX of the Social Security Act, the Children's Health Insurance Program (CHIP) under title XXI of the Social Security Act or any applicable State or local public program and if through screening of the application by the Exchange, the Exchange determines that any individual is eligible for any such program, enroll that individual in that program;

H. Establish and make available by electronic means a calculator to determine the actual cost of coverage after application of any premium tax credit under section 36B of the Internal Revenue Code of 1986 and any cost-sharing reduction under section 1402 of the Federal Act;

I. Establish a SHOP Exchange through which qualified employers may access coverage for their employees, which shall enable any qualified employer to specify a level of coverage so that any of its employees may enroll in any qualified health plan offered through the SHOP Exchange at the specified level of coverage;

Drafting Note: States may elect to operate a unified Exchange by merging the SHOP Exchange and the Exchange for individual coverage, but only if the Exchange has adequate resources to assist these individuals and employers. States that do so will need to reconcile the eligibility rules for participation, which are currently based on residence for individual coverage and based on employment for coverage through the SHOP Exchange.

J. Subject to section 1411 of the Federal Act, grant a certification attesting that, for purposes of the individual responsibility penalty under section 5000A of the Internal Revenue Code of 1986, an individual is exempt from the individual responsibility requirement or from the penalty imposed by that section because:

(1) There is no affordable qualified health plan available through the Exchange, or the individual's employer, covering the individual; or

(2) The individual meets the requirements for any other such exemption from the individual responsibility requirement or penalty;

K. Transfer to the federal Secretary of the Treasury the following:

(1) A list of the individuals who are issued a certification under subsection J, including the name and taxpayer identification number of each individual;

(2) The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the premium tax credit under section 36B of the Internal Revenue Code of 1986 because:

(a) The employer did not provide minimum essential coverage; or

(b) The employer provided the minimum essential coverage, but it was determined under section 36B(c)(2)(C) of the Internal Revenue Code to either be unaffordable to the employee or not provide the required minimum actuarial value; and

(3) The name and taxpayer identification number of:

(a) Each individual who notifies the Exchange under section 1411(b)(4) of the Federal Act that he or she has changed employers; and

(b) Each individual who ceases coverage under a qualified health plan during a plan year and the effective date of that cessation;

L. Provide to each employer the name of each employee of the employer described in subsection K(2) who ceases coverage under a qualified health plan during a plan year and the effective date of the cessation;

M. Perform duties required of the Exchange by the Secretary or the Secretary of the Treasury related to determining eligibility for premium tax credits, reduced cost-sharing or individual responsibility requirement exemptions;

N. Select entities qualified to serve as Navigators in accordance with section 1311(i) of the Federal Act, and standards developed by the Secretary, and award grants to enable Navigators to:

(1) Conduct public education activities to raise awareness of the availability of qualified health plans;

(2) Distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits under section 36B of the Internal Revenue Code of 1986 and cost-sharing reductions under section 1402 of the Federal Act;

(3) Facilitate enrollment in qualified health plans;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act (PHSA), or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint or question regarding their health benefit plan, coverage or a determination under that plan or coverage; and

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange;

O. Review the rate of premium growth within the Exchange and outside the Exchange, and consider the information in developing recommendations on whether to continue limiting qualified employer status to small employers;

P. Credit the amount of any free choice voucher to the monthly premium of the plan in which a qualified employee is enrolled, in accordance with section 10108 of the Federal Act, and collect the amount credited from the offering employer;

Q. Consult with stakeholders relevant to carrying out the activities required under this Act, including, but not limited to:

(1) Educated health care consumers who are enrollees in qualified health plans;

(2) Individuals and entities with experience in facilitating enrollment in qualified health plans;

(3) Representatives of small businesses and self-employed individuals;

(4) The [insert name of State Medicaid office]; and

(5) Advocates for enrolling hard to reach populations; and

R. Meet the following financial integrity requirements:

(1) Keep an accurate accounting of all activities, receipts and expenditures and annually submit to the Secretary, the Governor, the commissioner and the Legislature a report concerning such accountings;

(2) Fully cooperate with any investigation conducted by the Secretary pursuant to the Secretary's authority under the Federal Act and allow the Secretary, in coordination with the Inspector General of the U.S. Department of Health and Human Services, to:

(a) Investigate the affairs of the Exchange;

(b) Examine the properties and records of the Exchange; and

(c) Require periodic reports in relation to the activities undertaken by the Exchange; and

(3) In carrying out its activities under this Act, 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.

Drafting Note: States should consider revising the language above to ensure that the commissioner, consistent with the provisions of the State insurance code and regulations, is given specific authority to investigate the affairs of the Exchange, examine the properties and records of the Exchange and require the Exchange to provide periodic reporting to the commissioner in relation to the activities undertaken by the Exchange under this Act, as may be appropriate given the structure and governance of the Exchange.

Section 7. Health Benefit Plan Certification

A. The Exchange may certify a health benefit plan as a qualified health plan if:

(1) The plan provides the essential health benefits package described in section 1302(a) of the Federal Act, except that the plan is not required to provide essential benefits that duplicate the minimum benefits of qualified dental plans, as provided in subsection E, if:

(a) The Exchange has determined that at least one qualified dental plan is available to supplement the plan's coverage; and

(b) The carrier makes prominent disclosure at the time it offers the plan, in a form approved by the Exchange, that the plan does not provide the full range of essential pediatric benefits, and that qualified dental plans providing those benefits and other dental benefits not covered by the plan are offered through the Exchange;

(2) The premium rates and contract language have been approved by the commissioner;

Drafting Note: States should modify the language in paragraph (2) above for consistency with their State law and regulations governing rate and form review and approval.

(3) The plan provides at least a bronze level of coverage, as determined pursuant to section 6E of this Act unless the plan is certified as a qualified catastrophic plan, meets the requirements of the

Federal Act for catastrophic plans, and will only be offered to individuals eligible for catastrophic coverage;

(4) The plan's cost-sharing requirements do not exceed the limits established under section 1302(c)(1) of the Federal Act, and if the plan is offered through the SHOP Exchange, the plan's deductible does not exceed the limits established under section 1302(c)(2) of the Federal Act;

(5) The health carrier offering the plan:

(a) Is licensed and in good standing to offer health insurance coverage in this State;

(b) Offers at least one qualified health plan in the silver level and at least one plan in the gold level through each component of the Exchange in which the carrier participates, where "component" refers to the SHOP Exchange and the Exchange for individual coverage;

(c) Charges the same premium rate for each qualified health plan without regard to whether the plan is offered through the Exchange and without regard to whether the plan is offered directly from the carrier or through an insurance producer;

Drafting Note: States whose licensing laws do not use the term "producer" should substitute the appropriate terminology.

(d) Does not charge any cancellation fees or penalties in violation of section 5C of this Act; and

(e) Complies with the regulations developed by the Secretary under section 1311(d) of the Federal Act and such other requirements as the Exchange may establish;

(6) The plan meets the requirements of certification as promulgated by regulation pursuant to section 9 of this Act and by the Secretary under section 1311(c) of the Federal Act, which include, but are not limited to, minimum standards in the areas of marketing practices, network adequacy, essential community providers in underserved areas, accreditation, quality improvement, uniform enrollment forms and descriptions of coverage and information on quality measures for health benefit plan performance; and

Drafting Note: As states consider certification standards, they should consider factors such as consumer choice and additional costs, in light of the value to enrollees provided by the proposed standards, when evaluating whether or not to include requirements above the minimum standards under section 1311(c)(1).

(7) The Exchange determines that making the plan available through the Exchange is in the interest of qualified individuals and qualified employers in this State.

Drafting Note: States should consider whether the Exchange should delegate all or part of plan certification function to the commissioner pursuant to the commissioner's rate and form review responsibilities.

B. The Exchange shall not exclude a health benefit plan:

(1) On the basis that the plan is a fee-for-service plan;

(2) Through the imposition of premium price controls by the Exchange; or

(3) On the basis that the health benefit plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

C. The Exchange shall require each health carrier seeking certification of a plan as a qualified health plan to:

(1) Submit a justification for any premium increase before implementation of that increase. The carrier shall prominently post the information on its Internet website. The Exchange shall take this information, along with the information and the recommendations provided to the Exchange by

the commissioner under section 2794(b) of the PHSA, into consideration when determining whether to allow the carrier to make plans available through the Exchange;

Drafting Note: States with additional rate filing requirements should review the language in paragraph (1) above to ensure that it does not conflict with other applicable State law.

(2) (a) Make available to the public, in the format described in subparagraph (b) of this paragraph, and submit to the Exchange, the Secretary, and the commissioner, accurate and timely disclosure of the following:

(i) Claims payment policies and practices;

(ii) Periodic financial disclosures;

(iii) Data on enrollment;

(iv) Data on disenrollment;

(v) Data on the number of claims that are denied;

(vi) Data on rating practices;

(vii) Information on cost-sharing and payments with respect to any out-of-network coverage;

(viii) Information on enrollee and participant rights under title I of the Federal Act; and

(ix) Other information as determined appropriate by the Secretary; and

(b) The information required in subparagraph (a) of this paragraph shall be provided in plain language, as that term is defined in section 1311(e)(3)(B) of the Federal Act; and

(3) Permit individuals to learn, in a timely manner upon the request of the individual, the amount of cost-sharing, including deductibles, copayments, and coinsurance, under the individual's plan or coverage that the individual would be responsible for paying with respect to the furnishing of a specific item or service by a participating provider. At a minimum, this information shall be made available to the individual through an Internet website and through other means for individuals without access to the Internet.

D. The Exchange shall not exempt any health carrier seeking certification of a qualified health plan, regardless of the type or size of the carrier, from State licensure or solvency requirements and shall apply the criteria of this section in a manner that assures a level playing field between or among health carriers participating in the Exchange.

E. (1) The provisions of this Act that are applicable to qualified health plans shall also apply to the extent relevant to qualified dental plans except as modified in accordance with the provisions of paragraphs (2), (3) and (4) of this subsection or by regulations adopted by the Exchange;

(2) The carrier shall be licensed to offer dental coverage, but need not be licensed to offer other health benefits;

Drafting Note: States that do not provide for a limited scope license should review the language above and either not include it or modify it for consistency with applicable State law and regulations.

(3) The plan shall be limited to dental and oral health benefits, without substantially duplicating the benefits typically offered by health benefit plans without dental coverage and shall include, at a minimum, the essential pediatric dental benefits prescribed by the Secretary pursuant to section

1302(b)(1)(J) of the Federal Act, and such other dental benefits as the Exchange or the Secretary may specify by regulation; and

(4) Carriers may jointly offer a comprehensive plan through the Exchange in which the dental benefits are provided by a carrier through a qualified dental plan and the other benefits are provided by a carrier through a qualified health plan, provided that the plans are priced separately and are also made available for purchase separately at the same price.

Section 8. Funding; Publication of Costs

A. The Exchange may charge assessments or user fees to health carriers or otherwise may generate funding necessary to support its operations provided under this Act.

Drafting Note: As provided in section 1311(d)(5)(A) of the Federal Act, in establishing an Exchange under this Act, the State must ensure that the Exchange is self-sustaining by January 1, 2015.

B. The Exchange shall publish the average costs of licensing, regulatory fees and any other payments required by the Exchange, and the administrative costs of the Exchange, on an Internet website to educate consumers on such costs. This information shall include information on monies lost to waste, fraud and abuse.

Section 9. Regulations

The Exchange may promulgate regulations to implement the provisions of this Act. Regulations promulgated under this section shall not conflict with or prevent the application of regulations promulgated by the Secretary under the Federal Act.

Drafting Note: States that do not establish the Exchange in a governmental agency with rulemaking authority should substitute the agency responsible for the administration or oversight of the Exchange. As appropriate, the commissioner should be granted rulemaking authority to promulgate regulations to implement the provisions of this Act within the scope of the commissioner's authority, as provided under State law or regulations.

Section 10. Relation to Other Laws

Nothing in this Act, and no action taken by the Exchange pursuant to this Act, shall be construed to preempt or supersede the authority of the commissioner to regulate the business of insurance within this State. Except as expressly provided to the contrary in this Act, all health carriers offering qualified health plans in this State shall comply fully with all applicable health insurance laws of this State and regulations adopted and orders issued by the commissioner.

Drafting Note: States should be aware that section 1311(d)(3)(A) of the Federal Act states that the Exchange "may make available a qualified health plan notwithstanding any provision of law that may require benefits other than the essential health benefits specified under section 1302(b) of the Federal Act," unless the State elects, pursuant to Section 1311(d)(3)(B) of the Federal Act, to require additional benefits and to make payments to or on behalf of enrollees to defray the cost of the additional benefits. Thus, if a State has benefit mandates that exceed the federal essential health benefit requirements, States may choose either to: 1) establish a mechanism under which qualified health plans may lawfully be offered through the Exchange without being required to provide benefits in addition to the federally designated essential benefits; or 2) establish a mechanism for evaluating and defraying the costs of the additional benefits. For States choosing to require additional benefits and defray the cost, it is recommended that the costs of the additional benefits be measured on a "net cost" basis to the extent permitted by federal law or regulations or guidance, considering both the costs of the service and any associated savings, based on an evidence-based methodology to determine the net cost, if any, of each additional benefit, and the value of the benefit to the State's residents. States also should be aware of the potential conflicts and opportunities for adverse selection created by having inconsistent benefits inside an Exchange and outside an Exchange.

Section 11. Effective Date

This Act shall be effective [insert date].

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