

HEALTH INSURANCE EXCHANGES

Timely News and Strategies for Doing Business on Federal, State and Private Exchanges

Contents

- 3** Three HR Execs Detail Transition to Private Exchanges and Results
- 4** Ruling for King May Cause Carriers to Abandon Exchanges
- 5** Table: Average In-Network Deductibles Differ by Exchange Type
- 6** Can 1332 Waivers Counter a Decision in Favor of King?
- 7** New Governor Puts Cover Oregon Out of Its Misery
- 8** Most State-Based Exchanges Offer Special Enrollment Period
- 9** Federal Reg Tracker: Feb. 5 — March 10
- 10** Who Will Pick Up the Pieces if SCOTUS Rules Against HHS?

Life After King

In this issue, we look at how states, carriers, Congress and the administration might respond to a Supreme Court ruling against HHS. The American Academy of Actuaries suggests HHS let carriers submit alternate rates (p. 4). Several industry observers say the solution might be in an existing provision of the ACA (p. 5), and a March 11 panel at AHIP's policy conference debated on whether Congress could save the day (p. 12).

Managing Editor
Steve Davis
sdavis@aishealth.com

Executive Editor
Jill Brown

Special Enrollment Periods Can Add More Members, but Do They Add New Risk, Too?

The open-enrollment period for federally run public insurance exchanges concluded Feb. 15. It will reopen — in the form of a special enrollment period (SEP) — March 15. Most state-run exchanges have announced similar extensions (see story, p. 7). But industry observers warn that SEPs, without proper verification systems, could enable people to “game the system,” which could harm the risk pool for health plans.

On Feb. 20, CMS announced a SEP for individuals and families who were assessed a “shared responsibility” penalty for not having coverage in 2014. That gives millions of eligible uninsured a second shot to buy insurance and avoid a larger penalty for remaining uninsured in 2015. While enrollment will run from March 15 until April 30, many uninsured will be eligible to enroll through another SEP throughout the year if they have a qualifying event, such as the loss of employer-sponsored coverage, marriage or a baby.

The six-week, tax-themed SEP is available only to uninsured taxpayers who were subject to the tax penalty for 2014, which limits the potential for adverse selection compared to a simple extension of the regular open-enrollment period, explains Lisa Campbell, a principal at Groom Law Group in Washington, D.C. She recently left her position as group director of the Consumer Support Group within CMS’s Center for Consumer Information and Insurance Oversight (CCIIO). She tells *HEX* that the SEP is “fairly narrowly crafted” to minimize adverse risk.

continued on p. 11

Private Exchanges: When Will Employer Adoption Catch Up to the Industry Buzz?

Last June, technology firm Accenture predicted 9 million people would select benefits through private health insurance exchanges in 2015 — triple the number in 2014 — and 40 million would participate by 2018. Despite a sustained buzz around private exchanges over the past few years, employer adoption is lower than expected. Industry observers, however, remain optimistic that participation will continue to increase among employers.

“The predictions were overly ambitious,” says Paul Fronstin, Ph.D., director of the Employee Benefit Research Institute’s (EBRI) Health Research & Education Program. EBRI estimates just shy of 3 million active employees participate in multi-carrier exchanges offered by the “big four” — Mercer, Towers Watson, Aon Hewitt and Buck Consultants. Another 3 million collectively enrolled in coverage through other private exchanges.

One explanation for the slow take-up rate could be the improving job market. Five years ago, unemployment topped 10% and some employers eyed private exchanges and defined contribution as a way to stabilize coverage costs. Now that unemployment has dropped to 5.5%, employers are leery of any change that could impact their ability to attract and retain workers, Fronstin says.

More than 70% of employers are taking a wait-and-see approach when it comes to private exchanges, and just 8% plan to join in 2015 or 2016, versus 16% of employ-

ers expressing no interest in this strategy, according to a March 2 research note from Christine Arnold, an equities analyst at Cowen & Co. Interest among small employers, however, is growing — to 32% this year versus 15% last year — while large employer interest is stable at around 25%, she wrote.

During recent conference calls to discuss earnings, CEOs from Aetna Inc. and Anthem, Inc. noted limited interest in multi-carrier private insurance exchanges among large employers (*HEX 2/15*, p. 9).

Large employers are likely waiting to see how private exchanges — and sustainable cost growth — play out beyond the initial years “where rate guarantees and vying for market share may mean lower premiums,” says Steve Wojcik, vice president of public policy for the National Business Group on Health. “I think they are also looking to see whether the exchanges use their growing leverage to improve network performance, which they are starting to see in some exchanges.”

Fronstin notes that employers historically have been slow to embrace new trends in employee benefits. More than a decade after health savings accounts (HSAs) became available, just 20% of employees have one. In 2004, however, Mercer suggested that 74% of large employers would offer HSA-based plans by 2006, Fronstin says. “It has materialized; it just took longer than initially ex-

pected,” he says. “So why should private exchanges be any different?”

Although adoption of private exchanges has been slower than anticipated, interest remains high, notes Barbara Gniewek, a principal in PwC’s Human Resource Services health care practice. “With the initial reports of savings being very favorable, and the experience by both employers and employees being viewed as positive, adoption will begin to accelerate,” she says.

Large employers, she tells *HEX*, understand that the private exchange market offerings are diverse, and they are taking time to evaluate the options to see which one best meets their needs and/or is in line with their strategic objectives. “We are seeing a lot of interest in employers using an independent evaluator to help them assess the market. This process is taking longer than simply converting to an exchange,” she says. And early adopters are warning employers to spend more than six months to roll out a private exchange, she adds (see story, p. 3). To be ready for the 2016 plan year, employers will need to finalize plans by April or May.

But Gniewek says there could be a “piling on” effect if competitors are successful in switching to a private exchange. Nearly half of employers have implemented or intend to implement a private exchange for full-time active employees before 2018, according to a 2014 survey of 446 employers conducted by the Private Exchange Evaluation Collaborative, an initiative launched by PwC and four non-profit business coalitions — Employers Health Coalition, Inc. (Ohio), Midwest Business Group on Health, Northeast Business Group on Health and Pacific Business Group on Health. But 57% of employers said they’d be more inclined to consider a private exchange if a peer switched to one.

Cadillac Tax May Drive Some to Exchanges

Arnold predicts that the so-called Cadillac tax on rich employee benefits, which is slated to go into effect in 2018 as part of the Affordable Care Act, could propel private exchange momentum.

About 40% of large employers would trigger the penalty, according to an employer survey released March 5 by Towers Watson. Gniewek agrees that the Cadillac tax is driving interest in exchanges. Employers can use the tax as an excuse to change the way they provide benefits, she tells *HEX*. Fronstin says the Cadillac tax could be a “game changer.”

Wojcik agrees that the Cadillac tax could spur some movement in 2018 and beyond, “but it doesn’t necessarily immunize employers from the tax if the exchanges are unsuccessful in keeping trend below [the consumer price index],” he notes.

Inside Health Insurance Exchanges (ISSN: 2161-1521) is published 12 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 800-521-4323, www.AISHealth.com.

Copyright © 2015 by Atlantic Information Services, Inc. All rights reserved. On an occasional basis, it is okay to copy, fax or email an article or two from *HEX*. But unless you have AIS’s permission, it violates federal law to make copies of, fax or email an entire issue, share your AISHealth.com subscriber password, or post newsletter content on any website or network. To obtain our quick permission to transmit or make a few copies, or post a few stories of *HEX* at no charge, please contact Eric Reckner (800-521-4323, ext. 3042, or ereckner@aishealth.com). Contact Bailey Sterrett (800-521-4323, ext. 3034, or bsterrett@aishealth.com) if you’d like to review our very reasonable rates for bulk or site licenses that will permit monthly redistributions of entire issues. Contact Customer Service at 800-521-4323 or customerserv@aishealth.com.

Inside Health Insurance Exchanges is published with the understanding that the publisher is not engaged in rendering legal, accounting or other professional services. If legal advice or other expert assistance is required, the services of a competent professional person should be sought.

Managing Editor, Steve Davis; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Director, Andrea Gudeon.

Subscriptions to *HEX* include free electronic delivery in addition to the print copy, weekly e-Alerts, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *HEX* content and archives of past issues.

To order an annual subscription to **Inside Health Insurance Exchanges** (\$497 bill me; \$467 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

More than 25% of the 444 employer representatives surveyed for the Towers Watson report say they have “extensively analyzed private exchanges,” and 20% say they are more interested in adopting a private exchange today than they were a year ago. Employers that have completed extensive analysis of private exchanges — versus companies that have not — are twice as likely to find private exchanges a viable alternative in 2016, according to the report.

The Towers Watson study also found that the vast majority of U.S. employers (84%) expect to make changes to their full-time employee health benefit programs over the next three years, despite cost increases remaining at historically low levels.

Contact Fronstin at fronstin@ebri.org, Gniewek at barbara.p.gniewek@us.pwc.com and Wojcik at wojcik@businessgrouphealth.org. ✧

Three HR Execs Detail Transition To Private Exchanges and Results

Last fall, employees at AMN Healthcare selected health insurance plans and voluntary benefits through RightOpt, a multi-carrier private insurance exchange from Buck Consultants, a Xerox company. Employees, however, have no idea they are now part of an insurance

exchange, said Lisa Larson, senior director of human resources operations at AMN Healthcare, a San Diego-based medical and physician staffing company that has 2,000 employees and 6,000 clinicians nationally.

“It was critical to us that [employees] continued to see the benefits team as an extension of AMN Healthcare,” she said. She added that she was able to customize the language call center operators use so that employees see the call center, which is operated by Buck, as an extension of the HR office as well.

Larson is one of three employee benefits executives who described the transition to a multi-carrier private exchange during a March 4 panel discussion at the National Business Group on Health Business Health Agenda conference in Washington, D.C.

Cost pressure and the need to remain competitive with other staffing firms were the main motivators for moving to an exchange. Overall, she said success with the exchange has been “pretty significant.” Claims savings on a per-member basis is 3.74%, the result of improved benefit design rather than just cost-shifting to employees.

With the help of a third-party administrator, AMN issued a request for proposals in February 2014. After initially meeting with four private insurance exchange

Health Insurance Benefit Design 2016: Insurer Strategies for Large Groups

- What are the most pressing needs large-group purchasers have today ... and which 2016 benefit designs are likely to meet these concerns most effectively?
- How will health plans play the increasingly popular private exchange option in the large-group market? Is defined contribution leading this trend?
- Every conceivable wellness strategy is being explored to curb medical utilization, build company morale and reduce long-term chronic care costs. Which are likely to be most popular in 2016...under what circumstances?
- To what extent will employers be using specific bundles of care and centers of excellence to steer employees to the lowest-cost, highest-value settings for conditions?
- How much cost sharing is too much? What measurements will employers use to determine when additional costs in the form of deductibles and copayments are warranted?
- Which of the above strategies are likely to be most attractive to (and effective for) employers in which industry sectors?

Join **Erich Blumberg** and **Kelly King** of Lockton Dunning Benefits Co., and **Todd Van Tol** of Oliver Wyman for a **March 24 Webinar**.

Visit www.AISHealth.com/webinars or call 800-521-4323

operators, Larson said the choice was whittled down to two finalists.

"We made site visits, ... visited the call centers and we talked to the people we would be working with each day at each site. We really got to see how they would work for us and how they work together," she told attendees. In June, AMN selected RightOpt and kicked off open enrollment just 26 weeks later.

After two months with the exchange, Larson said 96% of employees say they are satisfied with customer service. About 90% of employees enrolled online and

the others used the call center. About 10% of corporate employees and 18% of clinicians enrolled in voluntary benefits, such as hospital indemnity and critical illness policies.

Hilton Checks in With Cost Savings

Prior to moving to Aon Hewitt's fully insured exchange model, Hilton Worldwide offered primarily self-insured coverage from two carriers to its 40,000 insurance eligible U.S. employees. Ted Nelson, vice president of benefits for the Americas, said he was highly

Ruling for King May Cause Carriers to Abandon Exchanges

Insurance carriers have until May 15 to submit proposed rates for the qualified health plans (QHPs) they intend to sell on public exchanges next fall. But in states that have a federally facilitated exchange (FFE), those rates will be irrelevant if the Supreme Court rules against HHS in *King v. Burwell* in June. If the advance premium tax credits (APTCs) stop flowing to health plans, carriers will need to revise their rates to reflect a likely older and sicker risk pool. If that's not allowed, carriers could pull out of exchanges in those states.

In a Feb. 24 letter to HHS Sec. Sylvia Burwell, the American Academy of Actuaries outlines two options that would help ensure solvency for carriers if the high court strikes down the availability of subsidies in the federal marketplaces. Carriers should either be allowed to revise their rates after the court's decision in late June, or they should be allowed to submit two sets of "contingent" rates this spring, according to the Academy.

The proposals don't factor in FFE states that transition to a state-based platform or anything that the administration or Congress does to restore subsidies to the affected states, cautions Cori Uccello, the senior health fellow at the Academy. Some Republican lawmakers have floated the idea of a temporary extension of the APTCs through HealthCare.gov.

"Absent those things [to restore the APTCs], there would be a massive disruption in states.... You'd have lots of people dropping coverage and the average cost [of insurance] for those remaining people would go up significantly," she says. "And carriers can't just automatically increase their rates to reflect the new normal."

How much might rates rise in states where APTCs become unavailable? Individuals with subsi-

dized coverage in affected states could see their out-of-pocket premium rates jump an average of 255%, according to a recent analysis from Avalere Health LLC. In 2016, The Urban Institute estimates that about 9.3 million people — out of 14.2 million enrollees in those states — would lose subsidies, about half of whom have incomes that are less than 200% of the federal poverty level (\$23,340 for an individual). The value of the lost tax credits and cost-sharing reductions is about \$28.8 billion in 2016, according to a brief published by the think tank in January.

Average premiums in the non-group insurance market, both inside and outside of exchanges, would increase an estimated 35%, "affecting not just marketplace enrollees but those purchasing outside the marketplaces as well," according to the brief. RAND Corp. pegs the likely premium increase at nearly 45% and predicts enrollment in FFEs will plummet by 70%, leaving behind a far older and sicker risk pool.

Carriers have until August to withdraw from the exchanges. If carriers are unable to adjust their rates to reflect the new risk pool, many are likely to leave the exchanges in FFE states. Uccello says that would make the disruption even more severe.

"As a profession, we are concerned with solvency issues and look for ways to revise the rate filing process to enable carriers to file rate revisions or submit new rates that are adequate," she explains. "The problem is that if the court rules at the end of June, it won't be immediately clear what Congress or the states are going to do in response."

See the Academy's letter at <http://tinyurl.com/mhdvz98>. See the RAND paper at <http://tinyurl.com/nroltjb>. See the Urban Institute paper at <http://tinyurl.com/lcwe5tl>.

Contact Uccello at Uccello@actuary.org.

skeptical that a private exchange could reduce benefits costs.

“We had already pulled many of the cost-saving levers that were available, such as closed provider networks, closed formulary drug plans,” he said. “I feared there would be a lack of transparency and shell games.” He told attendees that he was impressed with the lengths Aon Hewitt went to ensure all participating carriers played by the same rules. The model requires that any plan offered on the exchange comply with 180 plan-design elements. Aetna Inc., Anthem, Inc., UnitedHealth Group, Blue Cross and Blue Shield plans, Kaiser Permanente and Health Net, Inc. offer coverage through the exchange.

Hilton was facing an 8% increase in health benefits and another 4% hike related to provisions of the ACA. In the first year of the exchange, benefit costs decreased 1% — the first year he recalls rates going down without cutting back on designs and subsidies. “It worked despite my skepticism,” he said. Aon Hewitt, the first benefits consulting firm to launch a multi-carrier exchange, said it has 33 large employer clients representing about 850,000 lives and 30 participating carriers. The company beta-tested its exchange in 2012 (*HEX 10/12, p. 1*).

“We are trying to create accountability where there hasn’t been accountability before, and competition in a marketplace that historically has not been very competitive,” explained Ken Sperling, National Health Exchange Strategy Leader at Aon Hewitt, who spoke at the session.

Costs Savings Beat Expectations

Convergys Corp., a customer management firm with 33,000 U.S. employees and 125,000 worldwide, went live with Towers Watson’s OneExchange for full-time and active employees in January 2014. Previously, the company offered three comprehensive health plans and three limited medical coverage or mini-med plans. But there was virtually no variation between plans in the two tiers, explained Dennis Hicks, vice president of compensation and benefits.

In 2013, just 36% of the population had medical coverage through the company and 22% of them were enrolled in limited mini-med plans. The company decided to move to a fully insured exchange model because the health risk of employees who might enroll was unknown.

Through the exchange, employees can choose plans in four metal tiers offered by UnitedHealth, Anthem, Aetna, Cigna Corp. and Kaiser Permanente. Nearly half

Average In-Network Deductibles Differ by Exchange Type

Average cost-share amounts for prescription drugs do not vary drastically for plans offered on federally facilitated (FFEs) vs. state-based exchanges (SBEs). But overall and separate pharmacy deductibles for plans on SBEs can be several hundreds of dollars lower than FFEs and state-federal partnership exchanges, depending on the metal tier, according to data compiled by AIS. Platinum plan deductibles for plans on state-sponsored exchanges average less than half that of their FFE counterparts. And specialty drug copays are half the cost, on average, for plans on state-sponsored exchanges compared with those on FFEs.

				Average Rx Cost Share at In-Network Retail Pharmacy							
Exchange Type	Metal Level	Overall Deductible	Rx Deductible	Generic		Preferred Brand		Non-preferred Brand		Specialty	
				Copay	Coin.	Copay	Coin.	Copay	Coin.	Copay	Coin.
FFE	Catastrophic	\$6,575.14		\$0.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%
Partnership		\$6,600.00			0%		0%		0%		0%
State-Sponsored		\$6,577.52		\$5.00	0%	\$0.00	0%	\$0.00	0%	\$0.00	0%
FFE	Bronze	\$5,176.93	\$866.67	\$18.59	16%	\$60.95	18%	\$103.46	21%	\$150.61	24%
Partnership		\$5,285.14	\$968.75	\$20.40	19%	\$65.00	22%	\$119.49	25%	\$170.00	29%
State-Sponsored		\$4,492.59	\$514.00	\$14.83	22%	\$50.23	26%	\$79.40	33%	\$82.33	32%
FFE	Silver	\$2,833.89	\$637.77	\$11.47	18%	\$45.86	22%	\$84.39	26%	\$166.47	29%
Partnership		\$3,308.42	\$875.00	\$9.00	11%	\$47.99	14%	\$95.27	23%	\$165.55	28%
State-Sponsored		\$2,376.58	\$475.34	\$10.97	18%	\$42.90	25%	\$75.84	34%	\$89.76	32%
FFE	Gold	\$1,335.65	\$333.62	\$8.63	11%	\$35.56	14%	\$70.22	22%	\$143.37	26%
Partnership		\$1,547.97	\$483.87	\$6.32	8%	\$36.20	9%	\$78.83	17%	\$144.00	26%
State-Sponsored		\$956.63	\$247.24	\$8.85	15%	\$36.75	23%	\$68.64	35%	\$91.21	31%
FFE	Platinum	\$368.05	\$375.00	\$6.90	18%	\$28.69	19%	\$56.77	32%	\$114.95	28%
Partnership		\$305.00	\$325.00	\$4.23		\$28.33		\$62.25	31%	\$50.00	24%
State-Sponsored		\$141.81	\$150.00	\$7.98	15%	\$28.72	19%	\$54.42	38%	\$52.53	27%

SOURCE/METHODOLOGY: Calculated from data in RxB, AIS’s new online subscription database of drug benefit design parameters. Coin = Coinsurance. Visit <http://aishealthdata.com/dashboard/rxb/demo> to access a free interactive demo, or visit <http://aishealthdata.com/rxb> for more information.

of employees (49%) chose an option from UnitedHealth, which was the company's previous carrier. Benefits costs for 2014 came in 8% below projection, and benefit costs for 2015 increased just 1.7%, he told attendees.

Jean Moore, managing director of OneExchange, who spoke at the session, said the trend for the exchange needs to be at or near the consumer price index. The trend is now at 1.8% trend across the exchange product, substantially lower than the average 4% rate employers experience after a plan-design change. Moreover, employers are saving an average of \$1,400 per employee per year, which is \$500 more than Towers Watson had predicted.

Contact Sperling at ken.sperling.2@aonhewitt.com, Melanie Meharchand for Moore at melanie.meharchand@towerswatson.com and Sherri Bockhorst for Buck at Sherri.Bockhorst@xerox.com. ♦

Can 1332 Waivers Counter A Decision in Favor of King?

Republican lawmakers have introduced a flurry of bills to ease concern about the impact of a Supreme Court decision against HHS in *King v. Burwell*. If the court rules in favor of King, federal premium subsidies will be restricted to states that run their own exchanges.

But some industry observers say such legislation might not be needed. Sec. 1332 of the Affordable Care Act (ACA) could let states come up with their own solutions. Although 1332 waivers wouldn't be allowed until 2017, Republican lawmakers could introduce legislation to make them available sooner. Or states might pressure HHS to allow earlier implementation (*HEX 2/15, p. 5*). But any changes would need to ensure that the same number of people have access to affordable health care. The provision gives states the ability to waive most major elements of the ACA — from employer and individual mandates to the exchanges themselves — as long as the same number of people has access to affordable health coverage. To fund the changes, states can receive the aggregate amount of premium tax credits, cost-sharing reductions and small business tax credits that would have otherwise gone to the state's residents, explains a Dec. 4 *Health Affairs* article. Depending on the size of the state, those federal dollars could reach the hundreds of millions or even billions of dollars.

Through a waiver, federal funding of advance premium tax credits could be pooled with federal dollars for other state health programs such as Medicaid and Children's Health Insurance Programs (CHIP), suggests Dennis Smith, a managing director at the Washington, D.C., law firm McKenna, Long & Aldridge. And that could create new opportunities for health insurance carri-

ers if they can design products that would work with any consumer regardless of income or employment. Families that now are covered by a combination of employer-based and government-funded insurance could all have similar coverage through such a "mega waiver," he explains.

"This is the first time states will be allowed to combine those funding streams. How do we attract the young and healthy? Everyone wanted them in the exchange pool. Well, there are 35 million young and healthy lives in Medicaid and CHIP. Don't you want those lives in the pool with everyone else? What would that do to premiums?" he asks. Combining revenue streams also would mitigate churn as fluctuating income levels push people into and out of Medicaid, he explains.

Subsidies May Be Paired With Medicaid

Joel Ario, managing director at Manatt Health Solutions, agrees and says Medicaid is seen as a cost driver in the budget. To reduce costs, state officials might look to the waivers to make existing programs more efficient, such as by aligning payers. If the Supreme Court sides with the plaintiffs in June, "there will be a lot of interest in 1332," he predicts. "There are many roads that intersect with 1332 waivers." Ario was the first director of CMS's Office of Health Insurance Exchanges.

Using a 1332 waiver, a state might be granted permission to eliminate individual and/or employer coverage mandates; reconfigure the way advance premium tax credits are distributed; and expand, streamline or even eliminate the exchanges, Ario says. "Most key elements of the ACA are open to change under a 1332 waiver." Instead of having a state-based exchange, a state might instead look to an eligibility process where consumers are given a voucher for tax credits based on their income. They could then use the tax credit to buy coverage directly from an insurance carrier. Electronic tools would be available to help them compare plans and shop for coverage, he says.

And with federal grant funding drying up for state-based exchanges, 1332 waivers could be used to reduce some of the administrative costs of an exchange and ensure long-term sustainability, suggests Cindy Gillespie, a senior managing director at McKenna. States running their own exchanges are struggling with, or will soon be struggling with, ensuring long-term sustainability. One idea might be to allow a private exchange to take over some of the operational functions.

Flexibility May Be Limited

While the provision offers flexibility, any changes must also keep several key elements of the health reform law intact. And that could make potential changes very difficult. "I just don't see it," says Christopher Conde-

luci, a principal at CC Law & Policy in Washington, D.C. While 1332 grants states the flexibility to experiment, the end result needs to replicate the requirements of the ACA. A state, for example, could opt to waive the ACA's exchange requirement, but the state would still need to abide by Sec. 1311 of the law, which defines the functions that an insurance exchange must perform. "To me, it's almost like the requirements to get the waiver swallow the benefit of getting the waiver. You would just be replicating ACA requirements," he says. Condeluci worked for the Senate Finance Committee during the crafting of the health reform bill.

Change Must Emulate ACA

Ario agrees that any change proposed by a state would need to meet the basic requirements of the ACA. "There are four very important guardrails and three of them relate to coverage remaining as comprehensive and as affordable as it is under the ACA," he explains. And determining whether coverage is affordable could be a challenge.

Consider this: Suppose a state introduces a low-premium, high-deductible Copper plan. While premiums for those plans are lower than Bronze-level plans, the high out-of-pocket costs would make medical care unaffordable to some enrollees. But if such a plan attracted a

large number of young and healthy members, it would have a positive impact on the overall risk pool.

Gillespie contends the provision is "extraordinarily broad" and says the bar for meeting statutory approval is relatively low. And Gillespie notes that in 2017, HHS will be under a new administration, which might be more flexible. Waivers that are approved for 2017 might not create big changes, but they could pave the way for more ambitious experimentation, she says.

But HHS is "the referee" when it comes to determining whether a state can move forward with a 1332 waiver. And it's unknown whether HHS will be overly arbitrary when determining whether a proposal meets the requirements, Condeluci notes.

Ario acknowledges that the guardrails could be interpreted very narrowly, which could make 1332 waivers a nonissue. But he points out that people predicted the Obama administration would offer little flexibility around the Medicaid expansion called for by the ACA. So far, six states have received approval for Medicaid expansion alternatives.

Condeluci agrees that HHS has been flexible on granting Medicaid expansion waivers, but notes that approval didn't happen overnight. Rather, they were the

New Governor Puts Cover Oregon Out of Its Misery

On March 6, just 19 days after being sworn in as Oregon's governor, Kate Brown (D) signed legislation officially dissolving Cover Oregon, the state's battered state-run insurance exchange. Brown replaces John Kitzhaber (D), who left office amid state and federal corruption investigations. Brown previously was secretary of state.

Last April, state officials voted to scrap its dysfunctional IT system and transition to the federal platform as it worked to repair its failed state-grown IT system. Under the Supported State-Based Marketplace model, the state continued to perform plan management and consumer assistance at the state level. In January, Cover Oregon laid off 61 employees — about half of its staff. The layoffs, due to budget constraints, were anticipated after the organization transitioned to the federal platform. The rest of the exchange's operations will be taken over by the Oregon Department of Consumer and Business Services.

Last month, the exchange's main technology vendor, Oracle America Inc., filed a lawsuit blaming former Gov. John Kitzhaber's (D) administration for

problems that caused the marketplace to fail. The lawsuit echoes charges made in a \$23 million breach-of-contract suit filed by the technology company last summer (*HEX 8/14/14, p. 4*).

"The work on the exchange was complete by February 2014, but going live with the website, and providing a means for all Oregonians to sign up for health insurance coverage, didn't match the former-Governor's re-election strategy to 'go after' Oracle," Oracle spokesperson Deborah Hellinger said in a prepared statement provided to *HEX*. The suit claims members of Kitzhaber's team "acted in the shadows and took actions to undermine the ability of Oregonians to receive health coverage; create a false narrative blaming Oracle for the state's failures; and ultimately interfere with Oracle's business."

Last summer, Oregon filed its own suit against Oracle and several of its high-level executives. The 126-page civil complaint, filed Aug. 22 by Oregon Attorney General Ellen Rosenblum (D), blamed Oracle for the state's non-functioning insurance exchange.

result of a good deal of time, energy and political maneuvering.

A handful of state lawmakers are already looking into how such waivers could be used, says Ario. "In terms of health reform, most states, red or blue, want to do something different than just follow the path of the ACA."

In a March 9 op-ed in *Tulsa World*, Oklahoma Gov. Mary Fallin (R) said that if the court rules against HHS this summer, she hopes Congress will offer "targeted, temporary relief for people to maintain their current coverage." Regardless of the decision, she says states need greater flexibility and freedom to innovate to "respond to the different needs of their constituents."

Contact Smith at dgsmith@mckennalong.com, Gillespie at cdgillespie@mckennalong.com, Ario at jario@manatt.com and Condeluci at chris@cclawandpolicy.com. ✧

Most State-Based Exchanges Offer Special Enrollment Period

In federally facilitated exchange states, uninsured people who were unaware of the tax penalty for not having coverage in 2014 can enroll during a special enrollment period (SEP) that runs from March 15 to April 30. With the exception of Colorado, Idaho and Massachusetts, every state-based exchange has announced a similar SEP. Some tax preparation firms are directing those clients directly to the exchanges (*HEX 2/15, p. 1*).

"We were on the road for the two weeks leading up to the open enrollment deadline and we were hearing about consumers doing their 2014 taxes and coming to find out they would owe a penalty. Many were not aware of this," says Covered California spokesperson Roy Kennedy (see story, p. 1).

Here's a rundown of how state exchanges are handling their SEPs:

◆ **California:** People who were penalized for not having health coverage in 2014 now have until April 30 to sign up for coverage, Covered California announced. The SEP began Feb. 23. Covered California enrolled about 495,000 people through Feb. 22, including more than 36,000 who signed up Feb. 15 — the last day of the regular enrollment period.

◆ **Colorado:** The state Division of Insurance decided not to offer a SEP for universal tax payers, says Connect for Health Colorado spokesperson Curtis Hubbard. More than 141,000 people signed up for coverage as of March 10 — about 95,000 were renewals.

◆ **Connecticut:** Beginning April 1, uninsured residents unaware they would be penalized for not having cover-

age will have until April 30 to enroll. Access Health CT ended the enrollment period with 204,000 sign-ups.

◆ **Hawaii:** Hawaii Health Connector's shared-responsibility SEP runs from March 15 to April 30. As of March 9, the exchange had enrolled 30,100 residents in coverage. The exchange had set a goal of enrolling 27,000 by June 30, according to *Pacific Business News*.

◆ **Idaho:** Your Health Idaho on March 4 said opted not to offer an SEP for uninsured tax payers who are subject to a penalty.

◆ **Kentucky:** Kentucky Gov. Steve Beshear on Feb. 24 announced a special enrollment period that would run from March 2 through April 30. As of Feb. 20, 158,685 individuals had enrolled in health care coverage through kynect for 2015.

◆ **Maryland:** Maryland Health Connection on Feb. 25 said its special-enrollment period would run from March 15 through April 30 for tax payers who owe or have paid a tax penalty for not having coverage in 2014.

◆ **Massachusetts:** As of *HEX's* press time, Massachusetts had not announced a tax-penalty-inspired SEP. Winter weather prompted the state to extend its open-enrollment period until Feb. 23. More than 125,000 signed up for coverage for 2015, according to the Massachusetts Connector.

◆ **Minnesota:** MNSure's SEP for those hit by tax penalties runs from March 1 until April 30. The state's exchange had extended its original Feb. 15 enrollment deadline to Feb. 20 for people who created an account but had trouble signing up. The exchange says 60,092 people enrolled in a qualified health plan during the official enrollment period. Nearly 40% of 2015 QHP enrollees chose a silver level plan, and Blue Cross Blue Shield of Minnesota took 43% of the total QHP enrollment.

◆ **Nevada:** On March 10, Nevada Health Link announced a SEP for people who face a tax penalty for not having coverage in 2014 — it will run from March 15 through April 30. More than 73,000 people signed up for coverage or were reenrolled through the exchange's marketplace as of Feb. 22.

◆ **New York:** The New York State of Health's SEP runs from March 1 through April 30 for people who were penalized for not having coverage in 2014. To be eligible, individuals must attest that when they filed their 2014 federal tax return, they paid a penalty for not having health insurance in 2014, and that they first became aware of or understood the implications of not having health insurance in 2014 when they filed their federal tax return.

◆ **Rhode Island:** HealthSourceRI on March 3 announced its taxpayer SEP would run from March 15 until April 30. To qualify, applicants must attest that when they filed

their 2014 tax return they paid the fee for not having health insurance coverage in 2014, “and attest that they first became aware of, or understood the implications of, the shared responsibility payment after the end of the 2015 open-enrollment period...in connection with preparing their 2014 tax return,” according to a statement from the exchange. As of Feb. 23, HealthSourceRI says 30,001 people enrolled in coverage through the exchange — about 21,000 were renewing customers. Another 3,282 enrolled through the small business exchange.

◆ **Vermont:** Vermont has the latest SEP for people who discover they owed a penalty for not having coverage.

Taxpayers have 60 days from the day they learn about the penalty to enroll. The final enrollment deadline is May 3. About 6,100 people signed up for coverage through the exchange as of Feb. 15.

◆ **Washington, D.C.:** The DC Health Benefit Exchange Authority on March 9 announced a SEP for residents subject to a tax penalty. The SEP runs from March 15 to April 30. To qualify, a resident must attest that when the person filed their 2014 federal tax return, the taxpayer paid a tax penalty to the IRS for not having health coverage in 2014. A person can also qualify if when preparing the 2014 federal taxes the taxpayer first became aware of,

Federal Reg Tracker: Feb. 5 – March 10

Regulations

◆ Establishment of the Multi-State Plan (MSP) Program for the Affordable Insurance Exchanges, 80 FR 9649

This rule clarifies the approach used to enforce the applicable standards of the Affordable Care Act with respect to health insurance issuers that contract with OPM to offer MSP options; amends MSP standards related to coverage area, benefits, and certain contracting provisions under section 1334 of the Affordable Care Act; and makes non-substantive technical changes. Visit <http://tinyurl.com/n4gt2ln>.

◆ HHS Notice of Benefit and Payment Parameters for 2016, 80 FR 10749

This final rule sets forth payment parameters and provisions related to the risk adjustment, reinsurance, and risk corridors programs; cost sharing parameters and cost-sharing reductions; and user fees for Federally-facilitated Exchanges. It also finalizes additional standards for the individual market annual open enrollment period for the 2016 benefit year, essential health benefits, qualified health plans, network adequacy, quality improvement strategies, the Small Business Health Options Program, guaranteed availability, guaranteed renewability, minimum essential coverage, the rate review program, the medical loss ratio program, and other related topics. Visit <http://tinyurl.com/mhucch8>.

Notices

◆ Health Insurance Marketplace, Medicare, Medicaid, and Children’s Health Insurance Programs, 80 FR 7911

This notice announces the renewal of the Advisory Panel on Outreach and Education (APOE) charter.

It also requests nominations for individuals to serve on the APOE. Visit <http://tinyurl.com/q64wv6d>.

◆ Agency Information Collection Activities, 80 FR 7607

CMS is announcing an extension of a currently approved collection of information on initial plan data collection to support Qualified Health Plan (QHP) certification and other financial management and exchange operations. Visit <http://tinyurl.com/nktx9qb>.

◆ Proposed Collection on SHOP; Comment Request, 80 FR 12488

CMS is announcing a new information collection of the Small Business Health Options Program (SHOP) effective date and termination notice requirements. Visit <http://tinyurl.com/q8wp6j2>.

Instructions/Guidance

◆ Final 2016 Letter to Issuers in the Federally-facilitated Marketplaces

This Letter provides issuers seeking to offer qualified health plans (QHPs), including stand-alone dental plans (SADPs), in the Federally-facilitated Marketplaces (FFMs) or the Federally-facilitated Small Business Health Options Programs (FF-SHOPs) with operational and technical guidance to help them successfully participate in those Marketplaces in 2016. Visit <http://tinyurl.com/nq5r7ge>.

◆ Issuers of Stand-alone Dental Plans: Intent to Offer in FFM States in 2016

HHS is releasing a table that lists the number of issuers that intend to offer standalone dental plans in states that are expected to have a Federally-facilitated Marketplace. Visit <http://tinyurl.com/okqcaqw>.

Compiled by AIS, March 2015. ✦

or understood the implications of, the tax penalty after open enrollment ended on Feb. 15.

As of March 8, 21,784 people have signed up for individual coverage through the D.C. exchange, and nearly 16,000 members of Congress, their staff members and families have enrolled through the Small Business Health Options Program (SHOP).

◆ **Washington state:** The state's special enrollment period runs from Feb. 17 until April 17. Healthplanfinder says nearly 160,000 people enrolled in a QHP as of Feb. 15. During the final weekend of the official enrollment period, the state-run exchange had 40,000 unique website visits and nearly 30,000 calls to the customer support center. ◆

Who Will Pick Up the Pieces If SCOTUS Rules Against HHS?

In the week since the Supreme Court heard oral arguments about the legality of subsidies distributed through federally facilitated exchanges (FFE), there has been wide speculation over the meaning of what was said, and what wasn't said, by the justices. There also is plenty of guesswork about how the administration, Congress, states and insurance carriers will respond if the court rules against HHS in *King v. Burwell* this summer.

During a March 11 session at America's Health Insurance Plan's (AHIP) National Health Policy Conference, several industry observers debated the issue. In the absence of a stay, Nicholas Bagley, assistant professor of law at the University of Michigan School of Law, warned that subsidies would dry up almost immediately if the court determines federally run exchanges can't legally distribute them. "You're talking about tax credits evaporating by the end of July, if not before. People who can no longer afford their insurance will drop coverage and lose coverage 30 days later. By the end of the summer, you're going to have 6 million or 7 million people who no longer have coverage," he said. "And Congress is scheduled to go on summer break in August."

The issue of delaying implementation of a ruling against FFE subsidies came up during oral arguments, when Justice Samuel Alito said the court could give Congress and the states more time to work out a reaction by pushing the effective date of the ruling to 2016. But Bagley suggested that a stay might not be enough to prevent a major disruption in the markets.

Mike Carvin, a partner at Jones Day and an attorney for the plaintiffs in *King v. Burwell*, played down the prospect of substantial market disruptions if the court rules for his side, and said Congress would be quick to act. He pointed to the court's decision two years ago that allowed states to opt out of the Affordable Care Act's

Medicaid expansion provision. "The arguments were remarkably similar.... All the hospitals were saying, 'if we don't get full Medicaid participation, we're going to go out of business,'" he told attendees, adding that hospitals actually are "doing fine" in states that opted not to expand eligibility.

Justice Anthony Kennedy "has made it clear that if there's an unconstitutionally harsh condition on the subsidy, the remedy is not to eliminate the condition.... You eliminate the subsidy," Carvin said. He suggested that in that scenario, all exchanges could be deemed unconstitutional, "which would leave all 50 states without federal subsidies. If you go with the constitutional avoidance theory, you would have unconstitutional subsidies in all 50 states."

Like Carvin, Lanhee Chen, Ph.D., director of domestic policy studies in the public policy program at Stanford University, was optimistic that Congress would be able to act quickly. "The doomsday scenarios, I tend to be a little skeptical of them. This is one situation where I think the Congress recognizes that failure to act presents policy and political problems, particularly for Republicans. I think they are prepared to act in a way that would offset some of the policy consequences. They understand the stakes," he told attendees.

What Would Obama Veto?

Carvin said there is agreement among conservative and moderate Republican lawmakers about continuing federal money but allowing consumers to buy "the kind of coverage they want," which would not have to include all of the required essential health benefits called for by the ACA. "What we're trying to do here is empower consumers, not empower the government," he said.

Chen wondered why the President might veto a Republican bill that would provide quality and affordable health coverage to low-income consumers. "The only reason I can come up with is that the politics are more important than the policy," he said.

Bagley, however, suggested it was unlikely the Congress would present the president with a bill that he would be willing to sign. The administration, he suggested, would view any threat to federal subsidies as a problem that was created by Republican lawmakers. "This is a mess you made; it's your responsibility to clean it up." Neera Tanden, president of the Center for American Progress, agreed and noted that Congress has failed to act quickly on a number of important issues in the past.

Carvin bristled at the idea that Republican lawmakers are to blame for any dire outcome. "A Democratic president and Democratic Congress without a single Republican vote passes a law, the IRS rewrites the law.... They are solely responsible for two-thirds of states say-

ing they don't want to start an exchange," he said. But he suggested that Democrats would be quick to point fingers at House Speaker John Boehner (R-Mich.) and Senate Majority Leader Mitch McConnell (R-Ky.) for any negative consequences resulting from the court's ruling. ✧

Who Enrolls Through SEPs?

continued from p. 1

"HHS expects that the population eligible for this SEP will be young and healthy individuals who felt like they didn't need health insurance before, but have been subject to their first tax penalty...and now they know they'll have a larger one next year unless they enroll now. And the window [to enroll] is limited," she says.

What's the demographic for people who didn't know about the tax penalty or the end of the open-enrollment period? "It's likely to be on the younger and healthier side," predicts Christopher Condeluci, a principal at CC Law & Policy in Washington, D.C. CMS is expected to announce more information about how eligibility for the SEP will be verified. But it might not be anything more than an attestation from the applicant.

Although the tax SEP is expected to be a one-time event, confusion among potential applicants next year could prompt another one. The end of open enrollment has been a moving target since exchanges launched in 2013. Severe IT problems caused CMS to extend last year's deadline more than once (*HEX 4/3/14, p. 1*). For the 2015 plan year, open enrollment began later and concluded earlier than in 2014. The next open-enrollment period begins Nov. 1 (two weeks earlier than last year) and had been slated to end Dec. 15. But on Feb. 20, CMS pushed that deadline to Jan. 31, 2016.

The addition of the new SEP "creates an environment ripe for gaming," warns Dan Schuyler, who leads the insurance exchange practice at Salt Lake City-based Leavitt Partners, LLC. "A limited number of reasonable SEPs are manageable as circumstances do change for people, which we should anticipate...but we're likely past the point of reasonableness here."

Outside of open enrollment, and the recent tax-penalty-inspired SEP, the uninsured can enroll through HealthCare.gov if they have at least one of nine qualifying events. There also are SEPs for complex issues.

Some state-run exchanges have made additions to the federal list. In California, for example, SEP eligibility can occur if an individual loses access to a medical provider during the course of treatment for a serious disease. In Washington, D.C., SEP eligibility can be triggered by the beginning or end of a domestic partnership.

While there is a difference between people who intentionally game the system and those who legitimately qualify for a SEP, both can increase adverse selection for carriers. Health plans have been critical of SEP verification that relies on little more than the honor system. "And there are always people who aren't going to be honorable," Condeluci quips.

For someone financially motivated to buy health insurance — due to a recently diagnosed illness, for example — creating a qualifying event isn't difficult. "You don't need to be very creative; all you have to do is move out of your current health plan's service area," adds Jim O'Connor, a principal and consulting actuary in Milliman's Chicago office.

For the exchanges, verifying SEP eligibility is difficult because it typically must be done manually. Minnesota's state-run exchange was unique in that it let the health plans verify documentation from people who enrolled during the SEP. Covered California asks applicants to self-attest their eligibility for special enrollment, but warns that they risk "the penalty of perjury" if they knowingly provide false information.

Insurance industry representatives interviewed by researchers at the Urban Institute and Georgetown University "consistently stated that they wanted stronger systems to verify SEP eligibility," according to a recent report on SEPs, which also included interviews with officials from five state-based exchanges and was funded by the Robert Wood Johnson Foundation.

Three Types of SEP Enrollees

According to O'Connor, there are three groups of people who enroll during a SEP:

- (1) People who are relatively unhealthy but failed to buy coverage during the open-enrollment period;
- (2) People who were healthy prior to the end of the open-enrollment period, but have since been injured or become sick; and
- (3) The healthy uninsured who face a penalty for not having health coverage in 2014.

The first two populations create adverse risk for carriers, while the third population can help to offset that risk. "I think there could be some very positive enrollment from that group of people. But we don't know how many people are in each of those groups," O'Connor says. On average, he estimates that between three and seven — or more — healthy people are needed to offset the risk of every unhealthy enrollee. It depends on how unhealthy the unhealthy are and how healthy the healthy are.

"I don't know if health insurers want to encourage people [to enroll during an SEP] because they don't

know which of those three populations they will get," he adds.

Carriers should begin to gather data about SEP enrollees to determine which qualifying events are most common, whether those enrollees stay enrolled and what their medical utilization looks like. That could help them reach out to potential enrollees who might actually improve the health of the overall risk pool. Along with defining the necessary documentation, exchanges also need to determine if there are potential work-arounds for people who lack that information.

The Urban Institute's report suggests that adults between the ages of 18 and 34 will likely qualify for certain

SEPs at higher rates than older adults "because they are more likely to experience qualifying events such as moving, getting married or having a child."

During the months after last year's open-enrollment period concluded, California's insurance exchange signed up about 50,000 members a month through the SEP — slightly less than the 60,000 a month it had projected, according to the Urban Institute report. But the risk won't be known until claims data are analyzed.

SEPs Will Grow in Importance

About 4 million people likely lose health coverage each year and become eligible for either an SEP or Medicaid, and another 2.7 million adults will likely have a qualifying event that triggers SEP eligibility, according to analyses cited by the Urban Institute.

Over the next year or two, as enrollment stabilizes, exchanges will be able to devote more resources to identifying and enrolling people who have a qualifying event outside of the open-enrollment period. "It seems there is a pretty big market out there for people who will become eligible every year," says Jane Wishner, a qualitative researcher and health policy analyst at the Urban Institute and lead author of the SEP study.

People who qualify for an SEP "will become a more important piece of the uninsured puzzle as we grow as an organization," says Covered California spokesperson Roy Kennedy. "Going forward, the open enrollment period will become less important with special enrollment becoming more important."

See the Urban Institute's paper on SEPs at www.urban.org/publications/2000122.html.

Contact Campbell at lcampbell@groom.com, Wishner at jwishner@urban.org, Condeluci at chris@cclawandpolicy.com, Kennedy at roy.kennedy@covered.ca.gov, Schuyler at dan.schuyler@leavittpartners.com and O'Connor at jim.o'connor@milliman.com. ♦

Recent E-News Alerts

These items were included in *E-News Alerts* that were transmitted since the last print issue of *HEX* was published on Feb. 12:

March 11, 2015

- HHS: 11.7 Million on Public Exchanges
- Florida, North Carolina and Texas Have Most to Lose in King Case
- New Mexico Wants to Use Federal Platform
- Cruz Wants to End Subsidies, Mandates

March 4, 2015

- Lawmakers in Ohio, Tenn. Discuss Launching, Blocking State-run Exchanges
- Actuaries Urge SCOTUS Contingency Plan
- Loss of Subsidies Could Boost Coverage Costs as Much as 774%
- 13,000 Were Overcharged by Healthplanfinder

February 25, 2015

- Majority of Exchange Customers Were Oversubsidized
- There Is No Back-Up Plan, Burwell Says
- CMS: Special Enrollment Period Will Run From March 15 to April 30
- How Prepared Were State Exchanges for 2014 Special Enrollment Period?
- Florida's Alternate Exchange Enrolls 42

February 18, 2015

- 11.4 Million Find Health Coverage on Exchanges
- Some State Exchanges Extend Enrollment Period
- Is the King Case Coming Apart?
- Will Enrollees of Failed CO-OP Be Reimbursed?

To retrieve copies of these *E-News Alerts*, visit *HEX*'s subscriber-only Web page at AISHealth.com. If you need a password or other assistance, please contact AIS's customer service department at 800-521-4323 or custserv@aishealth.com.

CLARIFICATION:

A roundup of single-carrier private exchange players in the February issue of *HEX* included incomplete information about Bloom Health. Blue Cross Blue Shield of Minnesota, BCBS of Michigan, Horizon BCBS and Medica Health Plan offer defined contribution plans, as the list noted, but they also offer defined benefit products. Anthem, Inc. (Health Marketplace) and Health Care Service Corp. (Blue Directions) also offer both types of plans but were not included in the list.

**IF YOU DON'T ALREADY SUBSCRIBE TO THE NEWSLETTER,
HERE ARE THREE EASY WAYS TO SIGN UP:**

1. Return to any Web page that linked you to this issue
2. Go to the MarketPlace at www.AISHealth.com and click on “Newsletters.”
3. Call Customer Service at 800-521-4323

**If you are a subscriber and want to provide regular access to
the newsletter — and other subscriber-only resources
at AISHealth.com — to others in your organization:**

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)