National Health Exchange Summit

Health Exchange Marketplaces 101 – Provider Strategies For Success

November 4, 2013

ECG Management Consultants, Inc.

For 40 years, ECG has served as a trusted adviser to some of the nation's leading healthcare providers.

- ECG is a national consulting firm focused on offering realistic, implementable solutions to healthcare providers.
- Our staff of approximately 120 consultants operates out of offices in Boston, Dallas, San Diego, San Francisco, Seattle, St. Louis, and Washington, D.C.
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Agenda

I. Introduction
II. Market Impact
III. Provider Financial Impact
IV. Contracting Strategy
V. Operational Impacts

Attachment A – Health Exchange Development Details
Attachment B – Individual and Employer Penalties
Attachment C – Exchange Market and Outreach Information

I. Introduction
Key Objectives

Today's discussion will highlight provider strategies for success with Health Exchange Marketplaces.

- During this open enrollment period, providers will gain an understanding of how many people in their state have signed up for a health plan on the exchange.
- As the implementation date of January 1, 2014, is fast approaching providers must now address the realities of caring and being reimbursed for this new patient category.
- Our objective is to answer the following questions about health exchanges in the United States:
  - How should providers prepare for this new type of insurance product?
  - What are the day to day operating implications of health exchanges?

II. Market Impact
Current Health Coverage Distribution

Some estimate there are as many as 48 million uninsured individuals who can flow into the exchanges. The additional insured patients could represent a strong opportunity, depending on location.

Source of Healthcare Coverage by State – 2011 (Millions)[1]

	United States
Employer	149.35
Individual	15.41
Medicaid	50.67
Medicare	39.99
Other Public	3.85
Uninsured	48.61
Total	**307.89**

NOTE: Figures may not be exact due to rounding.

[1] Source: Health Insurance Status of the Total Population, The Henry J. Kaiser Family Foundation, *http://www.statehealthfacts.org*.

Source of Healthcare Coverage Percentage – 2011[1]

	United States
Employer	49.0%
Individual	5.0%
Medicaid	16.5%
Medicare	13.0%
Other Public	1.2%
Uninsured	15.8%
Percentage of All Employers Offering Insurance	51.0%
Businesses With Fewer Than 50 Employees Offering Insurance	35.7%
Businesses With 50 or More Employees Offering Insurance	95.7%

II. Market Impact
Covered California – Benefit Plans

On February 13, 2013, California announced the Standard Benefit plan designs.

- Platinum and Gold plans have no deductible, and a physician's office visit will be $25 (Platinum) and $45 (Gold).
- Silver plans will have $2,000 deductibles, a $45 physician's office co-pay, and an additional $500 deductible for medications.

Covered California Benefit Plan Outline

Plan	Population Served	Out-of-Pocket Max. by Type			Actuarial Value		Deductible (Medical/Brand Drug)
		Coinsurance	Co-Pay	HSA/Cata.[1]	Coinsurance/ Co-Pay	Other	
Platinum		$4,000	$4,000		88%		$0/$0
Gold		$6,400	$6,400		78%		$0/$0
Silver	Individual	$6,400	$6,400	$6,400	69%	72%	$2,000/$500
Silver	SHOP	$6,400	$6,400	$6,400	69%	72%	$1,500/$500
Silver	100% to 150% of FPL	$2,250	$2,250		95%		$0/$0
Silver	150% to 200% of FPL	$2,250	$2,250		88%		$500,$50
Silver	200% to 250% of FPL	$5,200	$5,200		74%		$1,500/$500
Bronze		$6,400		$6,400	60%	59%	$5,000
Catastrophic				$6,400		60%	$6,400

Source: *http://www.healthexchange.ca.gov/Pages/Communications.aspx.*

[1] The Silver HSA plans have an integrated deductible of $1,500 for both medical and brand drug costs. The Bronze has a $4,500 integrated deductible.

II. Market Impact
Insurers and Providers Out

- Three big players in the group market – UnitedHealthcare, Aetna Inc., and Cigna, will not initially offer products on the Covered California individual plan exchange.
- As of 2011, those three insurers only had 7% of the individual market, while Kaiser Permanente, Blue Cross, and Blue Shield had nearly 87%, collectively.
- Cigna decided to only offer individual plans in 5 of the 10 states that it operates.
- According to the Covered California Health Plan booklet, 13 different health plans have tentatively been approved for the exchange.

Source: *http://articles.latimes.com/2013/may/22/business/la-fi-health-insure-20130523.*

- Although the premium rates in Covered California were lower than expected, the provider networks have been limited.
- Only Anthem Blue Cross included the Ronald Reagan UCLA Medical Center in its network.
- Blue Shield said that exchange customers will be restricted to 36% of the regular physician network statewide.
- Cedars-Sinai Medical Center, one of Southern California's most prestigious and expensive hospitals, was not included in any exchange plans.

Source: *http://articles.latimes.com/2013/may/24/business/la-fi-health-rates-deals-20130525.*

II. Market Impact
Rate Variation Within Metal Levels

While significant variation exists between plans in different geographic regions and between plans at different metal levels, substantial variation can exist even at the same metal level within the same region.

Rate variation can likely be attributed to the following factors:

- Difficulty for plan actuaries in estimating the likely participants in the health exchange market and their healthcare needs.
- Provider networks offered under each plan may be quite different.
- Plan members are typically loyal to the plan they choose, thus price sensitivity may be low.
- Health plan sponsors may be quite different in size and scale, and thus their ability to price competitively may be significantly different.

City	Second Highest Silver Premium	Second Lowest Silver Premium	Difference	Percentage Difference
Baltimore, MD	$417	$298	$119	40%
New York City, NY	$679	$387	$292	76%
San Francisco, CA	$383	$373	$10	3%
San Diego, CA	$328	$308	$20	7%

Source: Premium Rate Variation In Exchanges Is An Eye Opener, Health Affairs, August 7, 2013, *http://healthaffairs.org/blog/2013/08/07/premium-rate-variation-in-exchanges-is-an-eye-opener/*

II. Market Impact
Concern About Narrow Networks

- There is significant concern voice about access for health exchange patients due to narrow networks being developed.
- Health Net has the lowest premiums by nearly $100 dollars a month, but also has the smallest network of providers.
- Covered California is not necessarily focused on physician count, but available capacity is a better measure.
- Many insurers believe that consumers are willing to trade a bit less choice for cheaper premiums.

Source: *http://articles.latimes.com/2013/sep/14/business/la-fi-insure-doctor-networks-20130915*

III. Provider Financial Impact
Key Considerations

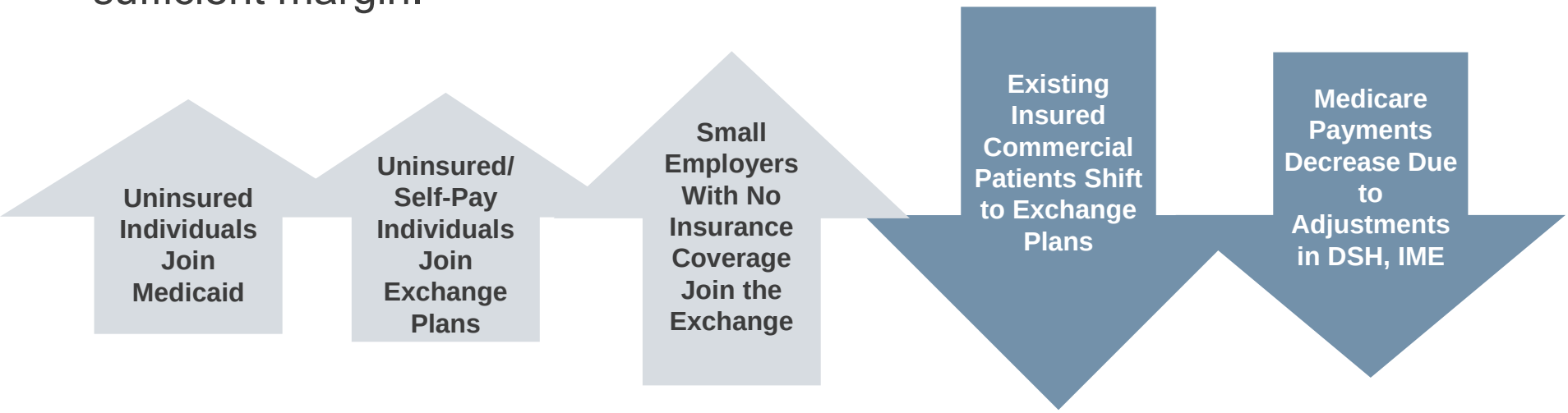
Deciding to participate in a payor's health exchange product network is a unique decision for each organization. "Why would I do this?"

Good Conditions for Participation	Participation Risks
• Safety net hospital. – High uninsured patient population. – High Medicaid population. • Potential for establishing a narrow network. • Network contracts that clearly exclude competitors. • Potential for increased volume that adds to contribution margin.	• Inability to negotiate rates at or above Medicare. • High percentage of small businesses in payor mix. Small businesses could drop coverage, and employees could buy on the exchange with low rates. • Commercial payors shifting groups to lower-paying rate schedules. • Volume loss to competitors that agree to narrow networks.

III. Provider Financial Impact
Impact on Current Payor Mix

A key step in preparing for the exchange will be to understand the reimbursement impact of a shift in payor mix from one category to another.

- The ACA and the introduction of exchanges will shift your payor mix.
- Depending on the value of the exchange category contracts, the delicate balance of cost shifting may be disturbed.
- This impact can be profound if the exchange population is large enough or if providers do not negotiate rates that ensure contracts with a sufficient margin.



III. Provider Financial Impact
Physician Contracts

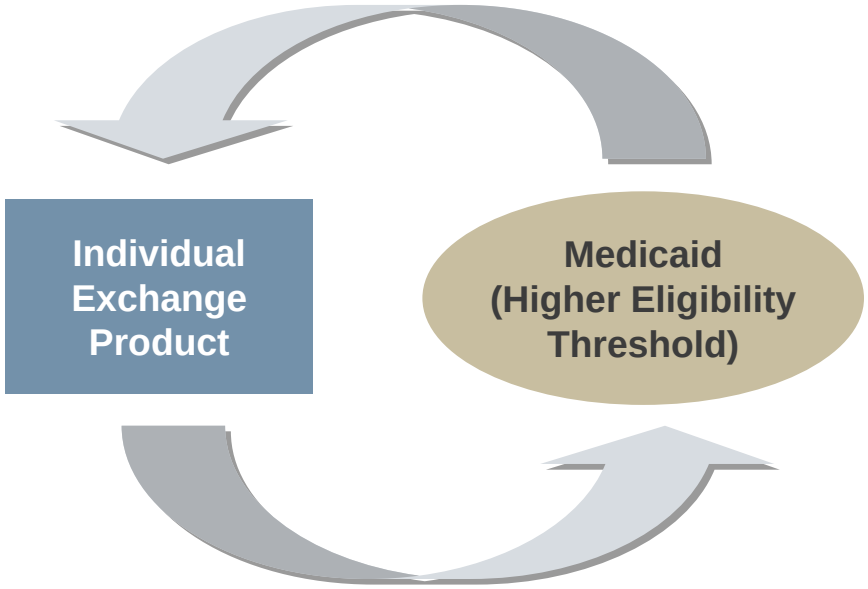
Contracting for physician risk will be critical to aligning incentives for utilization management as well as generating positive margins.

- ***High Physician Alignment*** – Systems that include a significant number of physicians should also be concerned with professional fee contracting for exchange products.
  - Physician contracts for exchange products could be both partial-risk (i.e., at risk for physician spending only) and full-risk arrangements (i.e., at risk for both physician and facility spending).
  - Your alignment with specialty physicians (financial, technological, and operational) will also largely dictate your ability to take on more physician risk.
- ***Low Physician Alignment*** – Organizations that have low to moderate alignment among physicians would focus on case rates and bundled payment approaches, while those with high levels of alignment can enter into broader shared-savings or global reimbursement contracts.
  - Reimbursement targets for physician services should mirror those on the hospital side, as close to commercial rates as possible.
  - It is important to also consider reimbursement under current utilization levels versus future utilization, which is expected to be lower based on care coordination efforts.

III. Provider Financial Impact
Medicaid Products

Providers must be concerned with patients with low income or unstable jobs situations "churning" between exchange products and Medicaid.

- Medicaid plans are expected to participate in the exchange so patients exceeding 133% of the FPL can continue with the same insurance provider by switching to another product.
- Continuity of care will be maintained for the patients moving to and from the exchange and a commercial product
- Income studies estimate that as many as 33% to 50% of Medicaid/exchange patients will have changes in eligibility each year.
- "Bridge plans" will provide some coverage stability to this population.



III. Provider Financial Impact
Analysis Factors

Based on the current projections, the volume of exchange patients can be large enough to have an impact on your hospital's financial performance.

- ***Commercial Insurance Shifts*** – Some previously uninsured patients will select a commercial or health exchange product. Also, some employers will move their commercial product to a health exchange product. With lower health exchange contract rates, provider profitability will be impacted.
- ***Self-Pay*** – There will be fewer self-pay patients, as this population will qualify for Medicaid or health exchanges. Undocumented workers will continue to be self-pay.
- ***Medicaid Growth*** – With Medicaid eligibility expanding to 133% of the FPL, the Medicaid business will grow.
- ***Bad Debt Expense*** – As a result of the health exchanges' high deductibles and co-insurance plans, provider bad debt expense will be impacted.
- ***Network Participation*** – Payors that want your system in the network will seek either to add the product to existing contracts or to initiate new contracts just for the impacted population.
- ***Utilization Impact*** – Utilization for an exchange population is expected to be minimal and largely impacting primary care services. Inpatient and specialty services are not expected to be impacted as much as primary care.

III. Provider Financial Impact
Revenue Shift Example – Balanced Payor Mix

In this example, revenue is shifting between payor categories. Given the respective margins, the organization's profitability moves from $2.10 million to $0.25 million, a variance of $(1.85) million.

Revenue Before and After Health Exchange – Balanced Payor Mix

(Dollars in Millions)

Payor Type	Profit Margin	Pre-Exchange			Post-Exchange			Profit Variance
		Revenue	Percentage of Total	Profit	Revenue	Percentage of Total	Profit	
Medicare	0%	$ 52.00	52.0%	$ 0.00	$52.00	53.6%	$ 0.00	$ 0.00
Medicaid	-45%	18.00	18.0%	(8.10)	19.00	19.6%	(8.55)	(0.45)
Commercial	40%	27.00	27.0%	10.80	20.00	20.6%	8.00	(2.80)
Self-Pay	-20%	3.00	3.0%	(0.60)	1.00	1.0%	(0.20)	0.40
Exchange	20%	0.00	0.0%	0.00	5.00	5.2%	1.00	1.00
Total		$100.00	100.0%	$ 2.10	$97.00	100.0%	$0.25	$(1.85)

III. Provider Financial Impact
Payor A POS at 54% of the PPO Rate

In order to participate on the health exchange, Payor A requested a discount of 46% off the current PPO product from this two hospital system. Profit margin would decrease by $3.1 million, and 6,993 new PPO days would be needed to replace the lost profit.

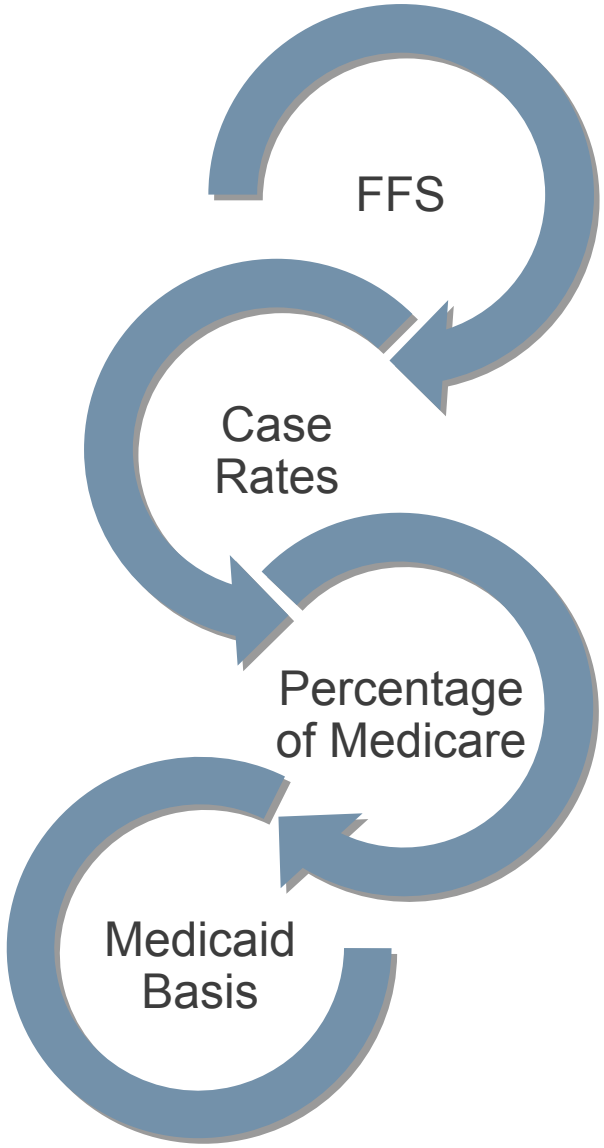
Hospital	Current POS Revenue	Revenue at 54% of PPO	Contribution Margin	Profit Margin	Profit Margin Change	New Profit Margin Percentage	Current Profit Margin Percentage
A	$ 315,587	$ 203,453	$ 103,550	$ 44,950	$ (112,133)	22.1%	49.8%
B	6,718,938	3,683,587	1,709,525	129,554	(3,035,351)	3.5%	47.1%
Total	**$7,034,525**	**$3,887,040**	**$1,813,075**	**$174,504**	**$(3,147,484)**	**4.4%**	**47.2%**

PPO Days Needed to Replace POS Profitability at Discounted Rates to Blue Cross

Hospital	Current POS Days	Additional PPO Days for 46% Revenue Reduction and Break Even
A	310	460
B	5,980	6,533
	6,290	**6,993**

IV. Contracting Strategy
Contract Questions

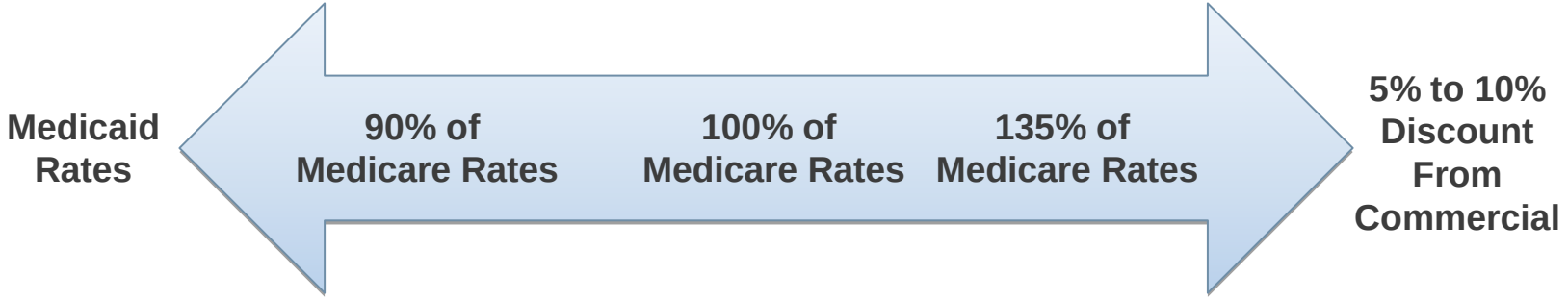
- What types of contracts will your organization be offered from the payors?
  - Plans are likely to continue to use existing reimbursement structures.
- What other approaches might payors in the exchange take?
  - In many markets, payors are building narrow networks to care for exchange patients.
  - Narrow networks may include non-exchange patients.
- Will your competitors be contracting for exchange patients?
- How will you respond if the payors continue to pay current contract rates even if your contract does not include a health exchange product?



IV. Contracting Strategy
Review of Current Contracts

There are a number of tactics that your organization can take to stay ahead of the curve in responding to health exchanges.

- ***Proactive*** – Proactively engage payors regarding exchange products.
- ***New Products*** – Understand that payors may want to include the new products in existing agreements.
  - Determine if current agreements allow for add-on products (e.g., exchange products) at will.
  - Focus on creating freestanding agreements for the exchange products so reimbursement for that population can be isolated.
  - If an amendment is necessary, add an amendment term clause.
- ***Competition*** – Evaluate the likely response of your competitors.
- ***Pricing Strategy*** – Determine your preferred pricing strategy for these products.



IV. Contracting Strategy
Preferred Contracting Approach

A new contract for exchange products is the preferred approach because it allows for the greatest flexibility. Most health plans are seeking to amend existing contracts.

New Contract Considerations

- A new agreement allows for the greatest flexibility for the provider.
  - Ability to negotiate rates.
  - Flexibility to limit the term.
- A provider can clearly specify the exchange participants (e.g., individuals and small groups only).
- A new contract does not interfere with your current HMO and PPO agreements.
- The base agreement requires amendments or mutual agreement for the addition of new products.

Given the uncertainty of pricing, the levels of participation, and the potential migration of commercial business to the exchange, providers need flexibility to negotiate rates and exit the contract if necessary.

IV. Contracting Strategy
Contract Language

- ***Product Definitions*** – Clearly specify in the contract that the rates are for health exchange patients only.
- ***Related Entities*** – Define in the contract if other owned or affiliated organizations can access the health exchange contract rates.
- ***Other Payors*** – Determine if other payors can access the rates.
- ***Product Offering Off the Exchange and On the Exchange*** – Clarify in the contract if the product being added is inside or outside the exchange.
- ***Payor Filings*** – Ensure that your hospital is not being filed with the state as in network at current contract rates without being informed.
- ***Narrow Networks*** – Verify that your competitors are included or excluded from the narrow-network definition.
- ***Existing Product to Become New Health Exchange Product*** – Payor selects an existing product to be the health exchange product, then requests a lower contracted rate. If a new contract is not agreed to, then the current product is terminated by the payor.

V. Operational Impacts
Organizational Readiness

Health exchanges will have varied impacts throughout a provider organization. Each provider should conduct an internal review to determine their readiness related to the potential issues.

- Health plan contract and network participation.
- Financial performance tracking.
- Premium payment grace period.
- Elective services for non-contracted payors.
- ED out-of-network claims.
- Communication and education.

Developing a plan and communicating it to the pertinent personnel will result in an easier transition for both patient and provider.

V. Operational Impacts
Readiness Assessment

Many organizations are initiating a plan for their managed care, revenue cycle, and patient financial services departments.

Example Readiness Plan Goals

- Identify the affected contract.
- Capture accurate information at the time of registration.
- Evaluate the financial performance of the new managed care contracts.
- Plan and implement the appropriate changes.
- Communicate with/educate the staff, physicians, patients, and community.

Department Readiness Assessment Questions

- What do you anticipate will be the major impact on your department or functional area?
- What action will be needed to plan for the managed care changes?
- What information will you need to communicate, to whom, and by when?
- What is your preparedness plan in advance of January 1, 2014?
- What is your action plan beginning on January 1, 2014?

V. Operational Impacts
Health Plan Contract and Network Participation

- ***Department Impacts*** – The new health exchange products will impact several operational departments.
  - Admitting/Registration (Patient Access).
  - Case Management.
  - Patient Financial Services.
  - Marketing and Communications.
- ***Strategic Questions*** – Each organization should internally address key questions and communicate the strategy to impacted personnel.
  - Are you contracting with all the health plans?
  - Will there be any new or unfamiliar plans?
  - What are the implications of not contracting with all payors? Will a specific departments and/or functions be impacted?
  - Who needs to know about the newly contracted and non-contracted plans?
  - Will you accept non-contracted health plans members requesting elective services?

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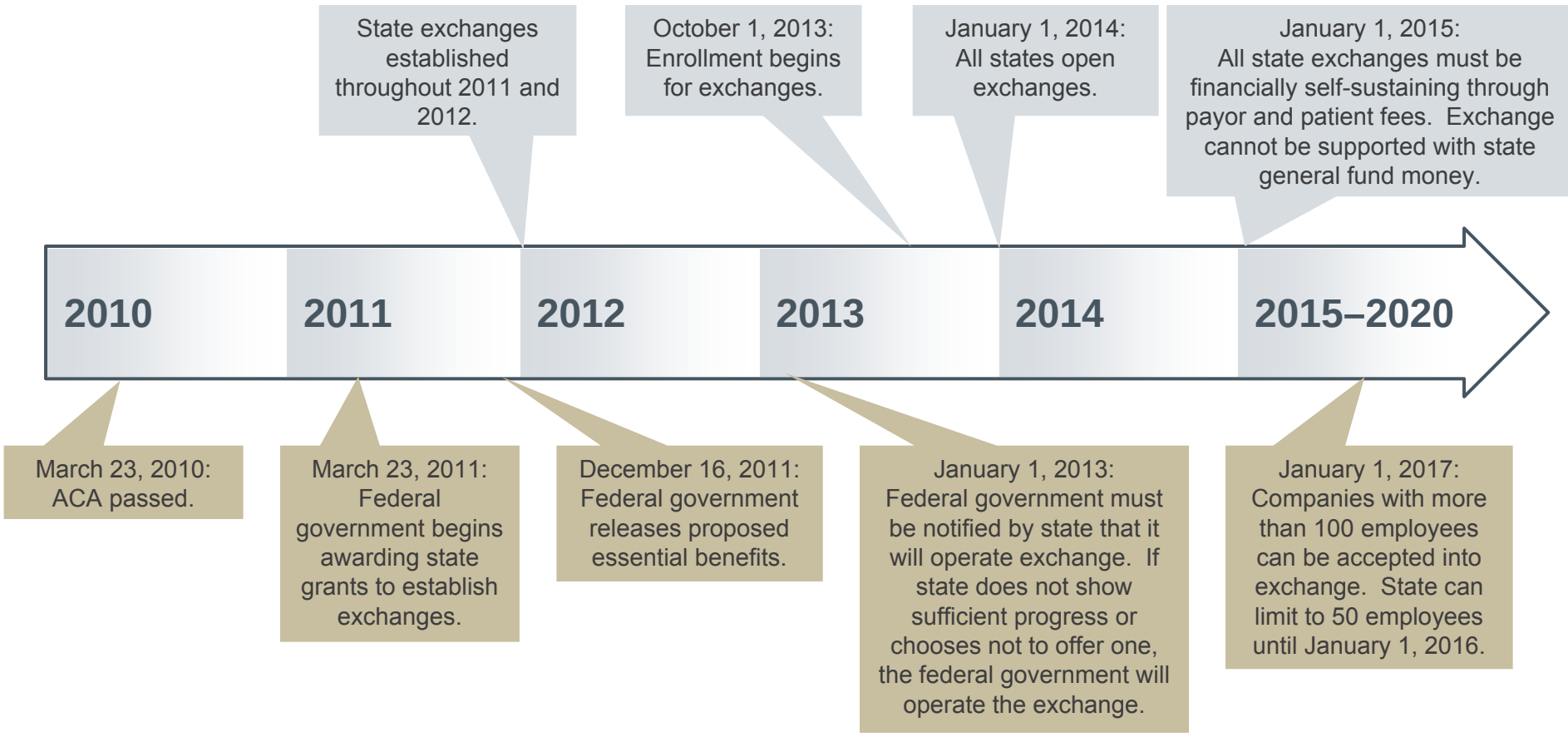
Attachment A
Health Exchange Development Details

Key Exchange Dates

There are several key dates related to state health exchanges that providers and patients need to know, including the initial start date of January 1, 2014.



Development Rationale

Exchanges are designed to be one-stop marketplaces for consumers to find an affordable insurance plan that best meets their health needs.

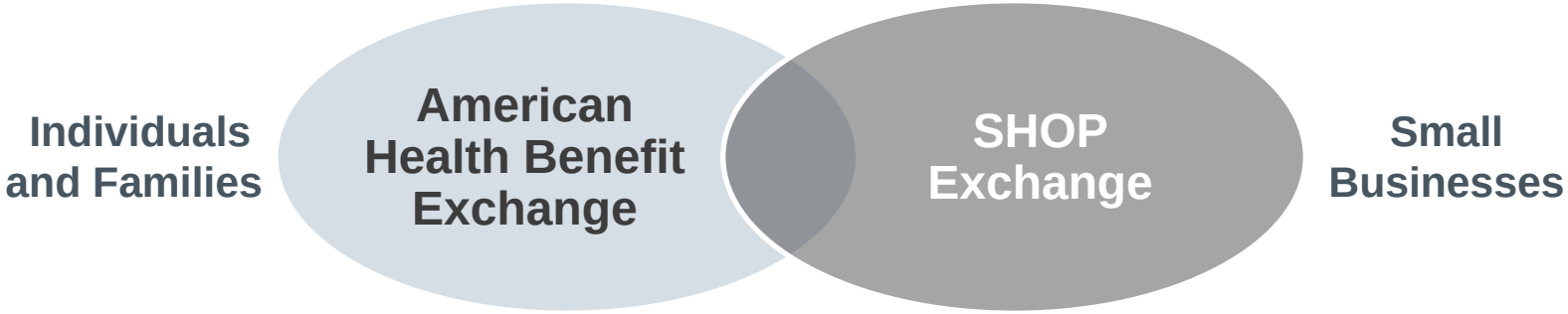
- ***State Control*** – Exchanges can operate as part of an existing state agency or office (operated by the state), as an independent public agency (quasi-governmental), or as a nonprofit entity (nonprofit).
- ***Qualifying Health Plans*** – Exchanges will provide guidance to consumers regarding qualified coverage.
  - *Clearinghouse* – All qualified health plans (QHPs).
  - *Active Purchaser* – Selected health plans and/or for the negotiation of premiums.
- ***Purpose*** – Exchanges are intended to offer the following:
  - *Competition* – Increase competition and choice to provide the leverage for small businesses and individuals who need to purchase insurance.
  - *Transparency* – Foster transparency whereby consumers can compare price, coverage, and quality.
  - *Comparison* – Facilitate shopping and enrollment in the coverage that best meets their health and financial needs.
  - *Coordination* – Coordinate eligibility for private as well as premium assistance plans.

Additional exchange development information is included in ATTACHMENT A.

Populations Served by Exchanges

The Affordable Care Act (ACA) created two distinct exchange types: the American Health Benefit Exchange and the Small Business Health Options Program (SHOP) Exchange.

Population Groups

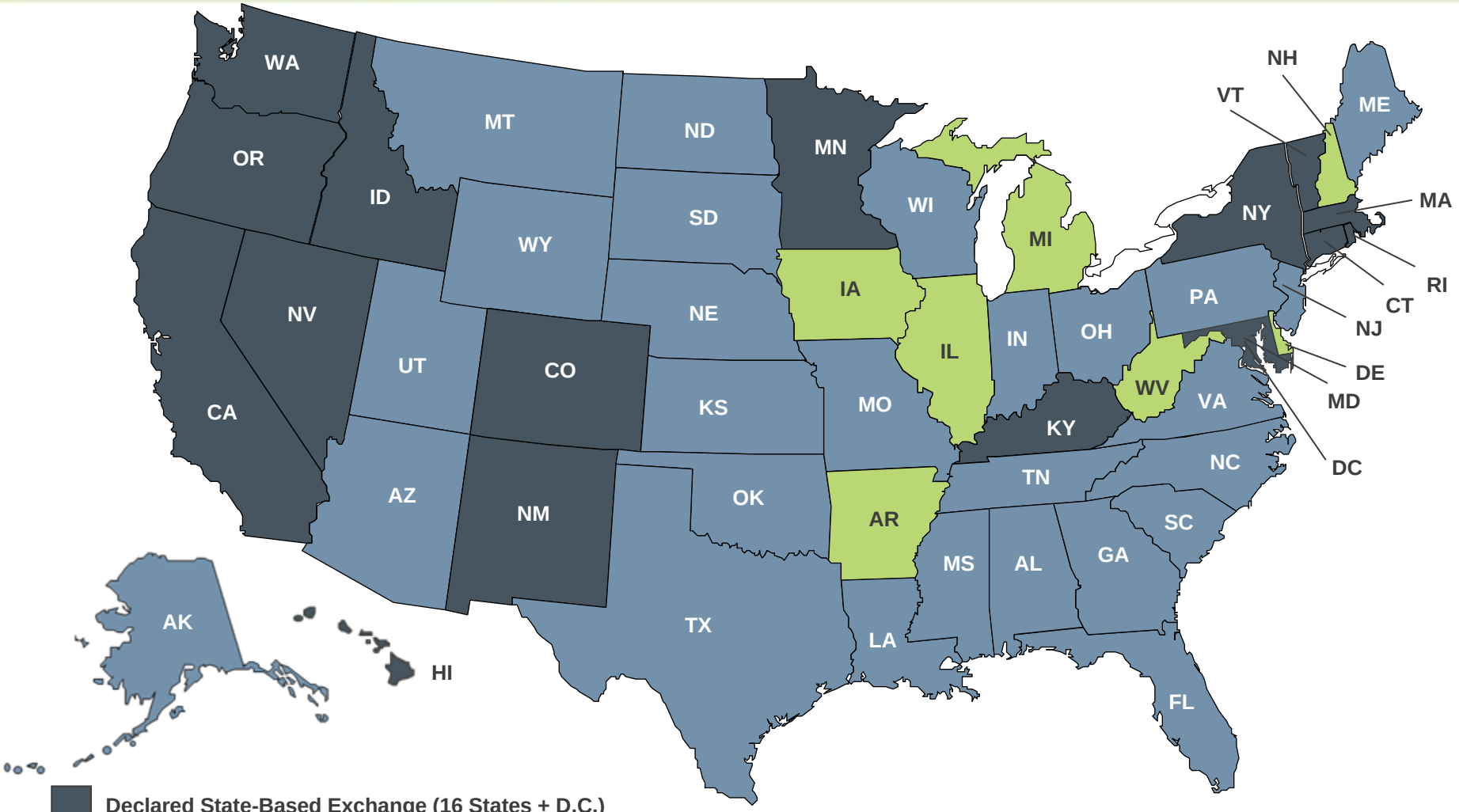


Employer Size	2014	2015	2016	2017	2018
1 to 50	Included	Included	Included	Included	Included
51 to 100	State Option	State Option	Included	Included	Included
More Than 100	No	No	No	State Option	State Option

- The U.S. Department of Health & Human Services (HHS) has recently delayed the required opening of SHOP exchanges until 2015. State operated exchanges can open them if they choose.
- Small businesses will still be able to obtain insurance through the exchange, but states will have the option to limit that to one choice in 2014, instead of multiple plans.

Source: *http://www.commonwealthfund.org/Newsletters/Washington-Health-Policy-in-Review/2013/Apr/Apr-8-2013/Delay-on-Choice-in-SHOP-Exchanges.aspx*.

State Decisions for Creating Health Exchanges



Source: *http://kff.org/health-reform/state-indicator/health-insurance-exchanges/#map*. Dated May 28, 2013.

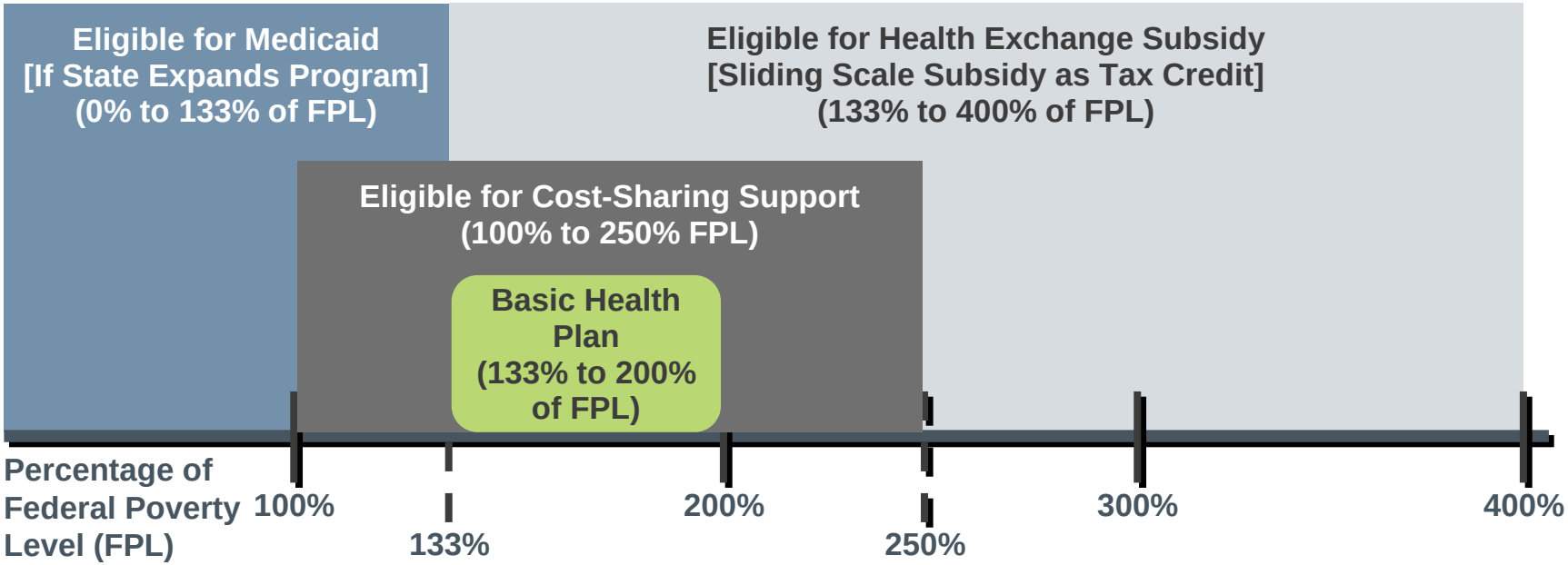
Federal Coverage Requirements

There are 10 EHB categories that all exchange products must include. Benefits within these categories are not mandated by the ACA.

Benefit Category
Ambulatory Patient Services
Emergency Services
Hospitalization
Maternity and Newborn Care
Mental Health, Substance Abuse, and Behavioral Health Treatment
Prescription Drugs
Rehabilitative Services and Devices
Laboratory Services
Preventive and Wellness Services and Chronic Disease Management
Pediatric Services, Including Oral and Vision Services

States have four options to establish a benchmark benefit plan from any category: small group insurance, state employee plans, federal employee plans, HMO option.

Coverage and Subsidy Support by Income Level



Income by FPL Percentage Level

Description	100%	133%	150%	200%	250%	300%	400%
Individual[1]	$11,490	$15,282	$17,235	$22,980	$28,725	$34,470	$45,960
Family of Four[1]	$23,550	$31,322	$35,325	$47,100	$58,875	$70,650	$94,200
Insurance Premium Cost Target Percentage of Income[2]	2.0%	2.0%	4.0%	6.3%	8.1%	9.5%	9.5%

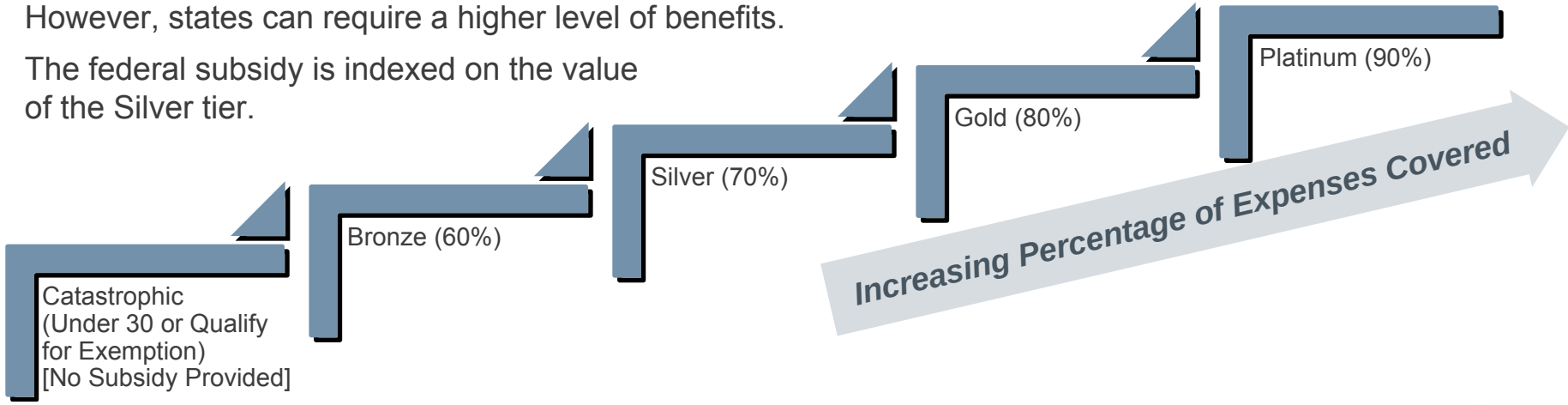
1 2013 Poverty Guidelines for 48 continental states and D.C. Source: *http://aspe.hhs.gov/poverty/13poverty.cfm.*

2 Source*: http://money.usnews.com/money/blogs/the-best-life/2012/07/27/how-new-health-insurance-subsidies-will-work.*

Coverage Requirements and Tiers

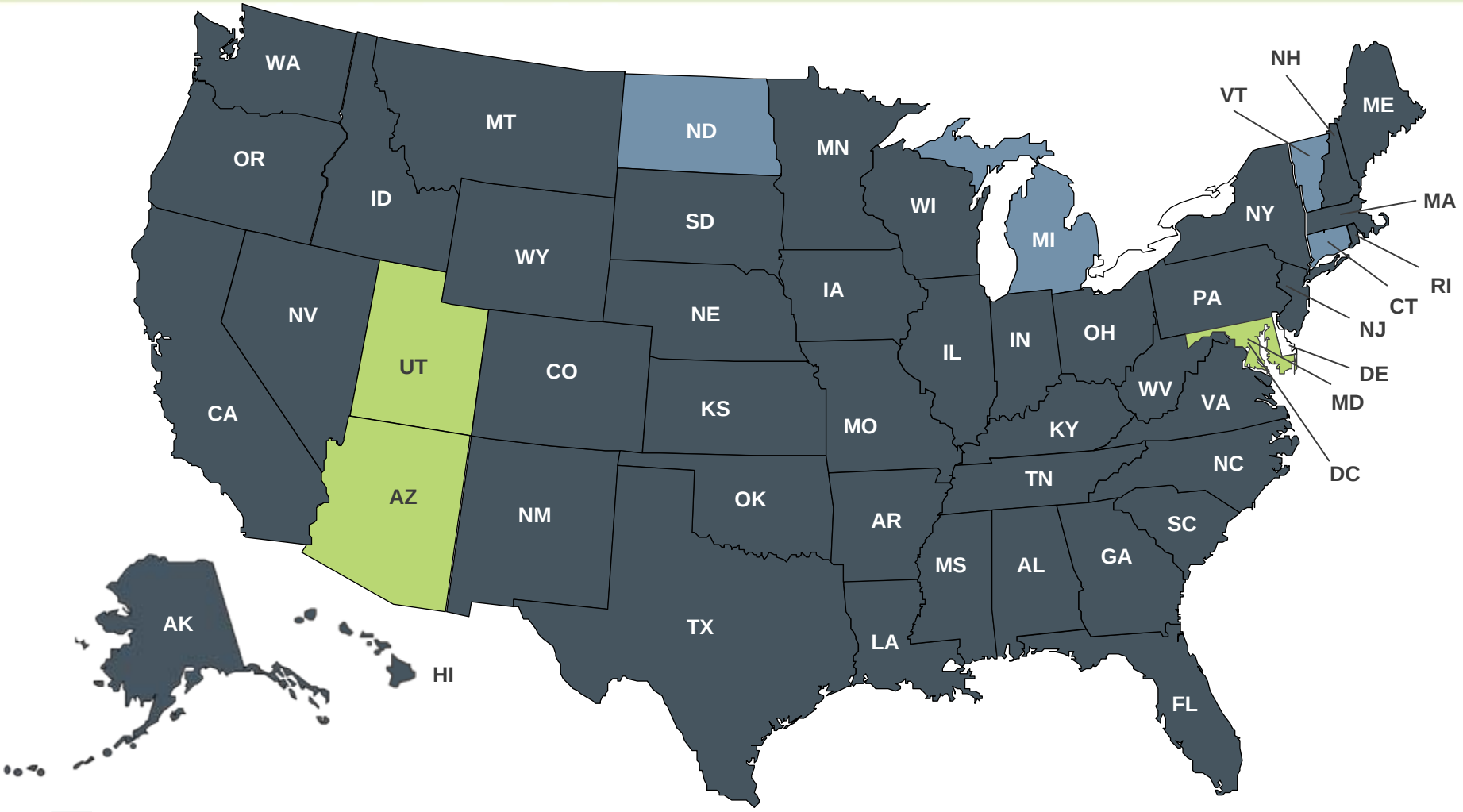
Exchanges will have five tiers of coverage to choose from.

- An exchange must offer a plan choice in each of the five categories, which are based on the actuarial value of the plan.
- The actuarial value is based on the average cost share of covered health expenses reimbursed by the plan for the typical population.
- In a given state, a participating payor must offer at least one Platinum or Gold plan.
- The ACA also states that the federal government will select at least two multistate carriers available in every state and every exchange.
- The plans must provide the 10 essential health benefit (EHB) categories in total, as defined by CMS. However, states can require a higher level of benefits.
- The federal subsidy is indexed on the value of the Silver tier.



For example, a Gold plan would cover the equivalent of $2,000 for an average patient's $2,500 in annual medical expenses. Higher coverage requires higher premiums.

Selection of EHB Benchmark



Small Group Plan (43 States + D.C.; 26 States Defaulted to Federal)

State Employee Plan (3 States)

HMO Plan (4 States)

Source: *http://www.kff.org/healthreform/quicktake_essential_health_benefits.cfm.* December 2012.

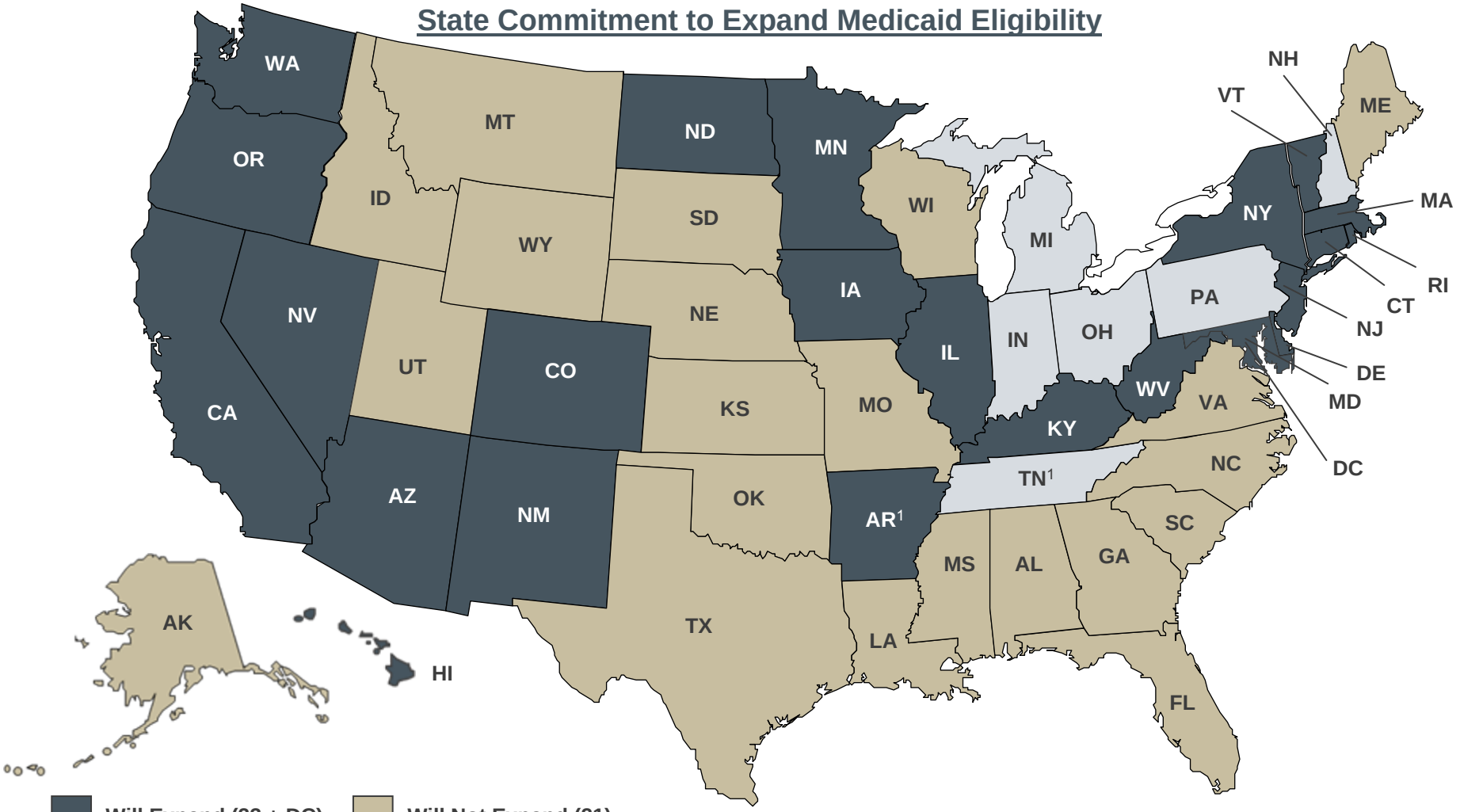
Bridge Plans

A "Bridge Plan" is part of the "Basic Health Program" part of the ACA. These plans are an option to provide subsidies to families between 139% and 200% of the FPL.

- Because people can experience a temporary increase in income that makes them ineligible for Medicaid, they would be uncovered by Medicaid during that time period.
- Bridge Plans would provide enhanced financial support to help a person maintain his or her Medicaid managed care plan and keep the same provider network.
- The enhanced continuity would aim to improve quality of care, more efficient delivery of care, and lower costs to the consumer.
- Eligibility for the Bridge Plan varies by state, but most are considering application of a Bridge Plan up to 200% of the FPL.
- Specific details of how the Bridge Plans will work are state-specific, and many states have not yet defined the functionality of the plan.

Medicaid Program Expansion

State Commitment to Expand Medicaid Eligibility



Source: Avalere *State Reform Insights,* Updated June 20 2013.

[1] Arkansas is proposing to use Medicaid funds to pay for premium assistance through exchanges, pending federal approval; Tennessee has indicated interest in expansion using a similar approach.

Medicaid Expansion – "Arkansas Plan"

Several states are considering accepting federal Medicaid expansion funds and applying them to buy plans on the health exchanges.

- Under the plan called "premium assistance," a state would accept the federal funds designated to expand Medicaid from 100% of the FPL to 133% of the FPL.
- Instead of expanding Medicaid enrollment, the state would use the money to purchase plans on the health exchange.
- The plan has been vetted by HHS as a demonstration project (Section 1115 of the Social Security Act).
- States would have to file for a waiver of existing Medicaid rules, and state and federal public hearings would be required.
- The program cannot cost more than the Medicaid expansion.
- Benefits to this approach include the use of the commercial health exchanges, probably access to a broader number of providers under the health exchange plan, and a potential positive impact to competition on the exchanges.

Source: *http://content.govdelivery.com/attachments/USCMS/2013/03/29/file_attachments/200058/Premium%2BAssistance%2BFAQ%2B03-29-13.pdf.*

Federally Operated Exchanges

For a state unable or unwilling to establish a state-based or a state-federal partnership marketplace, HHS has assumed primary responsibility for operating the marketplace.

- ***Functions*** – The states have the option to negotiate covered responsibilities with the federal government. Under the state-federal partnership, the state is handling more of the duties, particularly the consumer assistance functions.
  - *Plan Management Functions* – QHP certification and oversight; IT infrastructure and Web site operations (e.g., single online application); plan licensure, solvency, service area, and network adequacy; and determinations for the marketplace eligibility.
  - *Consumer Assistance Functions* – Consumer assistance and outreach, administration of the navigator program, and maintenance of an in-person assister program.
- ***Clearinghouse*** – The federally operated exchanges will accept all insurers whose policies meet the law's requirements. The National Committee for Quality Assurance (NCQA) and URAC (formerly the Utilization Review Accreditation Commission) will assist with deciding which plans in a state are qualified.
- ***Premiums*** – States with a federally operated exchange are not expected to post premium rates until the end of September 2013, just before the October 1, 2013, open enrollment start date.
- ***Regulation*** – The federal government cannot regulate (e.g., require matching benefit structures in and outside exchange) plans that are sold outside of the exchanges, only those inside the exchange. The lack of regulation could lead to increased adverse selection in a given state.
- ***State Coordination*** – Because the federal government will be operating 27 exchanges initially, the exchanges will likely not be customized to a particular state, which could limit effectiveness.

Reinsurance, Risk Corridors, and Risk Adjustment

The ACA has created three programs to eliminate incentives for "cherry-picking" behavior from payors and ensure that plans compete on the basis of quality and service, not on attracting the healthiest individuals.

- ***Risk Adjustment*** – A permanent, deficit-neutral, program will provide payments to plans that attract higher-risk populations by transferring funds from plans with the lowest-risk individuals.
  - This program is intended to reduce or eliminate premium differences among plans based solely on risk selection.
  - All non-grandfathered plans in the individual exchanges and SHOP are subject to this adjustment, inside and outside of the exchange.
- ***Reinsurance*** – A transitional program will help stabilize premiums for coverage in the individual market in the event that individuals who gain coverage during the first 3 years of the exchange operation (2014–2016) have higher-cost needs.
  - All plans, self-insured group plans, and TPAs on their behalf, will make contributions to support reinsurance payments.
- ***Risk Corridors*** – A transitional program will be in place to protect against uncertainty in rate-setting in the first several years of the exchange.
  - A mechanism for sharing risk and savings between the federal government and QHPs will ensure that plans costs are within 3% of initial cost projections.

Source: *http://www.healthcare.gov/news/factsheets/2012/03/risk-adjustment03162012a.html.* Referenced April 2013.

How Is the Exchange Financed?

Exchanges will initially be financed through a combination of grants. By 2015, they are required to be self-sustained through fees and assessments on exchange carriers.

- All states were eligible for a $1 million exchange-planning grant from the federal government.
- Furthermore, the federal government offered development grants for states that demonstrated progress.
  - Federal Level I establishment grants for administrative and consulting services have exceeded $100 million for larger states.
  - In addition, there are other sources, such as $5 million in working capital from the California Health Facilities Financing Authority to assist in the establishment and operation of the exchange.
- The exchange will assess a charge on the participating QHPs that is reasonable and necessary to support the development, operations, and prudent cash management of the exchange.
- The exchanges are required to be self-sustaining by January 1, 2015.
- Annual operating expenses for the exchange have not been published and are likely to be variable based on the number of patients and number of plans participating.

Additional development details, including details regarding the Basic Health Plan and the "Arkansas Plan" Medicaid expansion, are included in ATTACHMENT A.

Level I Grant Implementation

States were empowered to design their own exchanges using federal grants to facilitate feasibility studies, gather community feedback, and develop IT infrastructure. States receiving funding were required to complete activities in 11 core areas to become qualified by the June 2012 submission deadline.[1]

- Background research.
- Stakeholder consultation.
- Legislative and regulatory action.
- Governance.
- Program integration.
- Exchange IT systems.
- Financial management.
- Oversight and program integrity.
- Health insurance market reforms.
- Consumer assistance for individuals and small businesses.
- Business operations.

[1] A copy of the California Exchange Level I Establishment Grant Work Plan is available at *www.healthexchange.ca.gov/Documents/California%20Health%20Benefit%20Exchange%20Level%20I%20Establishment%20Work%20Plan.pdf*.

Health Exchange Fact or Fiction?

Confusion about health exchange details are pervasive in the market. Let's talk about some of the common questions and discuss those from the audience.

- *Can states avoid employer penalties by opting out of the state exchange?*
  - No. Although the law references penalties for employers that are eligible for a premium for state exchange coverage, the law will still be applied to federally operated exchanges.[1]
- *Can states avoid employer penalties by opting out of Medicaid expansion?*
  - No. A state that does not expand Medicaid may actually result in more employer penalties because more employees will be eligible for premium tax support.[2]
- *Is there a grace period of coverage?*
  - Yes. Enrollees who receive subsidies for a QHP offered through an exchange are given a 90 day grace period to make premium payments before coverage can be terminated. The health plan is only required to pay claims for the first 30 days of the grace period.
- *Will employers be subject to penalties if they hire many part-time employees?*
  - There is a full-time employee threshold as part of the formula for employer penalties. The individual and employer penalties are explained in greater detail in ATTACHMENT B.

1 Source: *http://employeebenefits.foxrothschild.com/2012/12/articles/plan-administration/ppaca-and-penalties-state-v-federal-exchanges.*

2 Source: *http://www.californiahealthline.org/articles/2013/3/15/employers-could-face-fines-if-states-opt-out-of-medicaid-expansion.aspx.*

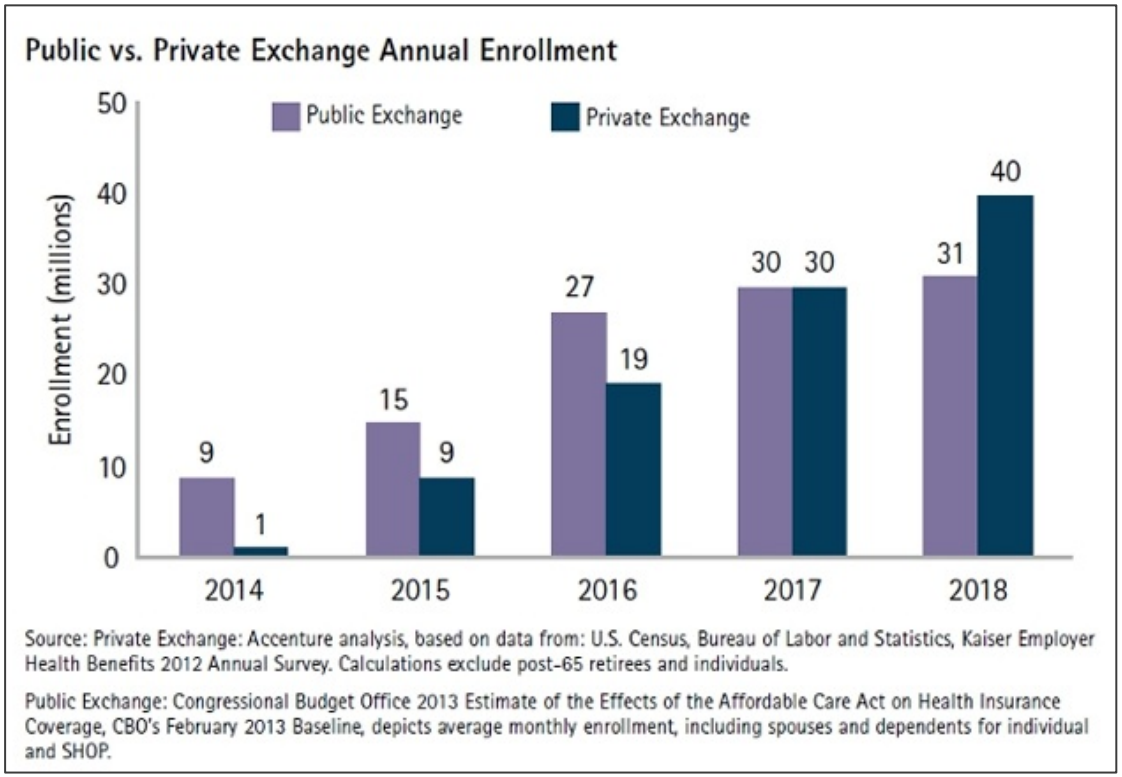
Private Commercial Exchanges

While significant focus has been placed on the state exchanges, private exchanges will be an important vehicle for expanding insurance coverage.

- ***Overview*** – Private exchanges, in existence since the 1960's, are health insurance marketplaces run by private entities.
  - They offer both individual and group products, but traditionally have been focused on groups.
  - Private exchanges were thought to be in danger of losing market share after the ACA passed because of the subsidies offered through the public exchanges.
- ***Impact Of The ACA*** – Private exchanges are expected to serve a prominent role in offering access to health plans to the public.
  - Consumers are eligible for premium subsidies on the private exchanges.
  - The exchanges must be web-based entities that verify eligibility for subsidies.
  - The health plans offered must meet the same QHP requirements and be approved by the state insurance department.
  - They are not allowed to offer any other incentives to the consumer or employer.

Private Exchange Expected Enrollment

One estimate predicts that 18% of the U.S. will purchase insurance through a private or public exchange by 2017 and that more than half will use a private exchange.



Source: Accenture, Public vs. Private Health Insurance Exchange Annual Enrollment Chart, May 23, 2013. *http://www.accenture.com/us-en/Pages/insight-public-vs-private-hix-annual-enrollment-chart.aspx*

Benefits of Private Exchanges

- Enables consumers to choose from a wide variety of health plans rather than just a few offerings from their employer.
- May provide filtering or plan selection features not available on a public exchange.

Attachment B
Individual and Employer Penalties

Individual Incentives and Penalties

- Any individual who does not have employer-offered insurance can buy it on the exchange.
- Even if an employer offers qualifying insurance an individual can still choose to buy on the exchange.
- The ACA provides a subsidy based on the Silver-level premium (geography-specific); this is considered the benchmark product.
  - The target is for individuals to pay no more than 9.8% of income.
  - The subsidy is a tax credit, not a tax deduction. In California, the subsidy would go to the insurer and appear as a discount on the policy.
  - Subsidy-eligible enrollees in a Gold or Platinum plan are responsible for premium costs above the benchmark.
- The individual penalty for no coverage is the greater of $695 per family member or 2.5% of income (to be phased in by 2016).

Individual Requirement to Buy Coverage

Start here.

Do any of the following apply?

- You are part of a religion opposed to the acceptance of benefits from a health insurance policy.
- You are an undocumented immigrant.
- You are incarcerated.
- Your are a member of an Indian tribe.
- Your family income is below the threshold requiring you to file a tax return ($9,350 for an individual, $18,700 for a family in 2010).
- You have to pay more than 8% of your income for health insurance, after taking into account any employer contributions or tax credits.

Yes → **There is no penalty for being without health insurance.**

No

Were you insured for the whole year through a combination of any of the following sources?

- Medicare.
- Medicaid or the Children's Health Insurance Program (CHIP).
- TRICARE (for service members, retirees, and their families).
- The veteran's health program.
- A plan offered by an employer.
- Insurance bought on your own that is at least at the Bronze level.
- A grandfathered health plan in existence before the health reform law was enacted.

Yes → **The requirement to have health insurance is satisfied, and no penalty is assessed.**

No

There is a penalty for being without health insurance.

(continued on next page)

Individual Requirement to Buy Coverage *(continued)*

(Continued From Previous Page)

2014

Penalty is $95 per adult and $47.50 per child (up to $285 for a family) or 1.0% of family income, whichever is greater.

2015

Penalty is $325 per adult and $162.50 per child (up to $975 for a family) or 2.0% of family income, whichever is greater.

2016 and Beyond

Penalty is $695 per adult and $347.50 per child (up to $2,085 for a family) or 2.5% of family income, whichever is greater.

The penalty is prorated by the number of months without coverage, though there is no penalty for a single gap in coverage of less than 3 months in a year. The penalty cannot be greater than the national average premium for Bronze level coverage in an exchange. After 2016, penalty amounts are increased annually by the cost of living.

Source: *http://healthreform.kff.org.*

Key Facts

- Premiums for health insurance bought through exchanges would vary by age. The Congressional Budget Office estimates that the national average annual premium in an exchange in 2016 would be $4,500 to $5,000 for an individual and $12,000 to $12,500 for a family for Bronze coverage (the lowest of the four tiers of coverage that will be available).
- In 2010, employees paid $899 on average toward the cost of individual coverage in an employer plan and $3,997 for a family of four.
- A Kaiser Family Foundation subsidy calculator illustrating premiums and tax credits for people in different circumstances is available at *http://healthreform.kff.org/subsidycalculator.aspx.*

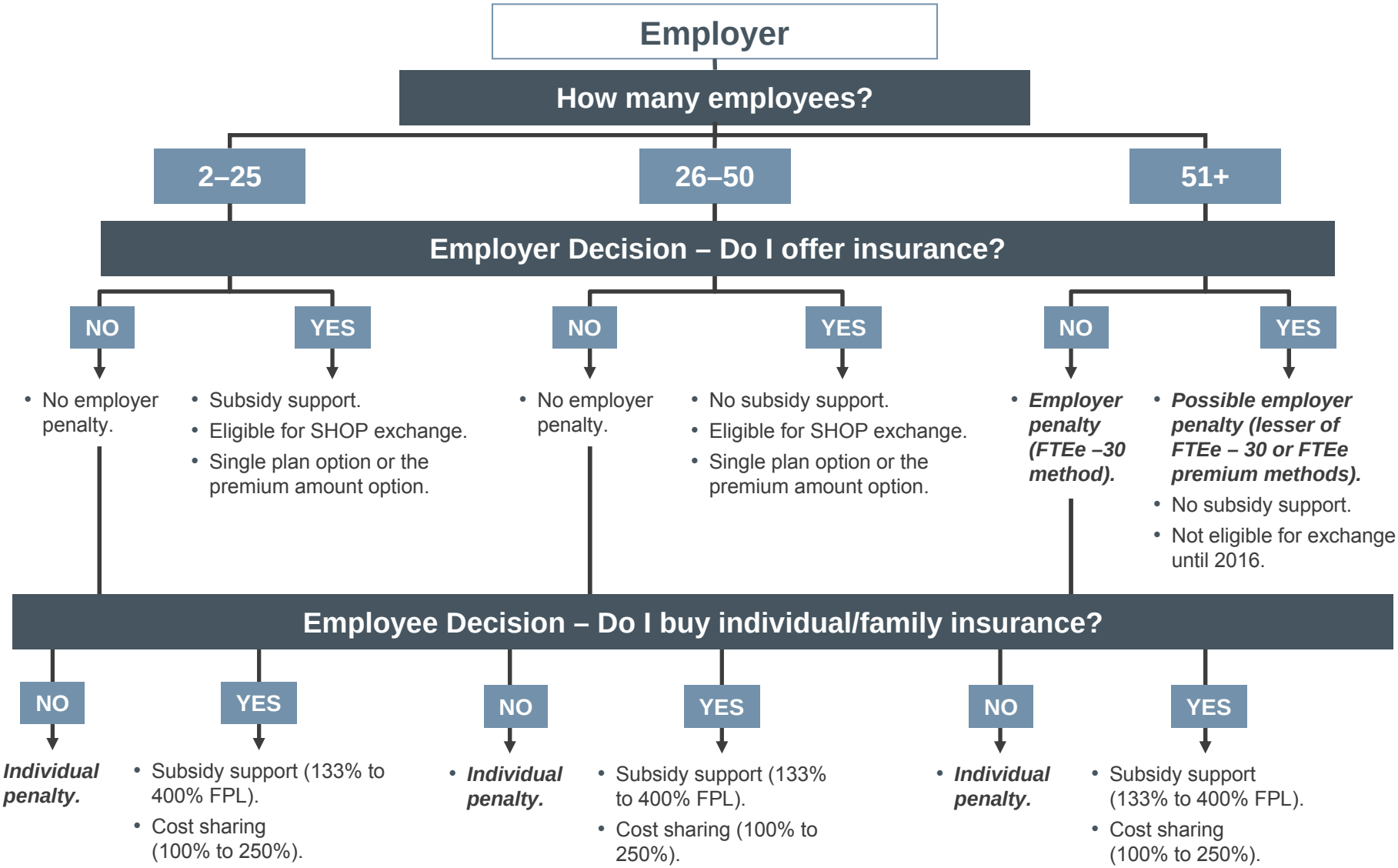
Full-Time Employee Versus Full-Time Equivalent

- An FTEe is an employee who works on average 30 hours per week or 130 hours per month.
  - *Hourly Employees* – Hours include actual hours of service for which payment is made (e.g., work hours, vacation, holiday, illness, incapacity).
  - *Non-Hourly Employees* – Hours could be derived from work logs or equivalency of 8 hours per day, 40 hours per week.
- Employers are required to calculate full-time equivalent (FTEq) based on monthly hours totals.
  - The calculation has a 12-month look-back period.

Description	Employer A	Employer B	Employer C
Service Hours (FTEe)	1,260	5,940	6,780
Monthly Calculation (Hours ÷ 130)	9.7	45.7	52.1
FTEq	9	45	52

Source: *http://www.irs.gov/pub/irs-drop/n-11-36.pdf.*

Coverage Decision



Employer Incentives and Penalties

Employers With 50 or Fewer Employees

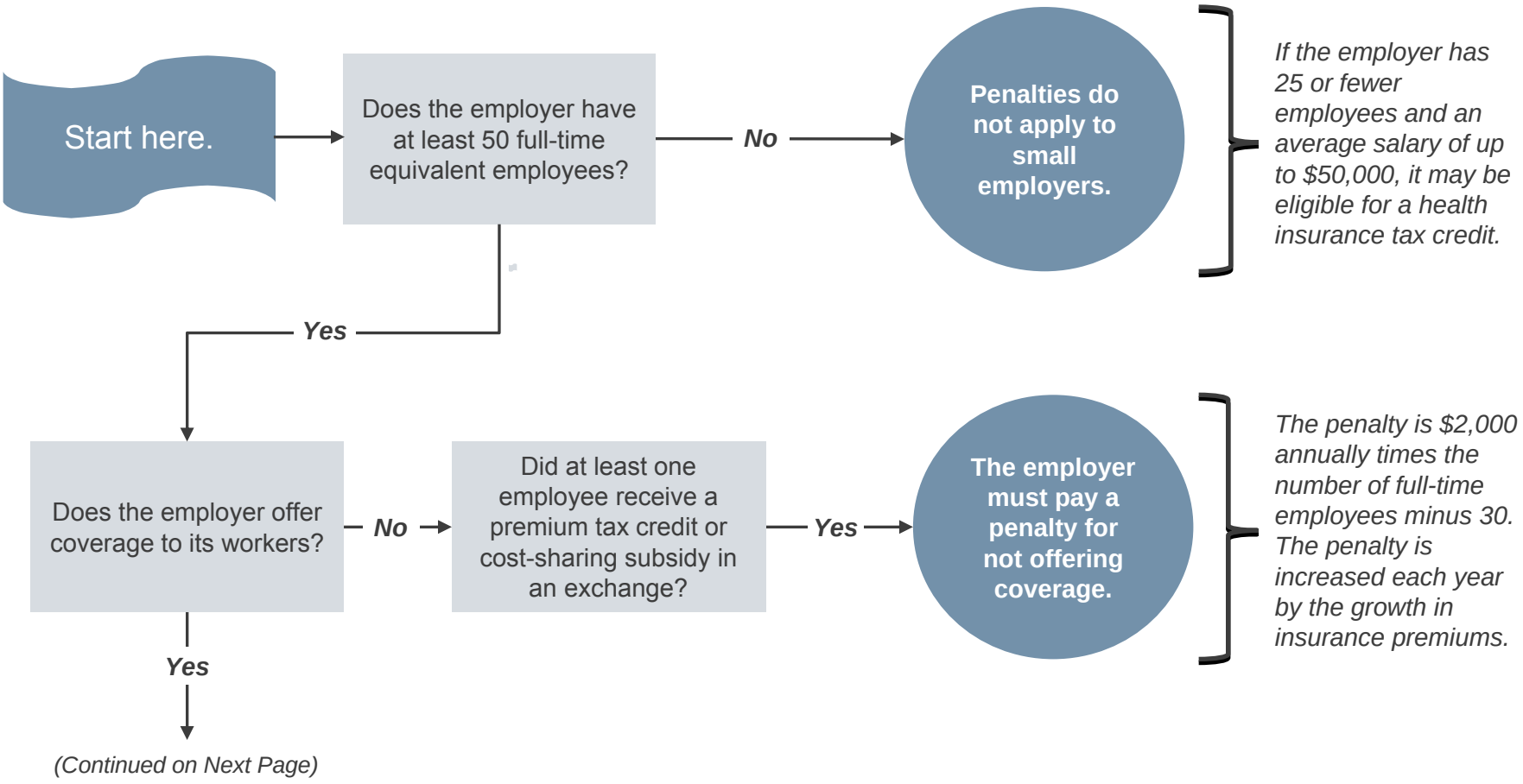
- There are no penalty fees.
- For employers with 25 or fewer full-time employees and average firm wages less than $50,000, these organizations can earn a tax credit of 35% of the cost of insurance in 2014; the credit increases to 50% in 2015.[1]

Employers With 51-Plus Employees

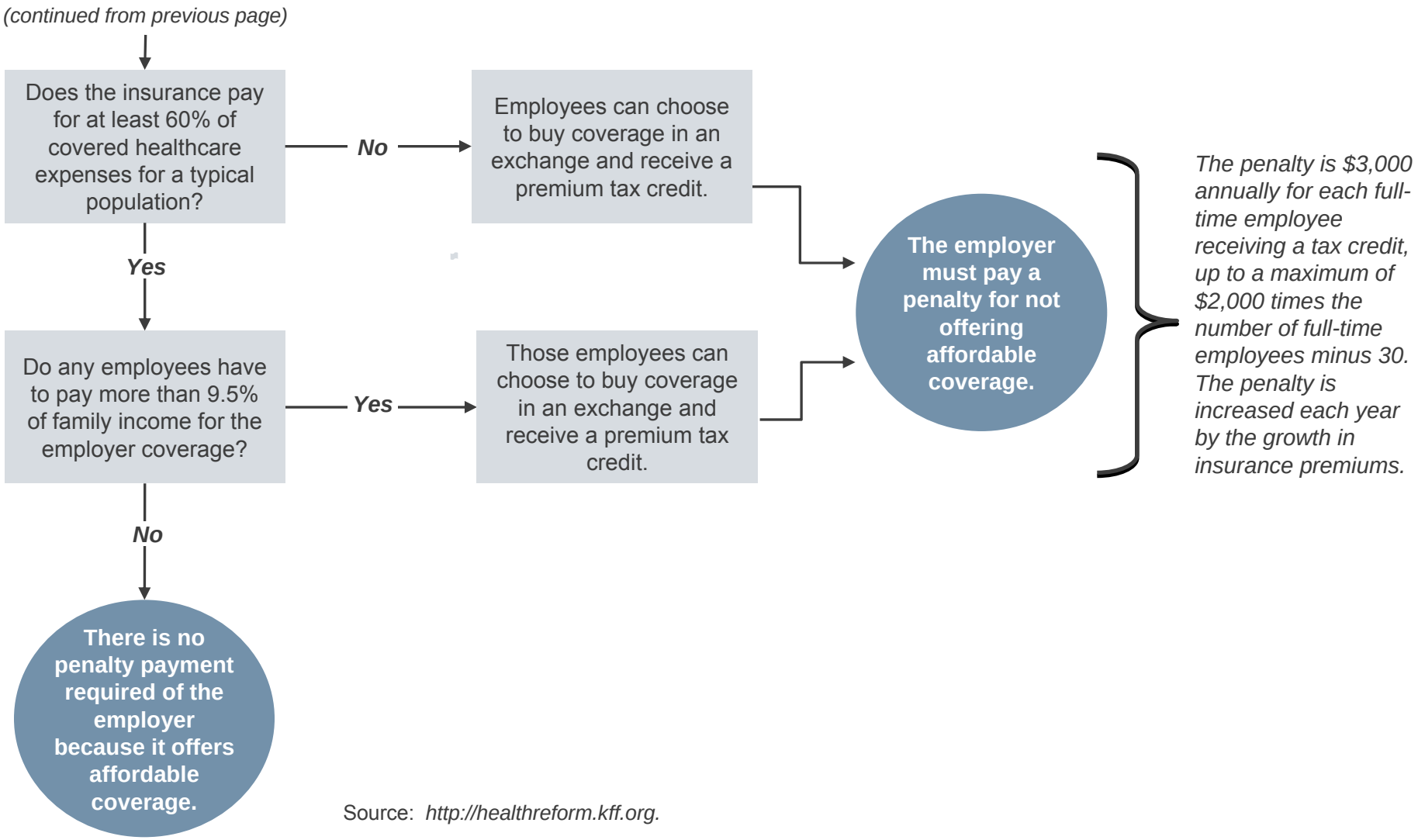
- These employers must offer a health insurance package for the employees that meets the federal EHBs (e.g., 60% actuarial value) and does not cost the employees more than 9.5% of their annual salary.
- If an employer does not offer an eligible plan, or at least one employee buys on the exchange with a tax premium subsidy, then the employer is subject to penalties.
- There are two methods for calculating the penalty.
  - *FTEe Premium Method* – The penalty will be $3,000 per employee that qualifies for subsidy.
  - *FTEe -30 Method* – If at least one person qualifies for a subsidy, then $2,000 × (FTEe – 30).
- For example, if an employer had 51 employees and did not offer coverage that met the requirements, the employer would have to pay penalty of up to $42,000 ($2,000 × 21) if this employer had an employee who qualified for a subsidy.

The following slides outline the penalties for individuals and employers that do not purchase coverage.

Penalties for Employers Not Offering Affordable Coverage



Penalties for Employers Not Offering Affordable Coverage *(continued)*



Source: *http://healthreform.kff.org.*

Employer Penalty Examples

Five example scenarios were created to demonstrate the impact of employer penalties.

No-Penalty Scenarios

	Scenario 1	Scenario 2	Scenario 3
FTEe	30	30	30
Part-Time Employees	10	50	50
FTEq (e.g., Part-Time Hours Divided by 130 Per Month)	5	25	25
Total Equivalents (FTEe + FTEq)	35	55	55
Number of FTEe Receiving Tax Credit	N/A	0	10
Employer Offers Qualifying Insurance	Either Yes or No	Either Yes or No	Either Yes or No
Penalty	No; Group Size Is Under 50	No; No FTEe Receive Tax Credit	No; FTEe ≤30

No penalty applies if any of the following are true:

- Total equivalents (FTEe + FTEq) are less than or equal to 50.
- No FTEe is receiving a premium tax credit.
- The number of FTEe are less than or equal to 30.

Employer Penalty Examples *(continued)*

Penalty Scenarios – Fewer FTEe With Premium Tax Credit

	Scenario 4	
	Employer Provides Qualifying Insurance[1]	
	Yes	No
FTEe	45	45
Part-Time Employees	50	50
FTEq	25	25
Total Equivalents (FTEe + FTEq)	70	70
Number of FTEe Receiving Premium Tax Credit	1	1
FTEe Subsidy Method	*$3,000 = $3,000 × 1*	N/A
FTEe – 30 Method	$30,000 = $2,000 × (45 – 30)	*$30,000 = $2,000 × (45 – 30)*

[1] Under the ACA, a plan is considered to provide adequate coverage (also called minimum value) if the plan's actuarial value (i.e., share of the total allowed costs that the plan is expected to cover) is at least 60%.

Employer Penalty Examples *(continued)*

Penalty Scenarios – More FTEe With Premium Tax Credit

	Scenario 5	
	Employer Provides Qualifying Insurance[1]	
	Yes	No
FTEe	45	45
Part-Time Employees	50	50
FTEq	25	25
Total Equivalents (FTEe + FTEq)	70	70
Number of FTEe Receiving Premium Tax Credit	12	12
FTEe Subsidy Method	$36,000 = $3,000 × 12	N/A
FTEe – 30 Method	*$30,000 = $2,000 × (45 – 30)*	*$30,000 = $2,000 × (45 – 30)*

[1] Under the ACA, a plan is considered to provide adequate coverage (also called minimum value) if the plan's actuarial value (i.e., share of the total allowed costs that the plan is expected to cover) is at least 60%.

Attachment C
Exchange Market and Outreach Information

Marketing Department Impact

Marketing will take on a larger role in the organization in preparation for health exchanges and other aspects of health reform.

Functional Shift	Move from promotional to educational.
Multidisciplinary	Media is much more interactive (with consumers/patients), requiring greater cross-function involvement.
Strategic Value	Develop a strategy to convey value and quality instead of simply drawing patients through convenience.
Tool Development	New skill sets and mindsets.
Stronger Voice	Increased prominence in the organization.

Adapted with permission from Trinity Health, Novi, Michigan, 2011.

Marketing Department Functions

Information Bank	Act as the integrator of information access and dissemination.
Regulatory Translator	Serve as the translator of medical jargon and relevant patient information.
Outreach Coordinator	Provide outreach as part of the communication strategy to ensure optimal effectiveness and appropriate focus.
Intelligence Gatherer	Conduct market reconnaissance on the interests and demands of the changing patient/consumer base.
Market Filter	Be the voice of market reason and business rationality in reviewing and determining the portfolio to highlight.

Adapted with permission from Trinity Health, Novi, Michigan, 2011.