Inside
HEALTH INSURANCE EXCHANGES

Volume 5, Number 8 • August 2015

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

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HHS Says Competition Kept Rates Low; Still, More Plans Look to Exit Exchanges

People who purchased 2015 coverage through a public exchange had more choice than they did the previous year. And markets that offered the greatest number of plans had "significantly enhanced consumer choice and lower premiums" compared to markets with fewer options, according to a report released by HHS July 27.

But competition on exchanges appears to be eroding as large publicly traded companies prepare to merge and other carriers abandon unprofitable markets.

Blue Cross and Blue Shield of New Mexico, a subsidiary of Health Care Service Corp. (HCSC), is unlikely to sell qualified health plans (QHPs) through the state's exchange for the 2016 plan year, the Office of the Superintendent of Insurance said Aug. 11. The Blues plan, which covers about 35,000 people through New Mexico's state-based exchange. Last year, total claims costs for individual plans exceeded premiums collected, resulting in a $19.2 million loss. In May, the Blues plan proposed an average 51.6% premium increase for its 2016 QHPs *(HEX eNews Alert, 5/27/15).*

New Mexico Insurance Superintendent John Franchini contends the insurer failed to offer sufficient information to justify the rate revision. "Based on the data presented, our analysis could only substantiate a much lower increase," he said in a prepared statement.

But HCSC spokesperson Lauren Perlstein says an independent actuarial firm reviewed the initial proposal and concluded the rates were reasonable and adequate. The Blues plan later offered to eliminate some of the more expensive QHPs, which would have resulted in an average rate increase of 11.3%, she tells *HEX*. "That rate proposal would provide HMO products and rates that are in line or in some markets lower than our competitors, even with the requested rate increase," she says. About one-third of the New Mexico Blues plan's exchange members are enrolled in an HMO. Franchini's office hasn't responded to that proposal yet.

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Has Death of CO-OPs Been Exaggerated? Despite OIG Report, Execs Remain Upbeat

Less than two years after opening their doors, Consumer Operated and Oriented Plans (CO-OPs) appear to be on the ropes. Two of the original 24 non-profit carriers — created as part of the Affordable Care Act (ACA) — won't be around when open enrollment begins Nov. 1. And a July 24 report from HHS's Office of Inspector General paints a bleak picture of the CO-OPs that remain. But executives overseeing the fledgling insurance companies say the OIG report offers an outdated and inaccurate assessment. They remain upbeat about their ability to succeed in a market dominated by larger and more established carriers.

According to OIG, 21 of 23 CO-OPs are losing money, 13 are falling short of enrollment goals and some might not be able to pay back their shares of the $2.4 billion in aggregate government loans provided to help launch the entities. As of Dec. 31, 2014, half of the nation's CO-OPs had achieved less than 50% of their projected enrollment, and five had less than 10% of projected enrollment. The low enrollments and net losses

might limit the ability of some CO-OPs to repay startup and solvency loans and to remain viable and sustainable.

The report comes on the heels of the Louisiana Health Cooperative, Inc.'s July 24 decision to voluntarily close its doors at the end of the year *(HEX eNews Alert, 7/29/15).*

The insurer was operating with a medical loss ratio (MLR) of 113%, according to the Louisiana Dept. of Insurance. That CO-OP has more than 16,000 members — not enough to sustain operations. Early this year, Iowa-based Co-Oportunity Health was liquidated by the Dept. of Insurance *(HEX 1/15, p. 1)*. And HHS requested that Tennessee's Community Health Alliance CO-OP freeze enrollment because of its "tenuous financial condition."

Dawn Bonder, CEO of Health Republic Insurance Company in Oregon, says overall enrollment among CO-OPs has grown substantially since the end of 2014. She notes that initial enrollment forecasts were made well before the market began to take shape and didn't account for transitional policies, which allow people to remain on less-costly, non-ACA-compliant plans through October 2016. "If I had known that when we started, I can guarantee my numbers would have been different," she tells *HEX*.

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.

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Between 20% and 30% of the state's individual market — and more than half of small groups — is covered by transitional policies. When the definition of a small group expands next year from 50 employees or fewer to up to 100, those larger small groups will be able to retain their transitional policies. "When you remove half of the available market and hold me to my original enrollment estimate and ask why I didn't reach it…it's not really fair," she asserts. The state's failed insurance exchange also hindered enrollment, and CO-OPs aren't allowed to use federal loan money for marketing, she adds.

Bonder's company is one of three Health Republic CO-OPs that were sponsored by Freelancers Union *(HEX 3/12, p. 1)*. Freelancers thought having three CO-OPs with the same name would help with branding. While the three CO-OPs have a common ancestor, there is no contractual or legal relationship. The CO-OPs are no longer affiliated with Freelancers Union in any way.

Shaun Greene, founder and CEO of Utah's Arches Health Plan CO-OP, says the OIG report and the failure of a couple CO-OPs create challenges for those that remain. One of the biggest challenges is in working with brokers.

"Brokers see [reports] like these and wonder if they are doing the right thing for clients by placing them with Arches," he says. In response to the OIG report, Arches issued a broker alert that noted that company's 2014 loss was expected and part of its business plan. He adds that the CO-OP is on track to break even this year.

Can CO-OPs Compete in a Land of Giants?

According to OIG, CMS has placed four unidentified CO-OPs on "enhanced oversight" or corrective action plans and two CO-OPs have been issued low-enrollment-warning notifications.

Under an enhanced oversight plan, CMS conducts more frequent and thorough reviews of the CO-OPs' operations and financial status.

Ashraf Shehata, KPMG's advisory leader for health plans, says it will become increasingly difficult for CO-OPs to compete with established and larger health plan operators that are on the cusp of getting even larger. One reason for the recent wave of mergers and acquisitions among insurance carriers is to reduce fixed costs by spreading them across a larger base of business.

"It takes a lot of financial strength to stand up a CO-OP. And CO-OPs just don't have the volume to spread out the fixed costs of running an operation," he says. "And as national carriers become more efficient, that bar is just going to get higher and higher. The gap between a local plan and a national plan will be almost insurmountable in a couple of years."

Christopher Condeluci, a principal at CC Law & Policy in Washington, D.C., worked for the Senate Finance Committee when the CO-OP idea was born. In a recent blog post, he explains that some CO-OPs underpriced their products in hopes of capturing market share, but didn't capture enough healthy risk to offset sicker enrollees. He says it's "hard to believe" that the CO-OPs will be able to re-pay the start-up and solvency loans.

Bonder, however, notes that all CO-OPs predicted they would lose money for the first two to three years. "Anytime you start a new business, particularly in health insurance, there are incredible barriers to entry. You have to assume you're going to lose money in the first couple of years. We were all approved with that notion. So to come back now and ask why the CO-OPs are losing money is ludicrous," she asserts. "I don't know when it shifted from a three-to-five-year start-up phase to a 9-to-12-month frame of success," says Bonder.

Cynthia Jay, chief marketing officer at Health Republic Insurance of New Jersey, adds that every CO-OP is experiencing a unique set of circumstances. "As with new start-ups in any industry, let alone an industry undergoing its most sweeping changes in nearly half a century, it shouldn't come as a surprise that the CO-OPs lost money in their first year of existence."

Some CO-OPs Report Big Growth

Here's a look at the most recent enrollment data from seven CO-OPs:

◆ ***Arches Health Plan:*** The Utah-based CO-OP ended July with 56,464 members. Greene projects enrollment of between 60,000 and 70,000 in 2016. About 65% of those members are enrolled in individual plans and 35% are small groups. Greene says Arches' current MLR is running in the mid-80s (see table, p. 4), and assets are more than $56 million. The company's risk-based capital is at 500% — double the state requirement of 250%. Arches intends to grow its group enrollment to about 60% of its overall business. The group market, Greene says, "is the foundation for the long-term sustainability of a health insurance company."

◆ ***Health Republic Insurance of New Jersey:*** The CO-OP is having "a phenomenal year" and has experienced immense growth in 2015. "Unfortunately, this growth is not reflected in the OIG report. We now have more than 55,000 members — far surpassing our original enrollment projections — and have established our brand in the New Jersey marketplace," says Cynthia Jay, the CO-OP's chief marketing officer. She says the CO-OP isn't concerned over its ability to repay federal loans.

◆ ***Health Republic Insurance of New York:*** The CO-OP is the market leader on the state's Small Business Health Options Program (SHOP) exchange, says Debra Friedman, the CO-OP's president and CEO. The New York-based CO-OP says it has introduced two new Qualified Health Plans (QHPs) and one small-group product for 2016.

◆ ***Health Republic of Oregon:*** For the second quarter of the year, Bonder says her CO-OP added 400 lives in the small-group market, while most other carriers in the state lost enrollment. She also touts a retention rate above 90%. The insurer has about 4,000 individual members. Carriers that sold individual qualified health plans in Oregon lost money last year, she says. Many of the state's young and healthy either opted to remain uninsured or enrolled in the state's expanded Medicaid program. Rates for 2016 are expected to be significantly higher.

◆ ***InHealth Mutual:*** The Ohio-based CO-OP is on target to meet its enrollment projections and now covers more than 22,000 members on and off the state's federally run exchange. Enrollment is split between its small-group and individual products. CEO Jesse Thomas says the company already has "adequate capital reserves."

◆ ***Kentucky Health Cooperative, Inc.:*** The OIG report notes that the CO-OP ended 2014 with about 57,000 members. While that number has dropped to 53,000 as of July 2015, the CO-OP maintains the number is still "tens of thousands more members than we had planned for based on actuarial forecasts provided in 2013," says spokesperson Susan Dunlap. The CO-OP's goal for 2016 is to retain as much of its existing enrollment as possible.

◆ ***Land of Lincoln Health:*** The Illinois-based carrier says it surpassed its goal of 50,000 members in the last open-enrollment period. This year, the company says it plans to continue promoting its Preferred Partners plans — engineered with local providers to offer members convenient, affordable access to high-quality health care — with an added focus on educating members about getting the most benefit from these innovative plans.

◆ ***Meritus:*** The OIG report notes that just 869 people purchased coverage from Arizona's Meritus — a mere 4% of its initial enrollment target of 24,000. The CO-OP, however, says it now covers nearly 56,000 Arizonans — about 28% of people who purchased coverage through Arizona's federally run exchange.

To see a copy of OIG's 27-page report, visit https://oig.hhs.gov/oas/reports/region5/51400055.pdf.

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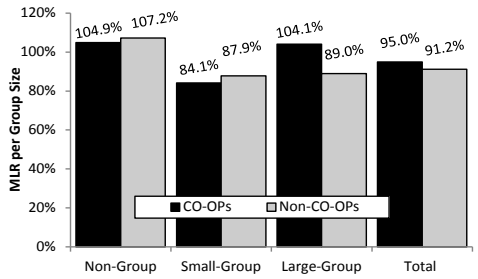
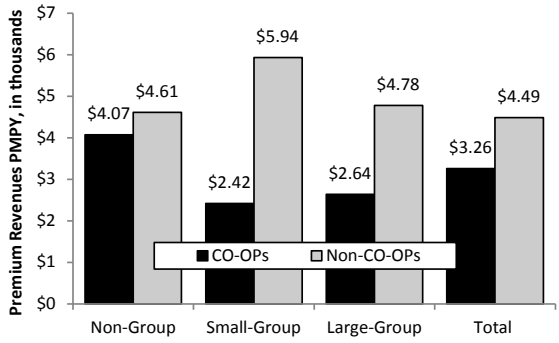
CO-OPs Have 6% of Exchange Market

An excerpt from an upcoming AIS report entitled *Commercial Health Plan Market Metrics* compares key profitability measures of Community Operated and Oriented Plans vs. non-CO-OPs based on 2014 annual data. AIS is compiling this report to provide a snapshot of the rapidly evolving commercial risk health insurance market and to assess the impact of exchanges and other Affordable Care Act (ACA) initiatives. Additional data collected by AIS indicate that CO-OPs now serve about 6% of all insured members who enrolled via public exchanges. For 2014, CO-OPs' margins were comparable to those of non-CO-OPs, particularly in the individual (non-group) sector. However, profitability is challenging in this sector, and CO-OPs do not have additional operations to absorb any losses, although a few (shaded in table) also reported sales in the large-group sector. Per-member per-year (PMPY) premium revenues and claims expenses were lower for CO-OPs because this represents their first year of operations.

Average Medical Loss Ratios (MLRs) for CO-OPs vs. Other Plans, by Group Size



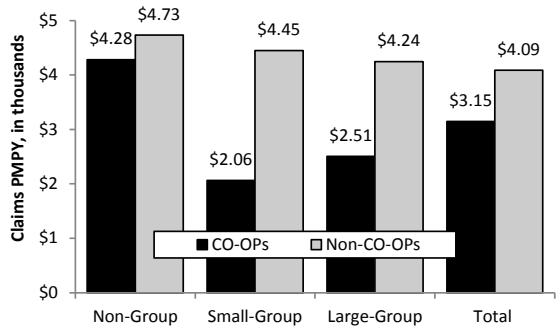
Average Premium Revenues PMPY for CO-OPs vs. Other Plans, by Group Size



Average Total 2014 MLR for CO-OPs

CO-OP Plan	MLR
Arches Health Plan	114.39%
Colorado HealthOp	97.51%
Common Ground Healthcare Cooperative	98.18%
Community Health Alliance	95.13%
Community Health Options	71.24%
Consumers' Choice Health Plan	93.26%
Consumers Mutual Insurance of Michigan	104.18%
Evergreen Health Cooperative, Inc.	66.23%
Health Republic Insurance (Oregon)	77.75%
Health Republic Insurance of New Jersey	131.60%
Health Republic Insurance of New York	75.32%
HealthyCT	106.34%
InHealth Mutual	110.51%
Kentucky Health Cooperative, Inc.	93.41%
Land of Lincoln Health, Inc.	141.35%
Louisiana Health Cooperative	113%*
Meritus Health Partners	106.40%
Minuteman Health	59.09%
Montana Health CO-OP	132.04%
Nevada Health CO-OP	83.12%
New Mexico Health Connections	53.95%
Oregon's Health CO-OP	119.87%
* Louisiana Dept. of Insurance	

Average Claims PMPY for CO-OPs vs. Other Plans, by Group Size



SOURCE/METHODOLOGY: Calculated by AIS from data reported in supplemental health care exhibits of insurers' 2014 annual insurance department filings. Company results are rolled up to include all subsidiaries in all states for which filings could be obtained by AIS. Filings that did not include sufficient data were excluded, as were filings that represented a significant proportion of run-off operations. MLR = Total Incurred Claims (including prescriptions) divided by Net Premium Revenue. *Commercial Health Plan Market Metrics* will be available in September from AIS.

Minnesota, N.Y. Exchanges to Offer Basic Health Program This Fall

The New York Dept. of Financial Services on July 31 said a new insurance plan — dubbed the Essential Plan — would be available to people whose annual income is at or below 150% of the federal poverty level ($17,655 for an individual and $36,375 for a family of four).

The Essential Plan was created under the Basic Health Program (BHP) provision of the Affordable Care Act (ACA). New York and Minnesota appear to be the only states that intend to offer a BHP for the 2016 plan year. And BHPs might not make sense in other states.

"Those two states are unique at this point in time, and they have a set of circumstances where the BHP makes sense for them," says Deborah Bachrach, a former New York Medicaid director who now is a partner in the law firm Manatt, Phelps & Phillips, LLP. Unlike most states, New York uses state funds to provide health coverage to low-income legal immigrants who have been in the country less than five years. Adding a BHP option will allow New York to substitute federal funds for state funds. In addition, New York's Medicaid program, prior to the ACA, provided coverage to parents with incomes higher than 138% of the FPL. The BHP enabled the state to continue to provide affordable coverage to these individuals, but now with federal, rather than state dollars, she explains.

BHPs Sit Between Exchange and Medicaid

The ACA allows states to install a BHP for individuals earning between 133% and 200% of the federal poverty level (FPL) who are not otherwise eligible for Medicaid, the Children's Health Insurance Program, other government programs or employer-sponsored insurance. Under New York's BHP, people who earn up to 200% of the FPL ($23,540 for an individual and $48,500 for a family of four) will pay a $20 monthly premium.

While the BHP concept was outlined in the ACA, it wasn't until last October that CMS issued a proposed notice on the rules. Final guidance followed in February 2015 for BHPs that would be offered for the 2016 plan year. Federal funding for a BHP equates to 95% of premium and cost-sharing subsidies that would have been provided to individuals through public exchange coverage, HHS said on Oct. 21.

New York's Essential Plan will offer coverage similar to Qualified Health Plans (QHPs) sold through the state-run exchange, but will have no annual deductible and low copayments. A person who earns about $20,000 a year and uses moderate health care services, including an inpatient hospital stay, prescription drugs and doctor's visits, will pay about $730 a year for premiums and out-of-pocket costs under the Essential Plan in 2016, compared to about $1,830 in 2015 if they were enrolled in a QHP, according to the New York Dept. of Financial Services.

Minnesota's BHP entity, known as MinnesotaCare, has been in existence for more than 20 years, according to the state. State lawmakers spent much of 2014 bringing that program in line with federal BHP requirements. MinnesotaCare provides coverage to low-income residents through a state tax on Minnesota hospitals and health care providers, federal Medicaid funds and enrollee premiums. The federal government took over paying half the cost for most adults without children on MinnesotaCare in August 2011 as part of the bridge to the ACA and the BHP funding opportunity. Before that, there was no federal match for adults without children on MinnesotaCare. Moving some of those beneficiaries into a BHP allows federal dollars to cover 95% of the costs.

121,155 BHP Enrollees Expected

BHP services will be provided via managed care organizations. In 2015, eight managed care organizations and county-based purchasing plans provide services to MinnesotaCare enrollees. The total cost of MinnesotaCare for state fiscal year 2014 was $520 million. Of that, $242 million came from the federal government, $31 million from premiums and $247 million from the state.

For state fiscal year 2017 — the first full year of full BHP funding — projected MinnesotaCare enrollment is 121,155 individuals. The projected cost is $824 million ($351 million from the federal government, $34 million from premiums and $438 million from the state), according to the Minnesota Dept. of Human Services.

To qualify for MinnesotaCare, individuals must have household income at or below 200% of the FPL and not be otherwise eligible for Medical Assistance, the state's Medicaid program. Individual MinnesotaCare premiums are on a sliding income-based scale and range from $0 to $80 per month. Children under age 21, some military families and families with an enrolled American Indian do not pay a monthly premium, according to the Minnesota Dept. of Human Services. Enrollees are responsible for copayments for certain services such as prescription drugs ($3/prescription), non-emergency visits to the emergency room ($3.50/visit), and eyeglasses ($25).

Other States May Wait for 1332

While other states might consider adding a BHP, Bachrach suggests they are more likely to restructure the subsidy after 2017 when states can apply for a 1332 waiver *(HEX 3/15, p. 1)*. Under a 1332 waiver, a state could develop a version of a BHP and receive 100% of the dollars, unlike the 95% allowed under a BHP, and might be

allowed to expand the program to individuals who earn more than 200% of the FPL, she explains.

States are going to have to figure out the likely fiscal implications for implementing a BHP, says Matt Salo, executive director of the National Association of Medicaid Directors. "There will be fiscal implications, and they could be positive or negative, but there will be implications," he says.

Some states that expanded Medicaid eligibility, as called for by the ACA, wound up with far greater enrollment than anticipated. But that enrollment could be indicative of a population that sought care through a fragmented system of emergency rooms and free clinics.

Kentucky, for example, saw higher-than-expected Medicaid enrollment, but determined that not expanding the program might cost more in the long run. Medicaid expansion is very hard to reverse.

At a June hearing, House Ways and Means Oversight Subcommittee Chairman Peter Roskam (R-Ill.) questioned HHS Sec. Sylvia Burwell about BHP programs. New York, he said, will spend an estimated $2.5 billion on the program, but he contended the funding had not been appropriated. Roskam's office did not respond to *HEX*'s request for comment on BHP funding.

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On Exchanges, Millennials Are Most Willing to Trade Access for Price

While health insurers have been criticized for their use of narrow provider networks, the strategy is popular with people who buy coverage through public insurance exchanges, particularly younger participants, according to the results of a survey published Aug. 3 by the Deloitte Center for Health Solutions.

Among exchange participants, there is a willingness to accept limited provider access for a lower price point. That was true among all age groups, but was most striking among millennials where about 80% were willing to make that trade-off conceptually, says Paul Lambdin, a director at Deloitte Consulting and an author of the report. Focusing on that angle, he says, could give local carriers and provider-sponsored health plans an edge over bigger competitors.

"The larger carriers certainly have the scale, efficiencies and cost advantages, but don't have the agility to appeal to all of the different market segments. The challenge for the large insurers is to appeal locally to consumers," he tells *HEX*.

Consumers who purchase coverage on exchanges are most interested in convenience, competitive prices and demonstrated value, according to the study. But demonstrating value to the most profitable members — young and healthy people who rarely access the health care system — is a challenge for an industry that traditionally has not focused on consumers.

"Health plans have to remember who their best customer is, and they're not used to thinking like that." Discounted gym memberships and access to telemedicine are among strategies that could demonstrate value to a millennial who doesn't access the system frequently, he suggests.

The study, which was conducted in March, compared people who purchased health coverage through an exchange with those who have it through their employer, Medicare or Medicaid. It determined that exchange enrollees better understand their benefits and costs and are more likely to compare providers and services on price and, to some extent, quality.

They also are willing to switch plans, thrusting carriers into a new arena of having to continually win over this segment based on price, product and service. The survey did not distinguish between people who enrolled through a state exchange and those who enrolled through a federally run exchange.

Cost Is Top Reason for Switching

Here's a look at some of the highlights from the study:

◆ ***Price is the top reason people switch plans:*** Among those who renewed exchange-based coverage for 2015, 45% chose a new plan. Price was cited as the most common reason for switching. It could be that people didn't understand what they purchased the first year. "If all you did last year was pay out of pocket, you're probably going to look for something with lower out-of-pocket costs," says Lambdin.

◆ ***Exchanges have a positive image:*** Despite their failed rollout in 2013, public exchanges have become a trusted source of information. Lambdin suggests that having "the government's seal of approval" provides consumers with a sense that the products have been screened and that the marketplaces are a safe place to shop — 35% of consumers said they viewed exchanges nearly as favorably as health care providers.

◆ ***Exchange enrollees are most likely to use tools:*** Slightly more than half of exchange enrollees used an online tool to compare and negotiate prices among doctors and hospitals, versus 45% of people with employer-based coverage and 36% for those on Medicare.

◆ ***Brand takes a back seat to price:*** Once prices stabilize on exchanges — which likely is a few years off — brand will resonate more with consumers. Provider-sponsored

plans could have a leg up in that area, particularly if a consumer has a strong connection to a local hospital.

◆ ***Price stability won't happen anytime soon:*** Although recently reported 2016 premiums on the California exchange seem tempered, insurers in some markets have had to raise rates significantly to correct prior-year miscalculations, Lambdin says.

"There is a lot of disruption still for 2016….You will still see a lot of disruption going into this year and going into next year. The next couple of years you will see winners and losers," he says.

Download a copy of "Public Health Insurance Exchanges: Opening the Door for a New Generation of Engaged Health Care Consumers" at http://tinyurl.com/pcpag8y. ✧

While CMS Urges Moderate Rates, Myriad Factors Could Push Them Up

When the 2016 open-enrollment period begins this fall, premiums for qualified health plans (QHPs) sold through New York's state-run insurance exchange will be an average of 7.1% higher than they were for the 2015 plan year, the New York State Dept. of Financial Services (DFS) said July 31. Carriers that sell QHPs through the state-run New York State of Health exchange had requested an average 10.4% increase.

Claims experience, rising medical costs, expensive specialty pharmacy drugs, the phase-out of the temporary reinsurance program in the Affordable Care Act (ACA) and an expansion of the small-group market are among the factors that will influence 2016 rates for the individual and small-group markets, according to an issue brief released Aug. 5 by the American Academy of Actuaries.

The economic slowdown that began in 2008 is credited with holding down medical trend. But medical spending will continue to grow and costs for prescription drugs, in particular, are expected to increase due to the availability of high-cost specialty drugs (e.g., for hepatitis C, high cholesterol and cancer).

The first year of the reinsurance program was intended to reimburse carriers for 80% of claims from $45,000 up to a cap of $250,000. While the reinsurance program fell short of its collections goal with just $8.7 billion, submitted claims totaled $7.3 billion, which allows CMS to reimburse high-cost claims at 100% and have money left over *(HEX 7/15, p. 1)*.

The three-year program will reimburse 50% of high-cost claims above $70,000 for 2015 and above $90,000 for 2016. While the program impacted rates by as much as 14% for 2014, that change in reimbursement is likely to reduce net claims by between 6% and 11% for 2015 and between 4% and 6% for 2016, according to the report. Reinsurance and risk adjustment, along with risk corridors, make up the so-called 3Rs provision of the ACA.

continued

Q&A With American Academy of Actuaries

In a telephone interview with *HEX*, David Shea, a member of the Academy's Individual and Small Group Markets Committee, and health actuary for the Bureau of Insurance in Virginia, offered his thoughts on factors that will have the biggest impact on rates for the 2016 plan year:

HEX: ***In July, HealthCare.gov CEO Kevin Counihan wrote a letter to state regulators urging them to approve only moderate rate increases. How much of an impact does something like that have on state regulators and the rates they approve?***

Shea: In the first year of exchanges, it was challenging for everyone because everyone was reaching into the great unknown. Moving into 2016, there is a bit more information. Regulators will look at all of the filings as they've done in the past. Actuaries have to follow their codes of conduct and standards of practice not only when they are preparing rate filings, but also when they're reviewing rate filings. Those standards have been in place for a long time. It's challenging on both sides. Decisions need to be actuarially supported and, from the regulator's standpoint, they need to understand how the actuary came up with those assumptions. Sometimes you hear comments about [regulators] being tougher, but it's always been that way.

HEX: ***When 2016 rates were proposed in the spring, some industry observers suggested carriers might have artificially increased their requests due to the then-unknown outcome of the Supreme Court's*** **King v. Burwell** ***decision. Did that uncertainty prompt higher rate requests?***

Shea: Personally, I didn't see that. But I think a lot of carriers may have taken the position….given they didn't know how [the case] would turn out. There was an acknowledgement on both sides of the fence that a decision in favor of the plaintiff could trigger a huge change in the market. A few carriers did send signals that if the decision went in favor of the plaintiff that they reserve the right to change their assumption. They had to presume status quo. In some states, they were allowed to resubmit rates had the decision gone the other way.

Upcoming Transparency Rules Could Have Carriers Seeing 'Stars'

During the bumpy implementation of the Affordable Care Act (ACA), Section 1311(e)(3) was pushed off to the side as the dust settled. But HHS indicated Aug. 11 that it will soon release guidance for qualified health plan (QHP) issuers to submit operational information beginning in 2016. The information could be used to build a national dataset of plan information for all commercial market insurers, but CMS is starting with the exchanges. Carriers that sell QHPs in states relying on the federal exchange platform will send data to CMS via email until a dedicated platform is built. Data collection will be phased in to allow time for testing, HHS said.

The ACA envisioned a quality rating system similar to the stars program, which CMS has used to rate Medicare Advantage (MA) plans for the past seven years *(HEX 10/30/14, p. 1)*. A stars-like rating system for exchanges is expected by 2017.

Additional operational information from carriers would give employers and consumers another tool for evaluating coverage options. It also could be used by exchanges to establish a quality-based criterion for carriers that want to sell coverage.

"CMS is taking a cautious first step, but the transparency data eventually could facilitate consumer comparison tools, more thorough and empirical oversight by regulators, or even active purchasing," says Mike Adelberg, a former senior official in CMS's Center for Consumer Information and Insurance Oversight (CCIIO), now at FaegreBD Consulting in Washington, D.C. "This starts what will be a multi-year process….The end-point is impossible to know."

Carriers will be required to provide information related to cost sharing for out-of-network services, retroactive claims denials, and rules and review processes for members who want to use non-formulary drugs.

A parallel requirement under the Public Health Services Act (PHSA 2715A) essentially applies the same disclosure rules to non-QHPs sold in the individual market, as well as to fully insured and self-insured group plans.

"The employer community has been hoping it would never come out because disclosing this information is administratively burdensome," says Christopher Condeluci, a principal at CC Law & Policy in Washington, D.C. On a 1-to-10 scale of importance, he says the rule is a seven for employers.

For more information about implementation, see the Dept. of Labor's Aug. 11 notice at www.dol.gov/ebsa/pdf/faq-aca28.pdf.

HEX: ***In setting rates for 2014 and 2015, there was a lot of guesswork on the part of actuaries. How did they do?***

Shea: They had a lot of plates spinning. Most important was the solvency of insurance companies. At the end of the day, we hear about how high rates are, but people also want 100% assurance that when they file a claim, the company that they bought insurance from will be there to pay that claim. It created a new dynamic in the market. Rates were much easier to compare among carriers in a state. You have to make sure your rates are set to cover claims and administrative expenses. Actuaries did a pretty good job flying blind. They aren't flying blind anymore, but the blindfold isn't entirely off. They do have some experience, but that varies by state. The first people to enroll were more likely to be less healthy. For some people, this was their first time entering the health insurance market. The subsidies made it possible. As time has gone on, it seems like our enrollees have gotten a little bit healthier.

HEX: ***Is that dissipation of a pent-up demand something that is factored into rate calculations?***

Shea: Some carriers explicitly acknowledged pent-up demand, and in some cases they have reduced or eliminated that factor. They feel like the pent-up demand they saw [in 2014 and 2015] has passed.

HEX: ***It seems that the reinsurance program worked as intended. But what sort of an impact will the decreasing reimbursements have on rates?***

Shea: From an actuarial standpoint, if the government is going to pay less for 2015 than 2014, that's going to look like a [cost] increase. The main reason individual carriers did so well in the reinsurance program is it is funded by the entire health insurance market, including large group and self-insured employers. There were more funds than expected to pay for reinsurance claims for 2014, but that year is now water under the bridge.

HEX: ***The definition of a small group is set to expand from 50 or fewer employees to 100 or fewer under the ACA. What impact will that have on rates?***

Shea: It all hinges on the morbidity of the 51-100 [employee] market in each state compared to the morbidity of the current small-group market. If the larger small groups are healthier than the smaller ones, that could serve to lower rates, but if they aren't as healthy, that will raise rates. It's a matter of relativity. What does the larger group size look like compared to the smaller group size?

See the Academy's brief, "Drivers of 2016 Health Insurance Premium Changes," at http://tinyurl.com/q67vuhs.

Contact David Mendes for Shea at mendes@actuary.org. ✧

ACOs 'Make Sense' for Exchanges, But May Confuse Brokers, Members

With consumers and employers looking to trim coverage costs while ensuring high-quality care, public and private insurance exchanges might be an ideal vehicle for insurance plans that include an accountable care organization (ACO). Only a handful of ACO plans, however, are being marketed on either type of exchange.

David Muhlestein, senior director of research and development at Salt Lake City-based consulting firm Leavitt Partners, says the ACO model makes sense for the exchanges. The model, he explains, helps to reduce coverage costs by managing where enrollees receive care.

Aetna offers ACO products on both public and private exchanges. Its public-exchange ACO plans are sold in Arizona through an ACO relationship with Banner Health Network in Phoenix; in Houston through a relationship with Memorial Hermann, and in Virginia through a relationship with Carilion Clinic and Riverside Health System. In addition, Innovation Health, the health insurer jointly owned by Aetna and Inova Health System, offers its plans on Virginia's federally run exchange.

Medica May Expand Exchange ACOs

Medica Health Plans offered three ACO-type products through Minnesota's state-run exchange. Each is paired with a provider system, such as the Mayo Clinic. The insurer might work with providers in other parts of the state to expand its ACO portfolio on the exchange, but no decisions have been made. In 2012, Medica became the first carrier in Minnesota to make an ACO product available to the individual market. Such products have since proliferated in the state's individual market.

"We see ACOs as one of the few remaining ways to control costs under health care reform, and offer a lower premium alternative to more traditional network products," says Medica spokesperson Greg Bury. Partnering with key providers is "the best way to provide an integrated clinical/payer experience where we take the consumer out of the middle of the traditional complex relationship between providers and carriers," he says. "ACOs allow a laser-focus on improving the end-to-end health care consumer experience."

While early results are encouraging, he says the uptake, particularly on broker-sold business, has been somewhat less than expected. The market has grown accustomed to networks with almost every provider included across a state or region, and may be slow to change. However, as premiums increase, there could be more migration into the ACO plans, he adds.

continued

One hurdle has been in convincing brokers and potential customers that the model is not a return to a 1980s-style HMO. While some ACO-based insurance products place severe limits on providers that can be seen outside the ACO, Medica's products offer broad open access for primary and specialty care. The model doesn't use a referral approach and doesn't require enrollees to select a primary care clinic.

There is a belief within the ACO community that shared savings has short shelf life, Muhlestein tells *HEX*. "Shared savings is built on the premise of taking money out of the system, so eventually you are going to take all of the slack out and reach a new baseline," he explains. Provider groups, which are being asked by carriers to take on increased risk, might decide to build their own ACO-based products and sell them on exchanges by either building or buying an insurance subsidiary or partnering with an existing carrier to process claims.

"The question is, once you've maxed out shared savings, what's next?" he asks. The ACO model might not be any more effective at holding down coverage costs than a narrow-network plan. But unlike narrow-network plans, the goal of an ACO is to use payment models to improve the quality of care while reducing costs.

As we increase the number of distribution channels for health insurance, it's going to make sense for ACOs and health plan products to take advantage of the improved distribution bandwidth, adds Dan Schuyler, a senior director at Leavitt Partners.

For coverage that began Jan. 1, Aetna offered ACOs to group retiree and other employer customers on its proprietary private exchange. The company also offers ACO products through other third-party private exchanges, says spokesperson Sherry Sanderford. In November 2014, Aetna acquired bswift, which provides a technology platform that offers a retail shopping experience for health insurance exchanges and employers nationwide. That acquisition is part of the company's private exchange strategy.

Medica also operates its own private exchange where it offers five ACO-based products and a broader network within the ACO group. Employers that choose to offer coverage through the exchange give their workers a choice between the ACOs and the more expensive broader network option. To ensure adequate specialist representation, the broader option includes some specialists who are part of the ACO but not part of the major care system at its core. According to Bury, 93% of members enrolled in ACO networks re-enroll each year during open enrollment, indicating high satisfaction with the program, he says.

Contact Bury at greg.bury@medica.com, Sanderford at sanderfords@aetna.com and Jordana Choucair for Schuyler and Muhlestein at jordana.choucair@leavittpartners.com. ✧

Average Individual Premium Rates for Medica's 2015 ACO-based Exchange Plans, by Metal Level

Metal Level	Provider Group	Premium*
Catastrophic	Inspiration HealthEast	$134.66
	Medica with Mayo Clinic	$154.76
	North Memorial Acclaim	$128.32
Bronze	Inspiration HealthEast	$208.87
	Medica with Mayo Clinic	$240.07
	North Memorial Acclaim	$199.05
Silver	Inspiration HealthEast	$237.62
	Medica with Mayo Clinic	$273.09
	North Memorial Acclaim	$226.43
Gold	Inspiration HealthEast	$275.97
	Medica with Mayo Clinic	$317.17
	North Memorial Acclaim	$262.98

*Average premiums based on a non-smoking 40-year-old individual.
SOURCE/METHODOLOGY: Calculated by AIS from data in AIS's *Health Insurance Exchange Database: 2015 Plans and Premiums*. For more information or to order, call (800) 521-4323 or visit http://aishealth.com/marketplace/health-insurance-exchange-database.

Carriers Look to Retain Workers If Small-Group Market Fades

Rather than offering health coverage that complies with the Affordable Care Act (ACA), many small firms have dropped coverage and encouraged workers to buy individual products through a public exchange.

The ACA doesn't require small employers (i.e., those with fewer than 50 workers) to offer health insurance to their workers. While attrition in the small-group market is nothing new, transitional guidance that allows employers to continue their pre-ACA coverage expires in October 2016 in a majority of states. Moving to coverage that complies with the ACA will be more expensive for small firms and could prompt them to consider alternatives such as encouraging low-wage and part-time employees to buy coverage through the public exchanges.

Over the past two years, Blue Cross Blue Shield of Kansas City has seen almost 5,000 small-group members migrate to individual plans. In response, the insurer last year reorganized its sales department. Under the new arrangement, small-group and individual markets are merged and are serviced by one of two sales teams. Each team oversees 750 brokers who focus on both segments, says Ron Rowe, vice president of sales.

"We made this change because we thought the small-group market was going away. We decided we needed to get in front of it and manage it." It was a big

change, he recently told *HEX* sister publication *The AIS Report on Blue Cross and Blue Shield Plans.*

The federal subsidies available to low-wage workers through public exchanges have fueled an exodus from the small-group market, which is expected to grow as the definition of small-group increases to 100 or fewer employees under the Affordable Care Act. Wellthie, a health care IT company, recently launched a decision-support platform that it says will make it easier for health plans to retain members by helping employers and their workers evaluate coverage options as they transition from group coverage to individual insurance.

Wellthie CEO Sally Poblete says if employers view their insurance carrier as a consultative partner, their employees are more likely to consider enrolling in individual or group plans offered by that carrier. She notes that while a business owner can't require workers to buy insurance if an employer discontinues coverage, the employee could face a tax penalty for being uninsured. A communication platform helps explain the penalty and offers strategies for navigating the exchanges.

While there are differences between small-group and individual products, she says there are many similarities from a rating perspective. Prior to launching Wellthie two years ago, Poblete spent eight years at Anthem, Inc., where she led various aspects of product development for commercial insurance.

The group-to-individual program generates simultaneous quotes for small-group and individual product options, estimates for federal subsidies and penalties, and monthly and annual cost breakdowns for employers and employees.

While many health plans report a shrinking small-group market, the changing market also is an opportunity, Poblete says.

Visit http://wellthie.com. ✧

Will Exchange Competition Grow?

continued from p. 1

In a prepared statement, Janice Torrez, vice president of external affairs at the New Mexico Blues plan, said that without an "adequate" increase on premium rates, the insurer is left with little choice but to limit its offerings in the individual insurance market next year.

Amy Dowd, CEO of the New Mexico Health Insurance Exchange, says that if the New Mexico Blues plan pulls out of the exchange, there will still be plenty of choice for consumers looking to shop on the exchange during open enrollment this fall.

The New Mexico Blues plan isn't the first carrier to step away from a public exchange. Aetna Inc. in July said it wouldn't offer 2016 coverage through Washington, D.C.'s exchange. Assurant Health, which sold coverage through public exchanges in 16 states this year, left the health insurance business in the spring *(HEX 5/15, p. 10)*. Two Community Operated and Oriented Plans won't continue, and nearly all of the remaining CO-OPs are in the red, according to a recent report from the Office of Inspector General (see story, p. 1). Four of the nation's five largest health plan operators are awaiting regulatory approval to combine. And PreferredOne, the low-cost leader on Minnesota's exchange in 2014, opted not to participate for 2015 after capturing 60% of the exchange's business *(HEX 9/18/14, p. 1).*

Now that carriers have more information about their new exchange members, they have either adjusted their rates to reflect that population or they have exited the market. Some carriers have proposed rate hikes of more than 50%. If insurers can't sustain a provider network at any rate, they have to exit some markets, says Ashraf Shehata, KPMG's advisory leader for health plans.

And securing low rates from provider networks is getting more difficult as carriers enter the third year of public exchanges, he adds. The strength of the provider market means some health systems are able to refuse to cut rates for products sold on exchanges, Shehata says. They're asking why they should make price concessions for exchange-based products when they're getting pretty good pricing right now through Medicare Advantage and traditional Medicare. Even Medicaid, in states that expanded the program, is offering providers relief from bad debt. "Providers are starting to stand up now and say, 'maybe I don't want to take some of these concessions.' As a result, the environment is changing for rates to start increasing."

Will M&A Push Costs Higher?

According to the HHS report, most Americans who signed up for coverage on the federally run health exchanges for 2015 had more options than they had the prior year. A market-by-market analysis concludes that the increased competition helped hold down the growth in premiums. Christopher Condeluci, a principal at CC Law & Policy in Washington, D.C., questions the timing of the report, which was released shortly after the nation's largest carriers took steps toward consolidation.

On July 24 — a month after acquisition talks broke down — Cigna Corp.'s board agreed to be acquired by Anthem, Inc. in a deal valued at $54.2 billion. The proposed acquisition, which is expected to face close regulatory scrutiny, could close by the end of 2016. Earlier in the month, Humana Inc. agreed to be acquired by Aetna Inc. for about $37 billion in cash and stock. A combined Aetna Inc./Humana Inc. entity would represent a quarter of

all members enrolled via public exchanges. Also in July, Medicaid managed care operator Centene Corp. said it would purchase Health Net, Inc. in a cash and stock transaction valued at around $6.8 billion *(HEX 7/15, p. 8)*.

"The Administration apparently wants to get out in front of the Aetna-Humana and Anthem-Cigna mergers to tamp down any perceived hysteria about reduced competition," Condeluci wrote in his blog.

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 July 16:

August 12, 2015

- Booz Allen Wins $202 Million Contract for HealthCare.gov
- Vermont Exchange Cut Backlog In Half, Shumlin Says
- Eligibility Verification for Federal Exchanges Fell Short
- Automatic Data Processing Launches Private Exchange

August 5, 2015

- New York Slashes Requested Exchange Rate Hikes to 7.1%
- Most SEP Enrollees Lost or Are Losing Coverage
- Cost of Coverage Trumps Provider Choice on Exchanges
- Nearly All CO-OPs Are In the Red

July 29, 2015

- Another CO-OP Bites the Dust
- Covered California Touts 4.2% Average Rate Hike For 2016
- Study Shows Exchanges Were Effective at Re-Enrollment
- Estimated 300,000 Tax Filers Paid Fine for Being Uninsured

July 22, 2015

- Contractor Agrees to Refund $45 Million for Maryland's Failed Exchange
- GAO 'Secret Shoppers' Expose Flaws in Exchange Eligibility Checks
- Private Exchanges Are Poised to Alter Employer-Based Insurance
- Minnesota Exchange Rolls Back Projections

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While consolidation of the large publicly traded health plans is certain to have an impact on the competitive landscape, it isn't likely to be severe given the complementary nature of the deals, says Howard Lapsley, a partner in Oliver Wyman Group's Health & Life Sciences division. "And believe it or not, there are still plans —of all types — on the sidelines actively contemplating joining the fray, or expanding, and are feeling more confident as more information becomes available, even as the reinsurance and risk corridor programs are set to expire," he says.

The merged companies will have more clout when negotiating rates with providers, but they won't necessarily use that clout to drive rates down, says Shehata. "What they might do instead is drive preferred provider networks around some of their specialty products," he says. As health systems consolidate, they are better able to protect their pricing power in the market. Unlike health plans, they are combining forces to keep prices up. Carriers that are able to replicate provider networks across multiple products, such as Medicare Advantage, Medicaid and exchanges, will be better positioned to create leverage across that health system, he adds.

Other Carriers Might Fill Void

With no prior claims history, carriers had to leverage many assumptions when building rates for their exchange products. In many cases these assumptions were not realized. That led to losses and departures from the exchange. "As the program stabilizes, carriers should become more confident in their ability to underwrite, which could increase competition," says Laurie Doran, chief financial officer at Boston Medical BMC HealthNet Plan/Well Sense Health Plan, an insurance company owned by Boston Medical Center that sells coverage through the Massachusetts exchange. The company has more than 300,000 members. Doran says if there continue to be incentives for provider organizations to develop health plans, there are likely to be more of them on the exchanges. "Individuals shopping for insurance…may find well-priced limited network offerings desirable, as long as they are comfortable with the providers who are available. This offers a growth opportunity for accountable care organizations that are willing to develop insurance capabilities."

To see the Office of the Superintendent of Insurance's statement on the New Mexico Blues plan, visit www.osi.state.nm.us/docs/BCBSNM.pdf.

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