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The Emerging Exchange Marketplace

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Agenda

The Emerging Exchange Marketplace

Challenges Ahead

Medicaid-Marketplace Convergence

Future of the Employer Mandate

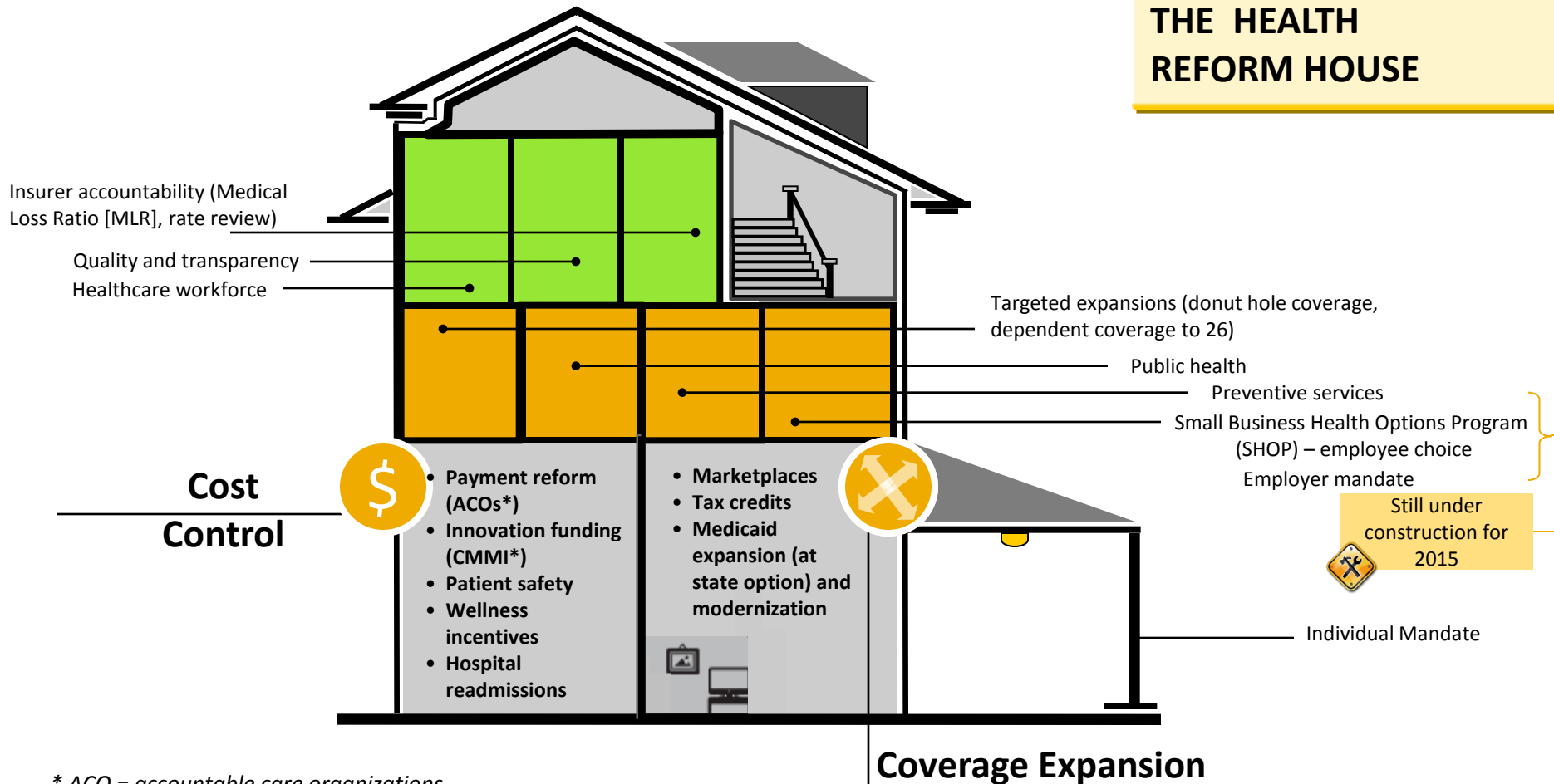
Consumer Experience

Broader Implications of Reform

The Emerging Exchange Marketplace

The Affordable Care Act (ACA) Is Complicated

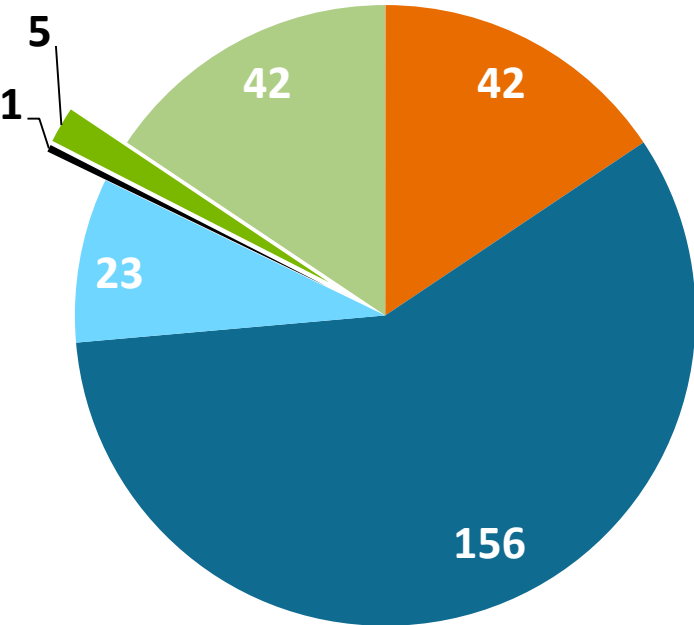
THE HEALTH REFORM HOUSE



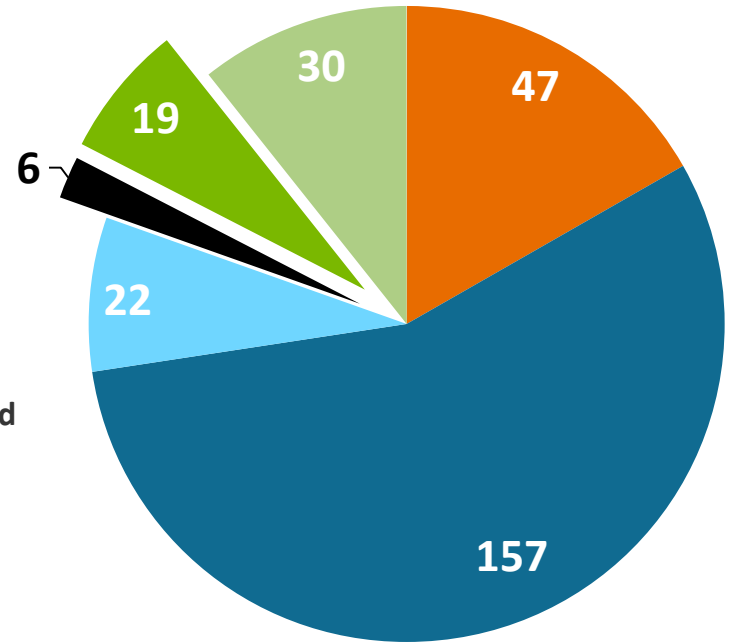
* ACO = accountable care organizations
 CMMI = Center for Medicare and Medicaid Innovation

Most Americans Will Remain in Employer Coverage

2014



2020



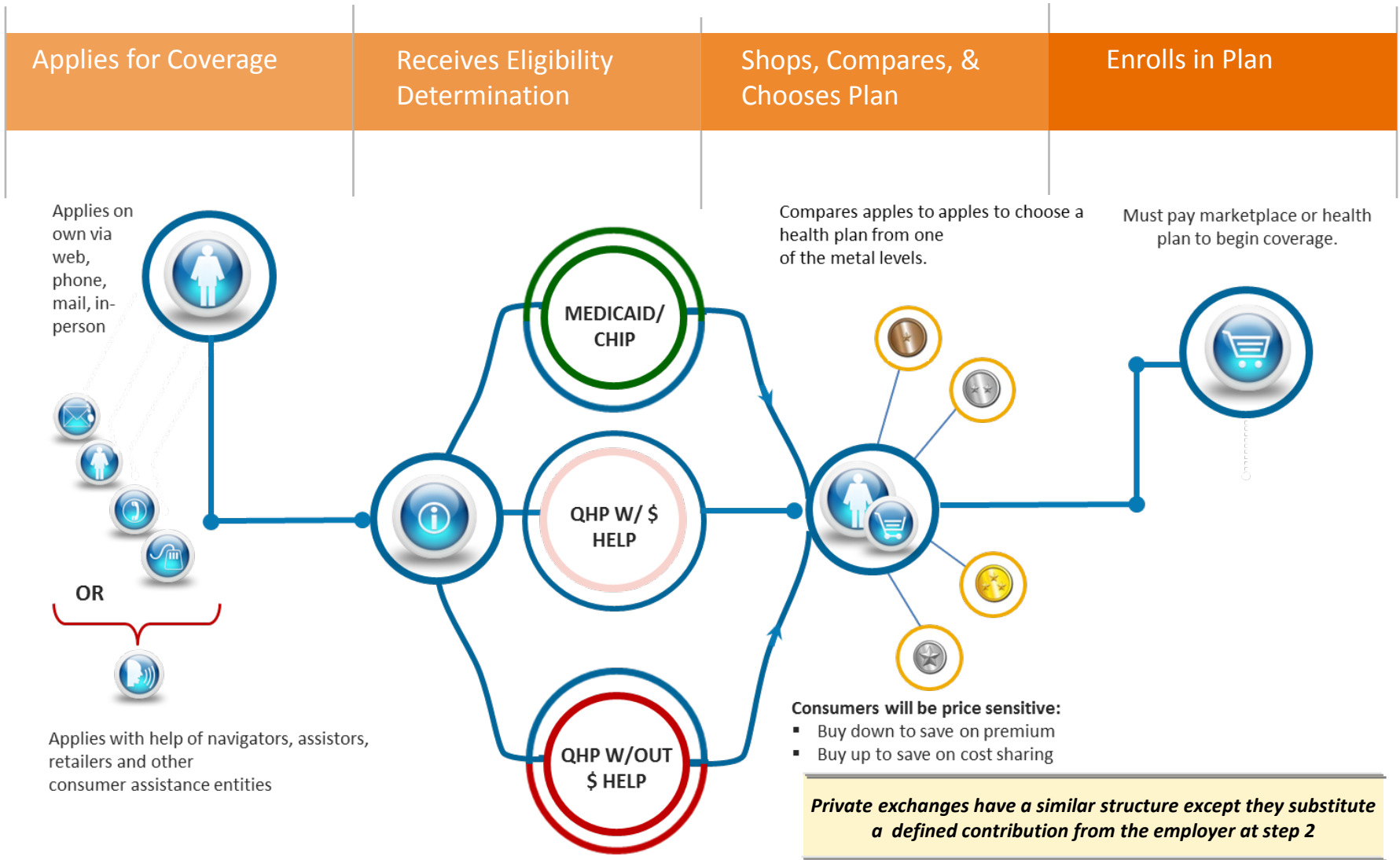
- Medicaid/CHIP
- Employer
- Non-Group/Other Individual
- Marketplace-Unsubsidized
- Marketplace-Subsidized
- Uninsured

227 million insured under age 65

251 million insured under age 65

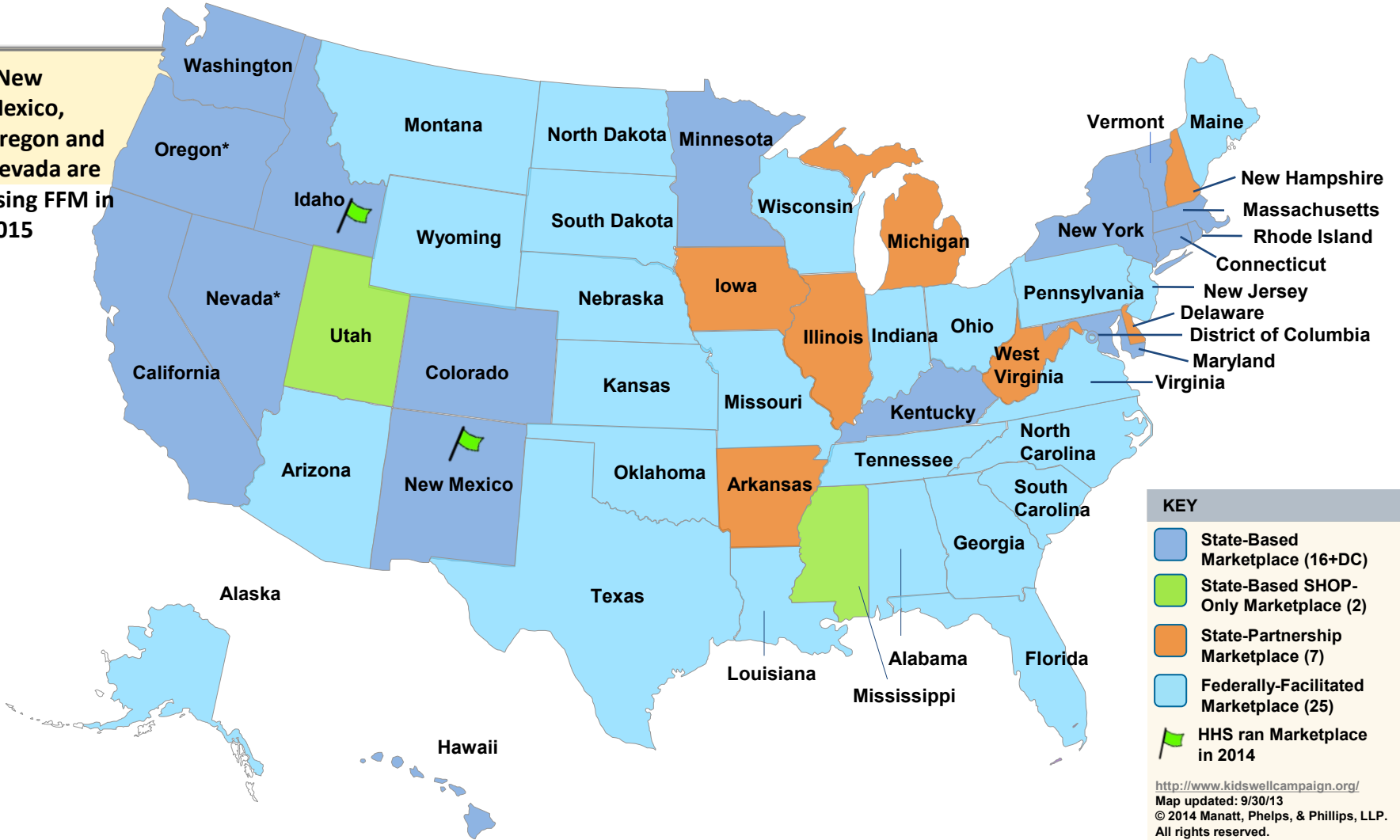
Congressional Budget Office estimates of current law, April 2014, http://www.cbo.gov/sites/default/files/cbofiles/attachments/45231-ACA_Estimates.pdf

Exchanges Will Change How Coverage Is Provided



FFM in 37 States in 2015

*New Mexico, Oregon and Nevada are using FFM in 2015



KEY

- State-Based Marketplace (16+DC)
- State-Based SHOP-Only Marketplace (2)
- State-Partnership Marketplace (7)
- Federally-Facilitated Marketplace (25)
- HHS ran Marketplace in 2014

<http://www.kidswellcampaign.org/>
Map updated: 9/30/13
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States Vary Widely in Their Marketplace Approaches

REGULATORY

MARKET-ORIENTED



Vermont

Intends to evolve its exchange toward a single payer



New York & California

Have standardized benefit plans beyond ACA minimums



Oregon

Intends to integrate its Marketplace and Medicaid strategies through comprehensive community care organizations



Maryland

Requires all carriers in individual and small group markets to participate in Marketplace



Massachusetts

Model for ACA but struggling to adapt, especially with small business and non-subsidized enrollment



Minnesota

Looking ahead to an innovation waiver to vary subsidies based on quality performance



Idaho & Nevada

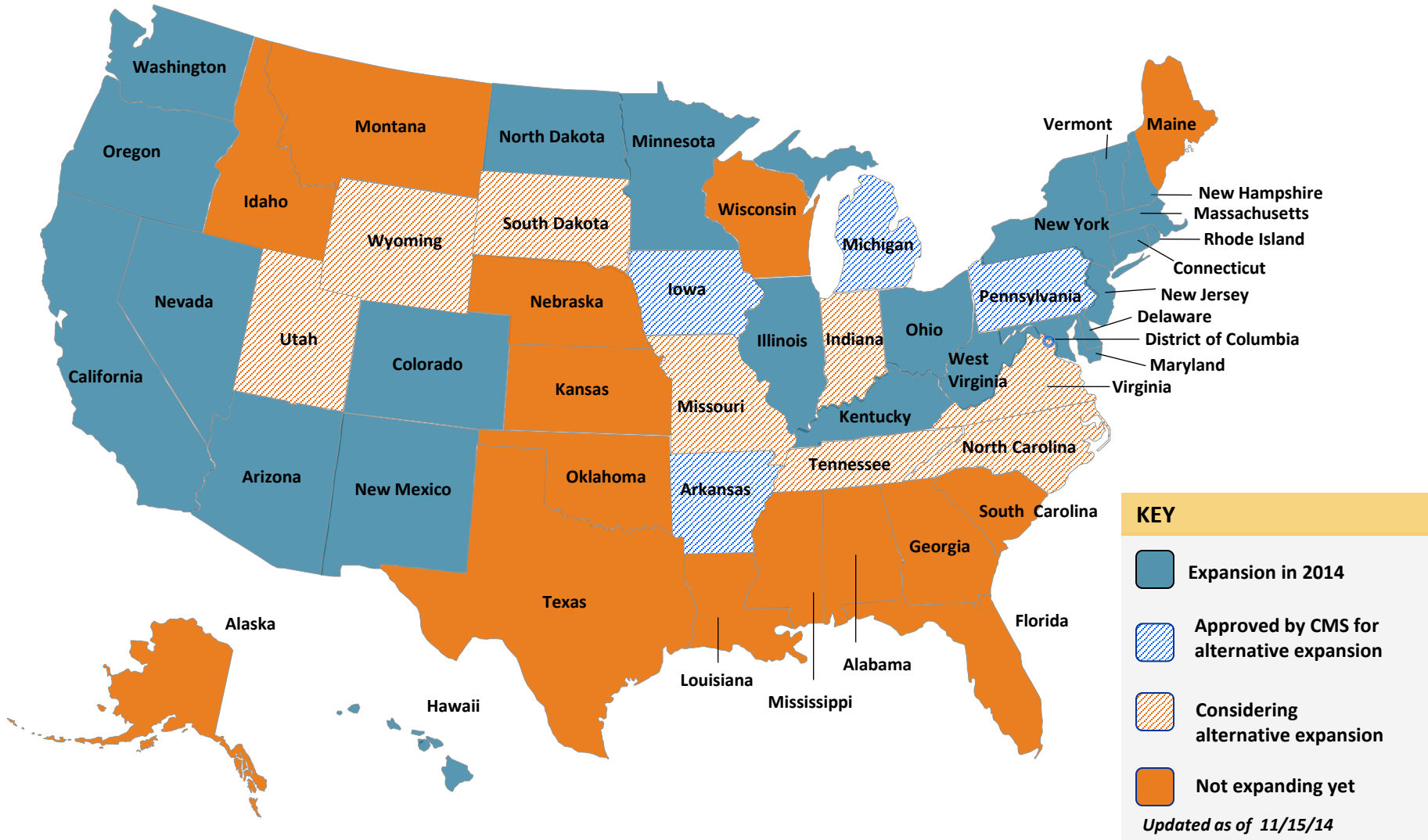
Operate clearinghouse Marketplaces with minimum regulation



Utah

Operates a SHOP Marketplace that it hopes to eventually privatize

Medicaid Expansion Continues with Alternative Approaches 9



Challenges Ahead

Status Report

- More than 8 million signed up in first open enrollment period with more than 7 million enrolled today
 - 85% chose silver or bronze, mostly silver (65%) to get cost sharing reductions
 - Surveys show significant drop in percentage of uninsured with much bigger gains in Medicaid expansion states
- Second open enrollment will be more challenging than first
 - HHS recently dialed back CBO projection of 13 million enrollees to 9-10 million, reflecting challenges of retaining enrollees in marketplace that has historically been highly volatile
 - FFM still building back end functionality and taking on more states
 - Auto renewal a work in progress and shifting prices will require most consumers to pay more unless they change
- More competitors in 2015 but prices vary widely
 - National carriers expanding, especially United and Cigna
 - Average price increases mostly in single digits but wide variations by region, and some pricing likely not sustainable (Preferred One in MN)
 - Transitional policies will hurt, but 3Rs will help

Expanded Federal Authority

- ACA continues pattern of federal expansion (new floor)
- But ACA preserves lead role of states in commercial market
- Balance of power will depend on state initiative, King could be game changer

Higher Cost Sharing

- ACA offers choice to consumers (platinum to bronze)
- But ACA promotes higher cost sharing plans (silver with cost sharing reductions)
- Higher cost sharing will drive transparency and cost reduction

Narrow/Value Networks

- ACA incents carriers to compete on networks
- Network competition will drive price and quality competition
- Transparency and choice will be key
- Regulator response will depend on consumer response

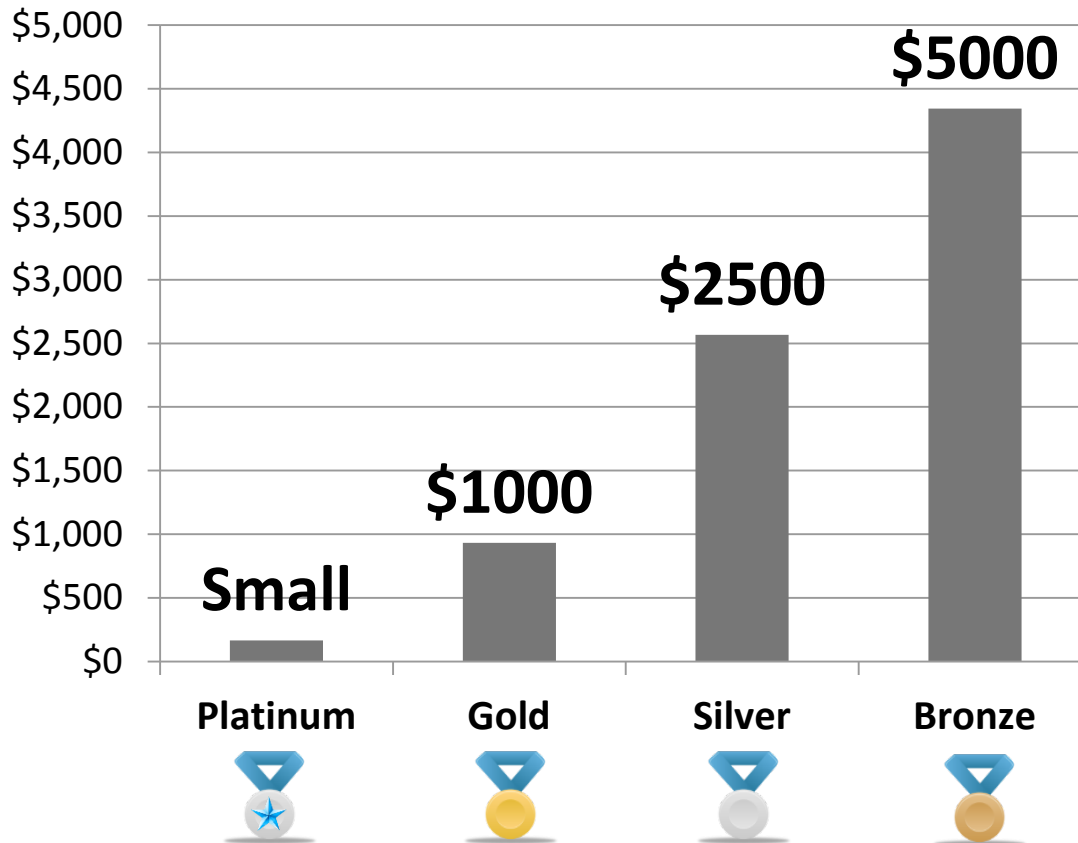
Federal and State Authority

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

- All but five states taking lead role on ACA enforcement



Deductibles by Metal Level



Cost-Sharing Challenges

- ACA incentivizes purchase of silver and bronze plans with tax credits pegged to silver.
- Low income consumers have favored silver over bronze with cost sharing reductions only available to those who purchase silver plans.
- Consumers generally underestimate their utilization, which creates issues during coverage year (caps will help).
- Long term trend toward higher cost sharing will accelerate in large employer market through private exchanges.

- ACA includes important limitations on consumer cost sharing obligations
 - Preventive services available on first dollar basis
 - No annual or lifetime limits (has been major source of bankruptcy)
 - Cap on in-network out-of-pocket expenses (\$6,450 and \$12,900 in 2015)
- Within those limitations, ACA allows higher cost sharing than is typical in group coverage
 - Bronze deductibles often over \$5,000 and silver often over \$2,500
 - Cost sharing reductions attracting those under 250% FPL to silver (65% share for silver)
 - Deductibles and coinsurance causing problems for hospitals and other providers
- Specialty drugs and drug formularies will be testing ground
 - 30% or higher coinsurance for specialty drugs creates access problems
 - More aggressive use of tiers and deductibles will get scrutiny (HIV drugs in FL)
 - Critics alleging benefit design discrimination in lawsuits and with regulators
- Two ways to maintain affordability are to restrict benefits or increase cost-sharing
 - Individual market has used both, but group market has mostly used cost sharing
 - Hard to see contraction in EHBs, so high cost sharing likely to remain

Universal Cost Sharing Continuum



- ACA requires premium contributions to gradually increase as income increases, starting at 2% of income at 138% FPL
- ACA has an analogous approach to cost sharing with gradual increases to 250% FPL for those who choose silver plan; large jumps for bronze plans (\$5000 deductible)
- Minnesota adopted Basic Health Plan to extend cost sharing protection to 200% FPL (also MA-style wrap)
- Arkansas and others using alternative expansions to increase cost sharing below 138% FPL and promote personal responsibility
- Challenge is finding best ways to smooth out cost sharing increases so the ramp up is more gradual as income increases, though balancing gradual ramp up with consumer choice will always involve trade offs

Debates Over Cost Sharing Will Continue



Questions will continue regarding what are “reasonable” levels of cost sharing, particularly as people churn between Medicaid and QHPs



Continued debate over personal responsibility and what impact cost sharing may have on effective utilization of health services, especially for low income population



High deductibles growing in popularity and fueling market for supplemental products, especially in the private exchanges serving employer-based market



Premium assistance may play a role for hospitals and others to cover cost sharing obligations; insurers concerned about misaligned incentives, adverse selection



Out of pocket limits will be critical check on cost sharing, but will be complicated by out-of network charges and new pricing strategies like reference pricing

- Insurers have been aggressive in limiting provider networks and defending the practice as necessary to achieve price points for Marketplace products
 - Quality control is second driver of narrow networks given challenges of managing quality in broad PPO networks
- State regulators have been engaged but careful in addressing network issues
 - WA Insurance Commissioner rejected five plans for Marketplace, but eventually allowed four of them with some adjustments and adopted new transparency-oriented regulations
 - Anthem excluded one third of NH hospitals from its network, resulting in proposed regulations that calibrate network adequacy standards by service type and geography
 - New York adopted regulations to protect consumers who use in-network hospital and end up with out-of-network charges for certain services
 - NAIC released draft model on Nov 15 that will be closely watched
- Federal regulators have been relatively cautious but are collecting data and did raise the floor for Essential Community Providers (ECPs) from 20% to 30% with exceptions
- Network adequacy will be key issue to watch on regulatory balance between federal government and states

- ACA sets standards for network adequacy and essential community providers (ECPs)
 - Sufficient network to ensure availability without unreasonable delay
 - More specific standards for low income providers (ECPs)
- States will be primary enforcers of network adequacy
 - Standards vary, some have strict time and distance standards
 - CMS playing a role with higher bar for ECPs and network adequacy reviews
 - CMS may play broader role in states not “substantially enforcing” law
- Pressure will grow on state and federal regulators to protect broad access
 - Insurers will have to be transparent and demonstrate that narrow networks are value-based
 - Insurers should be careful with reference pricing and other strategies that limit in-network access
- Narrow or “value” or “tiered” networks can be integral part of quality improvement strategies as well as a cost-saving strategy
- Many of highest performing networks on quality are Kaiser-like integrated delivery systems as exemplified with Medicare Advantage ratings and ACOs
- Ultimate resolution of network issues will turn on consumer preferences



- Inexorable movement from fee for service to risk-based payments (volume to value) will be amplified by Marketplaces
- More than 600 ACOs in various stages of formation, more on commercial than public side



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



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



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



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



- Marketplaces offer ideal market for testing narrow network products with consumers in Marketplaces where they are just one option among many

Medicaid – Marketplace Convergence

Woodwork Effect

- Exchange marketing campaigns and streamlined eligibility determinations are resulting in the enrollment of uninsured individuals eligible for Medicaid prior to 2014



- Basic Health Plan – MN, NY
- Wraps – MA
- Alternative Expansions – AR, IA, MI, PA
- Others Pending – IN, UT, NH

Options for Addressing Churn & Moving Towards Integration

Movement Between Medicaid and Marketplace

- A significant number of individuals whose income fluctuates will between Medicaid and the exchange, potentially causing lack of coverage and care continuity.



- Among a national sample of adults with family income <200% FPL, 35% would experience an eligibility change within six months, and 50% within one year. 24% would experience 2+ eligibility changes within a year

- There are gaps in coverage for those below 100% FPL in non-expansion states and eligibility hand-offs have proven challenging, particularly in FFM states

Gaps & Coordination Challenges

Market Segmentation Must Break Down for Expanded Coverage to Succeed

- Substantially different coverage rules cannot persist given coverage continuum and level of churn
- Major insurers are players in both markets (e.g., United, Wellpoint, Aetna, UPMC)
- Medicaid MCOs are largest category of new entrants in Marketplaces (e.g., Centene, Molina, Fidelis)
- Product differentiation will move to a continuum (already happening with private option)

Market Integration May Expand or Contract The Medicaid Model

- Some states will expand Exchange-like approach below 138% FPL (AR, IA, MI, and PA)
- Some states will expand Medicaid-like approach above 138% FPL (Basic Health Plan, MA wrap)

But All Models Will Force Market and Regulatory Convergence

- Reimbursement rates in new models will move to new equilibrium
- Regulators will find common ground in regulating same players across markets

Medicaid Premium Assistance in the Exchange: AR & IA

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	Arkansas	Iowa
Population	Includes all individuals in new adult group	New adult group with income between 100% - 138% FPL; individuals with income below 100% FPL are in traditional Medicaid
Premiums	No premium obligation	Premiums up to 2% of income in year 2 depending on whether enrollee engages in certain healthy behaviors
Cost-Sharing	Enrollees between 100-138% FPL will be subject to the same cost-sharing as QHP enrollees with incomes from 139% to 150% FPL, subject to Medicaid cost sharing limits	No cost-sharing obligations, with the exception of co-payments for non-emergent use of the emergency department
Benefits		Received one-year waiver on non-emergency transportation services

- Pennsylvania approved for 1115 waiver to increase “personal responsibility” for newly eligible through their Medicaid Managed Care (MMC) program
 - Not premium assistance for QHPs, so no 3R protections for carriers
 - Similar to Michigan approach
- Newly eligible have cost sharing obligations consistent with Medicaid law and those with incomes above 100% FPL owe premiums equal to 2% of income
- Can be dis-enrolled for three consecutive months of non-payment
 - Can reapply without a waiting period or repayment of back premiums
 - Individuals subject to premiums will be exempted from most cost sharing in 2016
 - Payment obligations can be reduced through healthy behaviors
- Carriers struggling to sign provider contracts for January 2015 launch
 - Questions about Medicaid vs hybrid rates
- Governor Wolf likely to watch carefully and avoid disruption

Future of Employer Mandate

Employer Mandate Has Minimal Coverage Impact

- Employer community has proven cautious about moving employees to public Marketplaces, especially with the growth of private exchanges as an option
- Small employers tending to self insure or drop coverage rather than move to SHOP
 - Wellpoint has lost 300,000 small group lives
 - GAO found 76,000 SHOP enrollments in SBM states in 2014 (33,000 in Vermont)
 - Outside market is typically a viable option with most states allowing renewal of pre-ACA plans
 - Employee choice remains controversial among carriers and difficult to implement
- Large employers continue to resist the employer mandate and related regulations
 - Urban Institute study shows minimal coverage impact if mandate is repealed
 - Drawing line between full time and part time workers may prove counterproductive
- Mandate already delayed until 2016 for medium-sized businesses (51-100)
 - Some states pushing to delay rate regulation for the 51-100 market as well
- Both political parties have compelling reasons for eliminating or at least delaying all or part of employer mandate

Private exchanges offer employers a middle ground between retaining full responsibility for health coverage and dumping employees into the individual Marketplaces

Public and Private Exchanges Will Reinforce Each Other

- Private exchanges have history with retirees (Extend Health) but key brokers and IT vendors have adroitly used the emergence of the public Marketplaces to ratchet up employer interest in private exchanges for current employees, including those not part of the group solution
- Employer surveys routinely find that 25% or more of the employer community has potential interest in private exchange solutions, though most are in the “look and see” stage and a few early movers have yet to provoke a stampede
- Accenture has predicted the private exchanges will surpass the public Marketplaces in enrollment by 2018
- If 25% of the employer market were to end up in private exchanges, that would be 40 million lives -- more than 100% of the number eligible for the public Marketplaces

- Private exchanges and public Marketplaces are likely to fuel a broader market trend from wholesale to retail sales of health insurance
- Employer-based coverage is a historical anomaly that may not hold if employees get comfortable with their individual choices in exchanges
- Cadillac tax already having impact that will grow as we approach 2018
 - After 2018, caps likely to grow more slowly than health care inflation
 - Congress may double down on Cadillac tax if and when it engages tax reform and looks at employer health tax deduction as largest tax expenditure
- If individual choice dynamics take hold, the case for tax parity between group and individual coverage will be strengthened
 - Individuals who like their plans will want to keep them as they transition between the individual and group market
 - The current group market is incompatible with portability of individual coverage
- Exchanges may prove to be a glide path to Wyden-Bennett

Consumer Experience

- Exchanges will fuel the competitive pressures driving toward greater transparency on costs and pricing across the Marketplace
- CMS will continue to open its data banks and researchers will have ready access to huge volumes of comparative data on cost and quality
- Consumers will increasingly expect easy product comparisons (pre-purchase) and real time information on the cost of services from various providers (post-purchase)
 - Vast majority of consumers will reach data overload quickly and look for trusted sources with instant solutions, few will do their own research
 - Entrepreneurs will offer Google-like search engines to match consumers with “best fit” products in five minutes or less
 - Public Marketplaces face more challenges with steering but can shape product mix
- Web brokers and private exchanges, including single insurer websites, will be ahead of the public Marketplaces on offering state of the art consumer experience
 - FFM will improve technology to support direct enrollment through carriers and web brokers and this functionality will spread to some SBMs as well
 - Opens door to making tax credits more broadly available outside public Marketplaces

Web Brokers and Carriers May Play Expanded Role

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- Web brokers have been selling health insurance on-line since eHealth opened for business in 1997
 - Similar mission to public Marketplaces: offering consumers a choice among multiple insurers, relying primarily on web sites and call centers for consumer assistance
- Carriers also well positioned to help Marketplaces with enrollment, particularly with renewals
- HHS has authorized Marketplaces to partner with carriers and web brokers to expand enrollment options through back office connections that meet security and consumer protection standards
- The FFM is actively partnering with carriers and web brokers to expand enrollment options and reduce burdens on the FFM
- SBMs could do the same thing to make enrollment easier and potentially expand enrollment numbers

eHealthInsurance®

- Founded in 1997
- Offers products from more than 180 insurance companies
- Has affinity relationships with over 1,000 businesses

GetInsured

- Founded in 2005
- Web-based platform supports over 70 carriers and 12,000 plans
- Operating as an IT vendor for several states including Idaho

GoHealth[®]

- Founded in 2002
- Online Exchange-Based
- Works with more than 20,000 brokers

Broader Implications of Reform

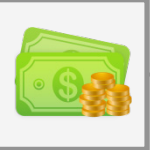


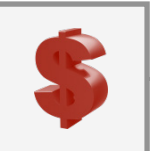
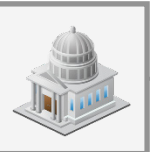

How Marketplaces Evolve Will Be a Litmus Test

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

Policy Implications of Regulatory and Market Approaches

- What limits should there be on insurer and provider consolidation?
- When does cost sharing impede care?
- Where is the right balance on network adequacy?
- What is role of government in evolution of ACOs and new care models?

Effective engagement will balance short and long term interests as regulatory vs. market dynamics play out through the next several election cycles at the state and federal level

	Reimbursement Rates	<ul style="list-style-type: none">• Market pressures will force Medicaid rates up and commercial rates down (new equilibrium will vary by state)
	Narrow Networks	<ul style="list-style-type: none">• Price competition in Marketplaces will drive insurers toward narrow network products• Market penetration will depend on consumer response
	Integrated Delivery Systems	<ul style="list-style-type: none">• Growing consensus towards emphasizing prevention, expanding primary care and coordinating care for high cost patients• Integrated delivery systems will tend to be narrower networks
	Payment Reform	<ul style="list-style-type: none">• Payment reform to reward quality outcomes not volume will drive more risk sharing by providers
	Regulatory Reform	<ul style="list-style-type: none">• Interagency coordination moving toward integrated regulatory framework
	Private Exchanges	<ul style="list-style-type: none">• Private exchanges will reinforce similar dynamics for those in employer-based coverage• Likely to cover more lives than public Marketplaces; may be more receptive to certain innovations



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About

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

Mr. Ario previously served as Director of the Office of Health Insurance Exchanges at the U.S. Department of Health & Human Services (HHS), where he worked closely with states

and other stakeholders in leading HHS efforts to develop the regulatory framework for exchanges, including the rights and responsibilities of the states in establishing exchanges and preserving their authority over the private insurance marketplace.

Prior to his federal service, Mr. Ario was Pennsylvania Insurance Commissioner from 2007 to 2010 and Oregon Insurance Commissioner from 2000 to 2007. He served on the Executive Committee of the National Association of Insurance Commissioners (NAIC) for a decade and was an NAIC officer from 2003 to 2005.



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About

With a health law background in both government and private practice, Mr. Kolber advises health insurers, pharmaceutical manufacturers, state and federal agencies, technology vendors, and others on implementation of health coverage issues, especially the Affordable Care Act (ACA), Medicare managed care, and employee benefits. He provides legal and policy advice, with particular focus on risk adjustment and related premium stabilization programs for health insurers under the ACA.

Prior to joining Manatt, Mr. Kolber was the lead legal adviser to the U.S. Department of Health and Human Services (HHS) on several key features of the ACA, including essential health benefits, health insurance exchanges, risk adjustment, and CO-OP loans. Now, health insurers,

actuarial consultants, state exchanges, technology vendors, physician specialty groups, and pharmaceutical physician specialty groups and pharmaceutical manufacturers turn to Mr. Kolber to advise them on complex legal and regulatory questions concerning health reform and advocate on their behalf in front of key federal decision makers.

Mr. Kolber advises Medicare Advantage organizations and Medicare prescription drug plan sponsors on compliance with federal regulations and guidance, including helping them design special needs plans and Medicare-Medicaid plans for the dual eligible population. He also counsels health insurers, third-party administrators, benefits consultants, employers, and others on the interaction of ERISA, the ACA, and other employee benefits laws.

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