Response to Request for Information

THE STATE OF WEST VIRGINIA
Insurance Commission

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Proposer Information

Qualifications

Wakely Consulting Group (Wakely), founded over 30 years ago, is a mid-sized consulting firm that specializes in health care financing, working directly with government and commercial health insurance carriers on public and private program offerings. Wakely has considerable experience in carrying out complex projects, yet its size and structure allow it to be nimbler and more responsive than larger, national firms. Its corporate headquarters is in Clearwater, Florida, with additional offices in Denver, Louisville, and Boston.

Wakely's business model succeeds because of the high level of service and time commitment from senior staff, consisting of 20 actuaries and financial and management consultants. Wakely professionals work with public and private boards of directors, advocacy groups, state agencies and authorities, health insurance carriers, hospitals, health centers and physician groups. In addition to many actuarial analyses for state programs and private firms, Wakely consultants have led efforts in:

- health plan strategic and financial planning;
- provider network development and contracting;
- public policy development;
- health insurance product development;
- use of predictive modeling and risk adjustment methodologies; and
- development and administration of state-subsidized health insurance programs for low income adults and health insurance exchanges.

Beginning even before enactment of the Affordable Care Act (ACA), and increasingly since its passage, Jon Kingsdale and Patrick Holland have consulted to numerous states and to the U.S. Center for Consumer Information and Insurance Oversight (CCIIO) on developing state-based insurance exchanges

and a federal fall-back exchange. The level of sophistication and experience that Wakely's professionals have accumulated in the health care industry, combined with a direct and deep understanding of health insurance exchanges and ACA, make Wakely uniquely qualified to lead the planning and development activities for the implementation of a health insurance exchange in West Virginia.

Wakely has assembled a broad and experienced team of consultants to deliver first-rate strategic advice, conduct research and data analysis, perform actuarial and financial modeling and provide project management services to assist West Virginia in determining the impact of a health insurance exchange on the individual and small group insurance markets. Patrick Holland and Jon Kingsdale, Managing Directors of Wakely's Boston office, will actively lead the project in West Virginia and are personally committed to ensuring that the entire project team provides the appropriate analytic and support services to the Offices of the Insurance Commissioner in a timely, responsive, and thorough manner.

Patrick Holland, with over 25 years of experience in the health care industry, will serve as the overall Project Director for this engagement. Patrick brings to this engagement a broad background, including accounting, finance, strategy and analytics, with direct leadership experience at several health insurance and several provider organizations. Prior to starting the Boston office of Wakely, Patrick was the Chief Financial Officer of the Commonwealth Health Insurance Connector Authority ("the Connector"), an independent authority established in 2006 to implement key provisions of Massachusetts' landmark health reform law and, as the first state-run health insurance exchange in the country, a model for national health care reform. At the Connector, Patrick was primarily responsible for the development of the financial operations, eligibility, enrollment integrity and reconciliation, and the analytical support planning and implementation of carrier procurements for the exchange. Under his leadership, the Connector designed health plan procurements which produced an annualized four-year trend of below 5 percent for the subsidized program, implemented an innovative risk adjustment methodology in the subsidized program, and developed an insurance program for unsubsidized legal immigrants. Patrick will coordinate and have ultimate responsibility for all financial analyses.

Jon Kingsdale, Ph.D. led a Washington, D.C.-based health policy consulting practice for three years, taught and conducted research at the Harvard School of Public Health, helped manage the Massachusetts, all-payer, prospective hospital rate-setting system, and led strategic planning, product development and public affairs for New England's third largest health plan. After 25 years of experience at two health plans, Jon served as the Connector's Executive Director for the first four years of reform. In this role, he led key initiatives to make health insurance universally available and to reform health

care financing in Massachusetts. Since leaving the Connector eight months ago, Jon has led Wakely's consulting engagement in California, which contributed to developing the first state insurance exchange under ACA, and has advised a half-dozen other states on developing their insurance exchanges. He is frequently asked to speak to employers, insurers, clinicians, hospital executives and policymakers on national health reform and insurance exchanges.

Ross Winkelman, FSA, MAAA, has over 17 years of experience as a health care actuary and has been involved in pricing for both commercial and government programs. He currently leads Wakely's actuarial efforts to support the Connector on rating, risk adjustment, and procurement strategy. He has developed a number of pricing models for government programs, including the Connector, Medicaid, Medicare and Tricare, in addition to Medicaid expansion programs in Colorado and Missouri, and financial models for high risk pools offered under ACA.

Debra Hayes is a Senior Consultant with extensive health insurance and provider experience. Her expertise will be invaluable for the tasks related to eligibility and enrollment systems, finance, and consulting services.

Ann Hwang brings a unique set of credentials to the project as someone who has worked in both the policy and clinical worlds – she was a senior policy advisor at the Connector and is also a practicing physician.

Jacqueline Snow is currently a graduate student at the Harvard School of Public Health. She will serve in a support-level capacity for this project.

Dr. Jonathan Gruber is a Professor of Economics at the Massachusetts Institute of Technology, where he has taught since 1992. He is also Director of the Health Care Program at the National Bureau of Economic Research. He is an Associate Editor of both the *Journal of Public Economics* and the *Journal of Health Economics*. In 2009 he was elected to the Executive Committee of the American Economic Association. He is also a member of the Institute of Medicine, the American Academy of Arts and Sciences, and the National Academy of Social Insurance.

Dr. Gruber received his B.S. in Economics from MIT and his Ph.D. in Economics from Harvard University. He has received an Alfred P. Sloan Foundation Research Fellowship, a FIRST award from the National Institute on Aging, the Kenneth Arrow Award for the Outstanding Health Economics Paper of 1994, the Richard Musgrave prize for the best paper in the National Tax Journal in 2003, and the 2009 Purvis Prize

from the Canadian Economic Association for the best public policy publication of the year. He was also one of 15 scientists nationwide to receive the Presidential Faculty Fellow Award from the National Science Foundation in 1995. In 2006 he received the American Society of Health Economists Inaugural Medal for the best health economist in the nation aged 40 and under. Dr. Gruber's research focuses on the areas of public finance and health economics. He has published more than 120 research articles, has edited six research volumes, and is the author of *Public Finance and Public Policy*, a leading undergraduate text.

During the 1997-1998 academic year, Dr. Gruber was on leave as Deputy Assistant Secretary for Economic Policy at the Treasury Department. From 2003 to2006 he was a key architect of Massachusetts' ambitious health reform effort and in 2006 became an inaugural member of the Connector's Board of Directors, the main implementing body for that effort. In that year, he was named the 19th most powerful person in health care in the United States by Modern Healthcare Magazine. During the 2008 election he was a consultant to the Clinton, Edwards and Obama Presidential campaigns and was called by the *Washington Post*, "possibly the [Democratic] party's most influential health-care expert." During 2009-2010 he served as a technical consultant to the Obama Administration and worked with both the Administration and Congress to help craft what would become ACA.

Claudia Page co-manages **Social Interest Solutions (SIS)**, which is a national technology organization that focuses on improving enrollment and retention in public and privately funded health and social services programs by reforming and modernizing systems and processes. SIS provides systems development, enhancement and hosting, systems analysis, gap assessments and consulting and technical assistance on products ranging from enrollment systems to case management and patient prescription assistance.

Social Interest Solutions' One-e-App eligibility and enrollment system is currently used in Arizona, California, Indiana and Maryland by state and county government agencies, hospitals, health plans, clinics, community-based organizations and other organizations – giving SIS on the ground experience in systems implementation and management. It is a "middleware" solution offering an intuitive consumer front end, an eligibility rules engine, and integration with back-end systems, many of which are old and inflexible state and county systems. For more information please visit www.socialinterest.org.

In addition to technical expertise, SIS drafted Section 1561 of the Affordable Care Act and has been consulting to the Office of the National Coordinator, for Health Information Technology, Department of

Health and Human Services, regarding online HIT enrollment standards. Claudia is intimately knowledgeable about eligibility determination for subsidized coverage in a number of states and federal IT guidance related to systems readiness for ACA implementation in 2014. In addition, SIS developed the Healthy Maryland enrollment system, which will be leveraged as part of the states recently awarded Early Innovator award from Health and Human Services to establish a state health exchange. Claudia and the SIS team will assess West Virginia's existing Medicaid eligibility system and identify integration opportunities and requirements for Medicaid, CHIP and exchanges.

Summary of Relevant Experience

Wakely has been involved in numerous government projects. We have helped these projects succeed through disciplined analytic work, thorough assessment of options, creative problem solving, attention to deadlines, and the ability to clearly communicate and document complex issues. While success can be measured in a number of different ways, we believe client satisfaction is the most important, and one in which we excel based on the feedback we have received from clients. Our clients have renewed our contracts as needed and have consistently referred us to other potential clients. Several examples of our government projects are below:

Commonwealth Health Insurance Connector Authority

Wakely is currently engaged with Massachusetts' Commonwealth Health Insurance Connector Authority ("the Connector"), the independent agency created in 2006 to implement key provisions of the state's landmark health care reform law, on a number of critical projects. Our engagement with the Connector is particularly relevant to West Virginia's Exchange Planning project.

We are assisting or have assisted the Connector in the following areas: selection of capitation rate assumptions, capitation rate build-up, RFP development, health plan rate negotiations, selection and calibration of risk adjustment model, impact on pricing of benefit changes, financial and carrier impact of eligibility rules changes and consideration of risk adjustment model implementation into rating approach, and consideration of risk adjustment model implementation into rating approach.

We are working with the Connector on pricing and modeling for both of its programs: Commonwealth Choice and Commonwealth Care. For Commonwealth Choice, a private insurance exchange for individuals and small business, Wakely is engaged in the following areas: minimum creditable coverage rules and impacts of changes, selecting standardized benefit designs and strategic advice and support.

For Commonwealth Care, a subsidized health insurance program for low income adult residents, Wakely is assisting with benefit plan modeling and pricing as well as with the implementation of risk adjustment.

Finally, we have developed several pricing models for the Connector and have trained the agency's staff in their use. These models could be used 'off the shelf' for planning purposes and would likely form a conceptual basis for models we may develop for West Virginia.

Colorado Department of Health Care Policy and Financing

The State of Colorado's Department of Health Care Policy and Financing contracted with Wakely to analyze various benchmark plans allowed for Medicaid expansion populations under the Deficit Reduction Act (DRA). Our analysis focused on the review of claim cost projections associated with the benchmark plans and a population largely concentrated toward adults without dependent children who fall below 100% of the federal poverty limit (FPL). The benchmark plans analyzed were: Colorado State Employee Plan, Colorado's largest HMO, FEHB Plan, Colorado Medicaid, Kansas Medicaid Expansion, Kentucky Medicaid Expansion, Idaho Medicaid Expansion, Virginia Medicaid Expansion, West Virginia Medicaid Expansion and Washington Medicaid Expansion.

Our analysis used underlying base period data that we believe to be comparable to the Medicaid expansion population in Colorado. The Massachusetts health care system provides a unique outlook into the health care utilization and costs associated with a Medicaid expansion population. Accordingly, we made use of the Commonwealth Care program's historical data for our work with Colorado.

Other government clients:

Wakely has engaged with other government agencies and programs, including the following:

1. Provided technical assistance to numerous states through a contract with Academy Health. This assistance has included planning for state-based exchanges; review of proposed legislation; educating and informing state officials regarding the financial and operational considerations in implementing an exchange; and developing an implementation timeline for key tasks.
2. State of California: We have worked with legislative staff, the administration of Governor Schwarzenegger and various stakeholders to inform the development and refinement of draft legislation S. 900 and AB 1602, authorizing the establishment of the California Health Benefit Exchange, (CHBE) in accordance with the federal Patient Protection and Affordable Care Act .
3. Arizona Medicaid: We developed the risk adjustment methodology for the Arizona Medicaid program. After developing the initial methodology and working through significant stakeholder

(health plan) concerns, the State asked us to update the model with new data for the current contract year.

4. Wisconsin: We consulted to the state on the development of its exchange, providing input on a suite of policy and implementation issues during the summer and fall of 2010. We also recently completed a draft issues and recommendations paper for the state that identifies key technical and operational issues states must consider under ACA relative to the risk adjustment provisions. This paper can be available to West Virginia when finalized by Wisconsin.
5. Missouri: We are consulting on a broad array of financial, operational and IT challenges in planning for Missouri's non-group and SHOP exchanges under ACA. We are beginning to work with state officials to develop a Level 2 proposal under CCIIO's recently released exchange establishment RFP.
6. CCIIO: We are working with HHS to identify requirements, evaluate the challenges and develop options for establishing the federal fallback exchange that ACA authorizes, as an alternative to state-based exchanges for "non-electing" states.

A final note about data: Wakely and our subcontractors have access to numerous data sets from various Medicaid and reform programs to augment data we purchase. Examples include the Medicare 5% Sample (Limited Data Set), the Federal e-Health database and the Medical Expenditure Panel Survey (MEPS). Our data analysts have thousands of hours of experience working with these healthcare datasets and our clients' own healthcare claims data.

The following is a small sampling of state and federal health care reform projects with which Jon Gruber has been involved (many more are available upon request):

- Universal Health Care Foundation of Connecticut
  Consultant to the Universal Health Care Foundation of Connecticut for modeling the impact of ACA on the state, considering in particular the role of the "Sustinet" option.
- California Blue Shield Foundation
  The California Blue Shield Foundation contracted with Jon Gruber to model the impact of the ACA on the State of California.
- The State of Wisconsin
  Consultant to the State of Wisconsin engaged to model the impact of ACA on the State of Wisconsin, considering in particular policy decisions faced by Wisconsin in implementing ACA.

The following is a small sampling of state and federal health care reform projects with which SIS has been involved (many more are available upon request):

- Health-e-Arizona Public Access
  SIS developed and implemented an eligibility and enrollment system known in the state of Arizona as Health-e-Arizona. While the system has been used for 5 years statewide by benefits counselors in clinics and hospitals, in December 2008, Social SIS and the State of Arizona launched a publicly accessible version of the online tool permitting consumers to apply for Medicaid, Food Stamps (SNAP), cash assistance and other programs from their homes, public libraries and other locations. SIS led requirements and technical development and manages the ongoing operations of this Web-based eligibility and enrollment system for public and private health and social services programs. In the first 24 months of the unassisted online channel, almost 775,000 individuals using the system without assistance were enrolled in or renewed coverage in Medicaid and CHIP and more than 325,000 households were enrolled in or renewed SNAP and TANF benefits. Greater than ninety percent of online consumers in Arizona are satisfied and would use the system again.
- Office of the National Coordinator for Health Information Technology (ONC)

Consulted in partnership with Senator Barbara Mikulski and Senate Health Education Labor and Pensions (HELP) staff, SIS drafted Section 1561 of The Affordable Care Act which relates to developing IT standards for enrollment and eligibility systems. After a successful initial consulting period, ONC contracted with SIS for a second phase of consulting to provide guidance and support on standards implementation and developing consumer-mediated processes and systems to support enrollment via health insurance exchanges.

Recommendations on Governance

Exchange Governance is left largely to the discretion of the states under the ACA, and we are familiar with a variety of models. For example, Utah runs its exchange on a highly outsourced model overseen by three staffers in the Governor's office. (With only 1,200 enrollees as of November 1, 2010, this is still a very modest-sized operation.) Connecticut's Health Connections, Cleveland's Council of Small Enterprises ("COSE"), and California's PACAdvantage are/were run by non-profit organizations representing employer coalitions. Massachusetts set up its exchange as a semi-independent state authority, governed by a board of directors from state agencies and the private sector, which is also the model for the recently authorized California Health Benefit Exchange. Wisconsin is considering a plan to

have Medicaid operate its exchange on contract to an independent exchange board. Washington and Oregon are considering super-agency models that would coordinate coverage for state employees, Medicaid and the new exchange.

Governance should support the goals and functions of an exchange, as described at a high level in the Conceptual Model. Various governance options will be presented and analyzed, in tandem with conceptual models. For example, an independent board representing the participating states would be one obvious choice for a multi-state exchange. We will describe how existing exchanges are governed, including what their stakeholders and managers think are the pros and cons of each model, and we will explore other options allowed by the ACA.

Perhaps more than any other issue, the choice of governance and its specific elements – which state agency to house an exchange in or to represent on its board, how much management should be outsourced, how it should relate to the Governor's office--will depend upon state traditions, current political circumstances, and the goals for the exchange set by state policymakers. Therefore, a key part of the stakeholder assessment and outreach plan will be to gather detailed feedback on the governance options. As in all aspects of outreach to stakeholders, we will plan and execute this work hand-in-glove with the client.

The product of this analysis should include a list of pros and cons for each governance option. This list should also include especially strong negative perceptions gathered in stakeholder interviews, meetings and focus groups, plus a confidential method of ascribing those "risks" to particular viewpoints or perspectives on reform.

Suggestions on Design

The layout of the tasks included with the RFI are very similar to those in RFPs issued by other states. We were awarded projects in a number of states and have begun work. We would suggest that West Virginia make it very clear who will be leading efforts on the State's behalf, what type of firm they desire to lead the Exchange planning efforts (management, economic, actuarial, technology, legal, etc.). In addition, assuming the state is currently working with consulting and technology firms in existing healthcare programs, listing those firms, their role and what coordination can and should take place during the Exchange planning efforts would be helpful to proposers.

Additional Necessary Information

If any decisions have been made regarding the structure of the West Virginia Exchange and reform approach, providing that information as part of the RFP would be helpful in understanding the scope of the project. For example, is West Virginia contemplating moving the Medicaid program underneath the Exchange? Are there any structural, political or market constraints regarding selective contracting? Knowing what is both on and off the table in terms of potential decisions and directions will focus proposals towards the key issues West Virginia needs to address.

Approach

We have assembled a team that combines deep policy expertise in health care reform and practical management experience with exchanges and Medicaid. Our team has considerable experience at both the federal and state level, including a wide variety of states. The approach described in this section reflects our experience working on the kind of insurance exchanges and reform that West Virginia must address under the ACA.

The core of our approach to the first four tasks is a novel integration of *economic* and *actuarial* modeling. Economic or "microsimulation" modeling is designed to assess the impact of interventions in health insurance markets on flows across those markets in terms of both people and dollars. Actuarial modeling is designed to assess the impact of changes in the rules governing insurance markets and the composition of individuals in those insurance markets on insurance market pricing. Both approaches have traditionally proceeded in a vacuum, but we propose to integrate them in order to achieve substantial gains in predictive power.

The primary weakness of economic models is the lack of expertise in translating reforms and population changes into insurance pricing rules. Microsimulation models can effectively capture movements across markets by different groups, but without actuarial techniques they can only make broad assumptions about how those movements, or other government regulations, will impact pricing in the insurance market. The primary weakness of actuarial models is that they typically do not model population movements in a very sophisticated way, e.g. not fully capturing the impacts of firm decisions for individual movements across insurance types. This is particularly important for a reform like ACA because the majority of those enrolling in the new exchanges will likely come from outside the existing non-group market.

A solution to these weaknesses is to combine these two modeling approaches: to use the sophisticated model of population movements from microsimulation modeling in combination with the sophisticated model of pricing from actuarial modeling. Such a combination is rare in policy analysis, but we propose to do so in addressing the questions raised above. It will generate considerably more reliable projections and estimates than would either one, alone. Since the budget and political consequences of mis-projection can be catastrophic, the value of this added credibility is very high.

We first describe the economic and actuarial models, and the qualifications of each team. We then discuss how they can be integrated to address the specific questions raised in the RFP.

The Gruber Microsimulation Model (GMSIM)

The economic analysis will use the Gruber Microsimulation Model (GMSIM), which has been used over the past decade by a wide variety of state and federal policy makers to analyze the impacts of health insurance reforms.

This model was first developed in 1999 for use in estimating the impact of tax credits on health insurance coverage, with funding from the Kaiser Family Foundation. Over the subsequent decade, the model's capability has been expanded to consider the full variety of possible health interventions, including public insurance expansions, employer or individual mandates, purchasing pools for insurance, single payer systems, and more. This model is widely used for a variety of health insurance modeling tasks; a partial list of sponsors over the past several years includes: The Kaiser Family Foundation; The Commonwealth Fund; The California Endowment; The California Health Care Foundation; The AFL-CIO; The Blue Cross/Blue Shield Association; the Universal Health Care Foundation of Connecticut; and The Robert Wood Johnson Foundation.

GMSIM has recently been used by a number of states to model state-specific health insurance reforms. In particular, GMSIM modeling for the Commonwealth of Massachusetts was a basis for recent health insurance reform proposals in that state. This model was used first by Governor Romney's administration as they developed their proposals, and then for the legislature as they considered alternative paths to translating this proposal into legislation. Over the past few years, the model has been used in states such as California, Delaware, Kansas, Michigan, Minnesota, Oregon, Vermont, Wisconsin and Wyoming to model policy options in those states. GMSIM was also used extensively by both the Obama administration and Congress during the debate over ACA.

Actuarial Modeling

Wakely's actuarial benefit pricing models will be used to inform the economic modeling and to understand the impact of changes in markets (i.e. merging markets) and benefit requirements (essential benefits, precious metal actuarial values, etc.). Wakely has developed pricing models for the previously uninsured population as part of our work on the Massachusetts Commonwealth Care health insurance program, on Medicaid expansion modeling in Colorado, and as part of our work for the St. Louis Regional Health Commission. We propose to use West Virginia specific data to calibrate these models, so that actuarial modeling can be integrated with the economic modeling. We have used these models on the Commonwealth Care Choice (CommChoice) program, in developing actuarial values and in standardizing precious metal benefit options under CommChoice.

Health plans will seek out advantages and opportunities in the new structure and exchange planning should anticipate these reactions and address them. Because Wakely actuaries have worked on behalf of states and health plans on many government sponsored program procurements, we understand the strategies that health plans employ. These strategies generally relate to procurement or product design if there are segmented markets. Health plan strategies include selective regional bidding strategies, provider network development to avoid individuals with certain conditions, targeting of certain populations or rate cells, gaming of certain enrollment mechanisms and reinsurance provisions and others. We have significant experience carefully thinking through the potential for these gaps and inappropriate incentives from both the health plan and government agency perspective. In addition, our historic and ongoing work on risk adjustment and risk selection, including the use of non-traditional risk adjustment factors, will be critical in working through ways to avoid or mitigate risk selection and gaming.

Modeling ACA and State Reforms

GMSIM has been used to produce estimates of the impact of ACA as part of the Sustinet board deliberations. These "first generation" estimates, however, did not incorporate the rich actuarial insights available through this collaboration with Wakely. Under this proposal we would integrate our teams to produce the best estimates to date of the impact of this law change on West Virginia. In particular, we will proceed as follows:

- GMSIM will be used to produce "first pass" estimates of the impact of the changes in ACA on the state

- GMSIM will then send to Wakely information on population flows under that first pass estimate – including, critically, the age and health of those who move into the exchange from other markets such as employer-sponsored insurance, public insurance, and uninsurance
- Wakely will use that information on the composition of the exchange, along with the effects of the various reforms to the market, to estimate a new set of premiums for the exchange
- GMSIM will use these new premiums to re-estimate population flows, and feed them back to Wakely
- If the population flows change meaningfully, then Wakely will estimate a new exchange price to feed back to GMSIM. And so on, in an iterative fashion until both sets of projections are fully integrated.

The end result will be a combined set of output from Wakely and GMSIM that shows the effect of ACA on a wide variety of outcomes:

- What is the impact of reform on prices in the insured markets? The insured markets that we will analyze include various segments such as:
    - Grandfathered vs. non grandfathered business
    - Non-group population
    - Small Employer group
    - Large Employer group, separated into up to 100 employees and 101+ employees
    - High risk pools
- Impact on prices paid by varying types of individuals and firms, e.g. young vs. old and micro vs. small firms
- Winners and losers analysis
- Who Gains Insurance and Who Remains Uninsured Under Reform?
- Demographic characteristics of this group (age, gender, race, education, income)
- How many newly insured were previously eligible for subsidized coverage, either through ESI or through Medicaid?
- How many remaining uninsured are eligible for ESI or new subsidies and are not taking them
- What do these reforms imply for the short run uninsured versus more chronically uninsured?
- Migration Among Insurance Categories
- Movements from and to each type of insurance coverage
- Breakouts of non-group coverage into exchange, grandfathered, and non-group coverage

- The characteristics of individuals who move across insurance categories (e.g. age, health status, income)
- Changes in the characteristics of the pool in each type of insurance coverage (e.g. does the pool of those with ESI get sicker due to reform)? How will these changes in characteristics impact the insured pool and price?
- Impacts on Employer Provided Insurance
- Changes in costs of ESI
- Changes in insurance offering rates
- Changes in employer contribution rates to insurance premiums
- Changes in the generosity of insurance packages purchased by employers
- Impacts on Household Budgets
- Tax credits to the cost of insurance
- Changes in wages in response to changes in ESI discussed above
- Changes in employee contributions to ESI
- Changes in expected out of pocket spending on medical care
- Changes in tax payments in response to wage and other changes

Survey and Analysis of the Current Insurance Market

Wakely has experience working with health insurance carriers to get data and information. The process can be difficult and needs to be managed carefully with clear expectations, timelines and detailed review of the information coming in. Wakely has access to the Federal e-Health database and can pull enrollment, premium and benefit design info for the individual and small group markets.

We will use our actuarial pricing models to review the benefit plan factors and/or paid to allowed ratios (actuarial values) provided by the carriers. These models will also allow us to assess the impact of essential benefit requirements and changes necessary to meet precious metals benefit levels. Our actuarial pricing models have been used on many different commercial programs, including the Commonwealth Choice and Commonwealth Care programs. We continually update these models and can calibrate them to a particular market using detailed or summary claims data and/or premium rate information.

The small group information will be used to inform the economic modeling so that estimates of the impact of various policy decisions can be made.

Analysis of Economic and Actuarial Models

High Risk Pools: A key decision for the state is the impact on coverage and pricing of integrating the existing high risk pool with the newly reformed exchange. We will model this by incorporating claims data collected from the high risk pool into our model, and assessing the impact on pricing of adding these less healthy individuals to the pool.

Small Group Definition: Another important decision is whether or not to expand the definition of small groups. Wakely will collect data on both groups – those below 50 and those size 51-99 - in order to understand the implications of including the latter group into SHOP exchanges. GMSIM will be used to model the implications on the size of the employer-insured population if this definition is expanded.

Impact on Employer-Sponsored Insurance (ESI). As noted above, a key feature of GMSIM is the ability to consider firm decision making. This decision making incorporates all of the features of ACA, including employer penalties and tax credits. Having modeled these effects, we can readily consider the impact of variation either the penalties or tax credit levels.

Pricing in the Small and Non-Group Markets and Market Mergers. A central aspect of the collaboration between GMSIM and Wakely is that we will be able to provide cutting edge dynamic estimates of the impact of reform on pricing in the small and non-group markets. Moreover, we can use the data collected from both markets to consider a market merger through similar methods to those described above: Wakely can provide estimates of a market merger on prices facing individuals and small groups, and GMSIM can then be used to assess the impact of the merge on movements into and out of the newly merged markets – with any feedback effects back to prices.

The Impact of the Individual Mandate. One of the pillars of ACA is the individual requirement to purchase insurance. GMSIM has been used repeatedly in the national setting to model the impact of this requirement on coverage and government costs, but a central aspect of any such modeling is the effect on prices. By combining these models we can assess how the large movements into insurance by the young health individuals mandated to purchase by ACA affects prices in the non-group market.

The Basic Health Option. A key flexibility under ACA is the ability of states to implement the Basic Health Option (BHP) for those 133-200% of poverty. Rather than simply enrolling individuals in this income range into exchanges, paid for by federal tax credits, the state can instead consider alternative innovative strategies that cost no more than 95% of what the population would have cost through

exchange credits. For example, the state could expand its Medicaid program to cover this population. We would model this type of BHP option to consider the implications for costs and coverage in the state.

Note that simply expanding public insurance would likely cost less than 95% of the cost of tax credits due to much lower provider reimbursement in the public program; in this case, we could model the extent to which the state could use the extra funds to raise provider reimbursement under the program.

<u>The Cost of State Mandated Benefits</u>. In West Virginia, as in all other states, there are a set of mandated benefits that must be included in fully insured products. ACA is explicit that the costs of any such state mandated benefits that exceed what is included in the essential health benefits definition must be broken out specifically. Moreover, for the large number of West Virginia residents receiving tax credits through the exchange, the state must supplement the government cost of such credits to the extent that they are increased by state mandated benefits. It therefore becomes important for the state to revisit the issue of state mandates as they consider ACA implementation. Unfortunately, during the time period of this engagement, we will likely not know with certainty what is in the federal essential health benefits package. But Wakely will consider some alternatives, and for each price the extra cost of state mandated benefits. Working with GMSIM, they will estimate the extra cost to state residents of purchasing insurance with these mandates, and the extra cost to the state of subsidizing low income individuals to purchase insurance that includes these state-mandated benefits.

<u>Impact on Insurer Profitability and Market Exit</u>: The health insurance exchange can create opportunities or challenges for the insurance market in general and for specific health insurance carriers. Each market is different and presents unique challenges and issues. Selective contracting, risk selection mitigation and other key issues will affect the potential for overall market challenges and for challenges to specific insurers. In addition, whether or not ACOs or new competitors enter the market will greatly influence insurer profitability and the potential for market exit. Because Wakely works for health plans on bids and feasibility in other government programs, we know how they evaluate and react to opportunities and challenges. We can also assist in the evaluation of communication from the health plans regarding the key structural elements of the exchange.

<u>Impact on Household Budgets</u>: As noted above, a key output of GMSIM is the impact of reforms on household budgets. This is a sophisticated analysis which includes all of the ways in which ACA changes household budgets: new public insurance entitlements; exchange tax credits; higher or lower wages; higher or lower out of pocket premium spending; higher and lower employer-sponsored insurance

contributions; higher or lower out of pocket medical costs; and so on. All of these various costs are aggregated to produce net impacts on household budgets, but the results can be displayed by category as well as divided by demographic or income group.

Analysis of The Large Group Employer Market Participation in the Exchange

Larger employers in West Virginia (and elsewhere) are priced using one of three methods: (1) a "progressive" blend of adjusted community and experience rating, with more weight accorded to their actual claims experience as mid-sized employers increase in size), (2) pure experience rating (for truly large employers), or (3) they are self-insured. These three methods are related to each other, but very different from community rating. Moreover, benefits and cost-sharing are often customized for large employers. By contrast, the exchange is required under ACA to use adjusted community rating ("ACR") for non-group and small-group pricing, and the benefit levels – Platinum, Gold, Silver, Bronze and catastrophic coverage –are also prescribed.

This feature of exchanges is more than a legal requirement—it is central to the concept of an exchange as a web-enabled store enabling comparison shopping because the exchange depends on what is often referred to as "manual rates" i.e. premium rates on standard products, contained in a table that can be accessed for instantaneous quoting. As a result, the individual buyer, employer or broker can enter some demographic data about the covered lives and generate premium rates which are fixed and comparable among plans. By contrast, experience rating starts with an analysis of the employer's claims history, adjusted according to each carrier's proprietary underwriting rules, plus a dash of the underwriter's "judgment" (for such factors as inflation, employment trend, aging, changes in benefits, etc.), and it often ends with a negotiation between the carrier and the employer over benefits changes and premiums.

If large employers were allowed to choose between these two approaches i.e., full or partial experience rating (or its close cousin, self-insurance) in the outside market, versus ACR in the exchange, that would disrupt insurance sales, underwriting and pricing. Generally, those employers with a sicker or older work force would go into the exchange to take advantage of community rating, whereas the younger, healthier groups would remain outside. Carriers in the exchange would have to raise their ACR premiums in anticipation of the influx of these sicker beneficiaries, and the resulting uncertainties would probably drive premiums up across West Virginia's entire insurance market.

Therefore, were large employers to be allowed into the exchange, one (or more) of several other major modifications in West Virginia's exchange and/or its insurance regulations would be required to avoid this catastrophe. Our analysis of the impact of allowing large employers into the exchange would differ considerably depending on which modifications are assumed.

Integration with Other Programs

We propose to lay out a vision for the exchange, taking improved program integration into account as one goal of that vision, and then proceed to map the differences and integration opportunities among both new and existing programs under this vision. We propose to begin this mapping process by overlaying the new non-group and small-group exchange programs (plus expanded eligibility for Medicaid) on top of existing programs. Part of the mapping process should include a quantification of the enrollee/patient flows amongst the different programs, so policymakers can focus on integrating those programs which are involved in the greatest amount of disruptive enrollee "ping-ponging." This will require data from the different programs on enrollee turn- over, sources of enrollment, average tenure in the program, etc.

In order to inform West Virginia's vision for an exchange, or to shape the vision, we propose to estimate the potential state cost savings, if any, from consolidating state programs. This work is especially relevant in the current budget environment, and we would perform this work by estimating how much: (1) shared federal/state cost could be shifted to 100% federal cost by changing or consolidating existing programs so that residents formerly covered under a state program would be eligible for the exchange and federal tax credits, and (2) how much administrative efficiency can be improved by consolidating and reducing the number of different coverage programs. Given a vision for exchanges and health reform in West Virginia, plus a map of the discontinuities amongst coverage programs under that vision—especially for enrollees, but for providers, employers and plans as well—we propose to develop a series of mitigating/integrating strategies and to test these recommendations with state policymakers and external groups, including consumer advocates.

This is best done as an iterative process, in which consensus is first built around the need for integration, identifying the particular programmatic opportunities for integration, and then considering various options for consolidation or for bridging the gaps between distinct programs. Because staff from the department of social services and other agencies knows the existing programs well, and because they will have to execute and "live with" any proposed integration strategies, we will explore integration opportunities and develop recommendations working hand-in-glove with them. If necessary, we can

consult with external groups, rather than propose to them, up to the point where we and the agency staff have developed concrete recommendations to present more formally to groups of users and advocates.

Develop a financial model for the exchange (cash flow) to understand the administrative charges necessary to be financially self-sustaining by January 2015 and offer recommendations regarding the options to receive such charges.

A critical task is to develop a five-year financial model that projects revenues and expenses for the exchange and identifies potential funding sources. The deliverable for this task will be two-fold: (1) a financial model with written analysis of revenue and expense projections that anticipates self-sufficiency by January 2015; and (2) a written analysis of potential funding sources with recommendations and an impact assessment on those sources.

State-based exchanges are expected under ACA to be self-sustaining by January 2015, and federal grants are available to finance start-up administrative costs, including part of the first year costs of operations (2014). On a steady-state basis, ACA legislation anticipates that state exchanges will levy a surcharge or assessment on premiums to support the exchange's operations. In Massachusetts, those administrative assessments are expected to run about 3 percent of health insurance premiums, for approximately 220,000 exchange enrollees, and result in a modest net positive margin. (Premium flow through the Massachusetts Health Connector is about $1 billion a year.) Short of a successful effort to starve or overturn ACA, it is assumed that federal support will suffice prior to 2014, thus providing West Virginia with sufficient start-up capital to develop the systems infrastructure and the human capital necessary to successfully begin operations. After that, premium levels and membership volume will be a major determinant of the level of premium assessment necessary to support an exchange in West Virginia. In addition, ACA does not prohibit other sources of funding, such as an assessment on health insurance premiums on qualified health plans across their entire market, both inside and outside the exchange, or an assessment across all carriers, however, such assessments would most likely require state legislative action. We will assess and discuss the pros and cons of all the options available to West Virginia relative to exchange funding.

Our team includes the Health Connector's founding CFO, who will model the administrative costs of running West Virginia's exchange under varying enrollment scenarios, and then estimate the level of assessment needed to support its administrative functions. This expense analysis should drive

consideration of options to reap greater economies of scale, such as: reliance on existing state agencies to share existing functionality and/or support new functionality, outsourcing many functions to one or more large private entities, terms of vendor contracts to be negotiated for large purchases, and the timing and sequence of "make" or "buy" decisions in order to maximize efficiency and minimize continuing cost. The financial modeling will also focus on cash flow for the exchange, which is typically a challenge for most start-up entities, and needs to be carefully managed by the exchange, especially if enrollment ramps up more slowly than projected, as well as the elimination of federal funding in 2014.

Assess the technical requirements and development of specifications for accounting and financial system functions for the exchange.

ACA requires the health benefit exchange to implement and administer a number of accounting and finance functions. For example, under Section 1313 — Financial Integrity —the exchange is required to keep an accurate accounting of all activities, receipts, and expenditures, and to submit annually to the Secretary of HHS a report of such accounting. The exchange is also subject to an annual audit by the Secretary of HHS, with a particular focus on systems of internal control to protect against fraud and abuse. In addition, it is likely the exchange will be under local scrutiny with the exchange governing body, the state's attorney general, inspector general and other interested stakeholders so will need a strong system of internal controls.

Because of the importance of sophisticated financial management for the exchange, our recommendations will analyze and address the following: (1) the type of accounting and financial reporting systems appropriate to the exchange model under consideration, including expected cost of implementation, reporting structure and chart of accounts; (2) premium billing systems, lockbox functions, and reconciliation of suspense accounts; (3) policies and procedures in the areas of financial reporting, accounts payable/receivable, and premium write-off; and (4) a proposed staffing plan and organizational chart for the Finance/Accounting area.

If the exchange is to be a mixed public/private entity, the accounting practices for various transactions and financial reporting elements can be complex. Our experience in this area, in both public entities, as well as private enterprises, will allow us to assist West Virginia in developing the appropriate financial structure that ensures that internal and external management reports are accurate and timely, and that the system of internal control is robust enough to meet the rigors of state and federal audits.