Reports and Research

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October 24, 2013 Board Meeting

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Small Employer Perspectives On The Affordable Care Act's Premiums, SHOP Exchanges, And Self-Insurance

DOI: 10.1377/hlthaff.2013.0861
HEALTH AFFAIRS 32,
NO. 11 (2013): –

ABSTRACT Beginning January 1, 2014, small businesses having no more than fifty full-time-equivalent workers will be able to obtain health insurance for their employees through Small Business Health Options Program (SHOP) exchanges in every state. Although the Affordable Care Act intended the exchanges to make the purchasing of insurance more attractive and affordable to small businesses, it is not yet known how they will respond to the exchanges. Based on a telephone survey of 604 randomly selected private firms having 3–50 employees, we found that both firms that offered health coverage and those that did not rated most features of SHOP exchanges highly but were also very price sensitive. More than 92 percent of nonoffering small firms said that if they were to offer coverage, it would be "very" or "somewhat" important to them that premium costs be less than they are today. Eighty percent of offering firms use brokers who commonly perform functions of benefit managers—functions that the SHOP exchanges may assume. Twenty-six percent of firms using brokers reported discussing self-insuring with their brokers. An increase in the number of self-insured small employers could pose a threat to SHOP exchanges and other small-group insurance reforms.

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Small employers are generally defined as firms with three to fifty full-time-equivalent workers. In the United States more than 2.9 million small firms employ about 29.5 million workers, or about 25.4 percent of employed Americans. These firms could obtain health insurance coverage for their employees in the small-group insurance market.[1]

It is generally recognized that the small-group market does not perform as well for its customers as the insurance markets for midsize and large groups do for theirs.[2] There are a variety of reasons for the worse performance of the small-group market, including its higher administrative costs, rigorous medical underwriting (because coverage availability and premium costs are tied to the health status of a smaller number of employees), volatile pricing (with premium costs that can vary substantially from year to year), and the offering of lower-value products (in which premiums are high relative to the financial protection that they provide). Competition among insurers in the small-group market depends heavily on insurers' skill in medical underwriting—a logical consequence of spreading catastrophic costs among a few employees in a small firm.

To improve the performance of the small-group market, the Affordable Care Act made multiple changes in the rules for the insurance marketplace. An overarching aim of these reforms is to alter the small-group market so that insurers in it no longer compete on skill in medical un-

derwriting but on price and quality. Policy makers anticipated that a reformed market would improve access to insurance, better control the growth in the cost of coverage, and improve the quality of care.

The Affordable Care Act's small-group reforms are too numerous to list here. Some of the major ones are the establishment of the Small Business Health Options Program (SHOP) exchanges; an end to medical underwriting based on an individual's health status; and the setting of premiums based only on "community rating," in which costs can vary only by an individual's age, geography, family size, and whether or not he or she smokes. There are also tax credits for companies with high percentages of low-income workers; state-defined essential health benefits required of qualified health plans—those plans permitted to offer coverage in the SHOP exchanges; a requirement that to qualify, plans have an actuarial value of at least 0.6, meaning that the plans must pay out at least 60 percent of covered expenses; and pooling of small-group plans so that pricing and medical loss ratios (the portion of premium dollars spent on medical care) are done in the aggregate rather than for separate plans.

As of October 1, 2013, companies with fifty or fewer full-time-equivalent employees began signing up for insurance coverage through the SHOP exchange in their state. Seventeen states and the District of Columbia are operating their own SHOP exchanges, and the remaining exchanges are being administered by the Department of Health and Human Services. Coverage takes effect January 1, 2014.

SHOP exchanges are electronic marketplaces where company managers can obtain information on each qualified health plan sold in the exchange—including its benefits, premiums, networks, and actuarial value—and sign their company up for the plan of their choice. SHOP exchanges will perform administrative functions such as aggregating bills, participating in claims adjudication, and answering questions from consumers. Employers will make a fixed contribution for each employee according to the cost of the base plan and tier—or level of coverage—that the employer selects.

In the "employer model" used by the federally run exchange, the employer chooses one plan, and all employees who take up coverage through the firm are enrolled in that plan. The "employee model" used by seventeen of the eighteen state-based exchanges has many variations. One common element is that if an employee chooses a higher-cost plan than the base plan selected by the employer, the employee pays the difference in premiums out of pocket.[3]

Although many of the provisions of the Affordable Care Act are intended to make it easier for small businesses to obtain health insurance coverage for their employees, it is not yet clear how these companies will respond to the exchanges. To get a better idea of their interests and expectations, we first examine the state of the small-group market in 2013, the last year prior to the act's near-full implementation. Second, we assess the attributes of health insurance and features associated with the SHOP exchanges that do and do not appeal to small employers. Third, we examine the impact on small employers of aspects of the health care law that are already in effect.

Study Data And Methods

From January through June 2013, National Research LLP conducted telephone interviews with benefit managers of private US firms with three to fifty employees. Thirty-seven percent of the respondents were CEOs, 33 percent office managers, 4 percent executives responsible for human resources, and 7 percent chief financial officers; 19 percent had some other position. The sample frame, obtained from Dun and Bradstreet, was randomly selected and stratified by firm size, with additional controls for industry and geographic location. Of the 604 firms whose representatives completed interviews, 434 companies already offered health benefits, and 170 companies did not.

The survey instrument included questions for nonoffering firms on why they did not purchase coverage, their experience shopping for it, and what would make them more likely to purchase it. Offering firms were asked about their purchasing experience, factors that would improve their shopping experience, their views about selected attributes of the exchanges, how the health care law had affected them thus far, and whether they had considered self-insurance.

All of our analyses used statistical weights based on the inverse of the probability that the firm would be selected for the survey; this is the firm's employer weight. Employee-based weights were the product of the number of workers in the firm and the firm's employer weight. Two additional weights—eligibility-based weight and coverage-based weight—were the products of the employee-based weight and the proportions of eligible and covered workers in the firm, respectively. Most of the statistics presented in this article used employer weights.

When calculating standard errors, we use the statistical software SAS Callable SUDAAN, version 9.2, to adjust for design effects. Differences presented in the text are significant at the 0.05 level.

Study Results

COST AND COVERAGE The average monthly premium for a single policy among small employers was slightly more than $502 per month, or about $6,029 per year, in 2013. Premiums were lowest for firms in the South; highest for companies with 10–24 workers; and—compared to companies with few low-income workers—lower for firms having larger proportions of younger, lower-income ($50,000 or less per year), and male workers.

Sixty percent of all small firms offered coverage in 2013 (Exhibit 1). Specifically, the shares were 53 percent for firms with 3–9 workers, 72 percent for firms with 10–24 workers, and 82 percent for firms with 25–50 workers. In contrast, 93 percent of all employers with 51 or more workers offered coverage.[4] Eighty-one percent of workers at small firms offering coverage were employed in firms that provided coverage for dependents. And among small firms offering coverage, 3 percent offered limited-benefit plans, also called mini-med plans. These plans typically have a low cap on the annual dollar value of covered services.

For offering and nonoffering small firms, only 57 percent of employees were eligible for coverage, and 41 percent obtained coverage from their employer (Exhibit 1). Some employees not covered by their employer's plan probably obtained coverage from a spouse's plan or from a public source such as Medicaid. Among small firms that offered health benefits, 72 percent of employees took up some coverage. Firms with more than 50 workers had significantly higher take-up rates. Similarly, midsize and large firms were significantly more likely than small firms to cover part-time workers.

VIEWS AND HISTORY OF NONOFFERING FIRMS When asked to choose "the *most* important reason why your firm does not currently offer health insurance to your employees," 75 percent of respondents chose the answer "cost of health insurance is too high," and 15 percent chose the answer "employees are generally covered under another plan." Only 0.4 percent of respondents at nonoffering firms said that their employees had no interest in health benefits. Ten percent of nonoffering firms had offered coverage within the past five years.

When respondents at nonoffering firms were asked what monthly premium for single coverage the firm could afford, they identified price points (that is, maximum prices that the firm would consider paying) considerably below the current market average of $502. Twenty-two percent of respondents indicated that their firm could afford $300 or more per month, and 15 percent said $200–$300. Fifty-six percent responded they could not afford monthly premiums of $200, and the remainder responded "don't know." Our survey data indicate that in the current small-group market, only 18 percent of plans cost less than $300 per month.

EXHIBIT 1

Differences In Coverage In Plans For Small Groups And For Midsize And Large Groups, 2013

	Small groups	Midsize and large groups
AMONG OFFERING AND NONOFFERING FIRMS, PERCENT OF:		
Firms offering coverage	60.1	93.3**
Employees eligible for coverage	56.6	74.8**
Employees covered by employer's plan	41.0	60.5**
AMONG OFFERING FIRMS, PERCENT OF:		
Employees eligible for coverage	81.1	76.0**
Employees taking up coverage	72.4	80.9**
Employees covered by employer's health plan	58.7	61.5
Employers offering coverage to part-time employees	17.2	34.2**
Employees working for a firm offering dependent coverage	80.9	—[a]
Employers offering more than one plan[b]	23.1	31.5

SOURCE Authors' analysis of data from: (1) Commonwealth Fund/NORC 2013 Survey of Small Employers; and (2) Kaiser Family Foundation and Health Research and Educational Trust. Employer health benefits: 2013 annual survey (Note 4 in text). **NOTES** A small group is a firm with 3–50 workers. Midsize and large groups are firms with more than 51 workers. Average monthly premiums for single coverage were $502 for small groups and $494 for midsize and large groups in 2013. [a]The Kaiser Family Foundation and Health Research and Educational Trust do not collect these data. [b]The Kaiser Family Foundation and Health Research and Educational Trust do not collect these data. Therefore, this percentage of employers offering more than one plan should be regarded as the minimum percentage of employers offering more than one plan. Given this difference, no statistical testing was conducted. **$p < 0.05$

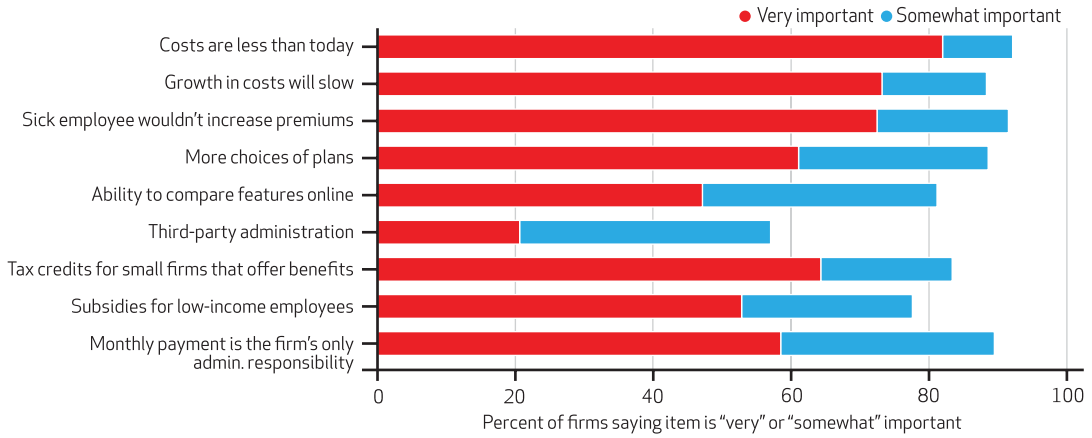
PURCHASING DECISIONS OF NONOFFERING FIRMS Thirty-seven percent of nonoffering firms reported having shopped for an insurance plan within the past five years. Firms in the East and Midwest were more likely to have shopped than those in the South and West.

We asked respondents from all small nonoffering firms, "How important would each of the following items be for your firm to consider offering health insurance?" Exhibit 2 displays the percentages of firms answering "very" or "somewhat important" and shows how closely purchasing decisions are linked to the cost of health insurance. For example, 82 percent of respondents said it would be "very important" "if health insurance cost less than it does today."

ROLE OF BROKERS FOR OFFERING FIRMS Insurance agents and brokers play major roles in small employers' purchasing decisions, often serving as de facto benefit managers. Eighty percent of offering firms use a broker or agent, and firms with 25–50 employees are more likely to use one than are firms with fewer workers. Small firms that use brokers have them perform various tasks: 84 percent use brokers to select a health plan, 79 percent to enroll employees, 59 percent to provide customer services such

EXHIBIT 2

Importance Of Various Items To Small Nonoffering Firms When Considering Whether To Offer Insurance, 2013



SOURCE Commonwealth Fund/NORC 2013 Survey of Small Employers.

as appealing denied claims, 57 percent to administer benefits through COBRA (the Consolidated Omnibus Budget Reconciliation Act of 1986), and 31 percent to determine employees' contributions toward premiums.

THE SHOPPING EXPERIENCE We asked small employers that offered a health plan, had offered a plan in the past five years, or had shopped for a plan in the past five years about the difficulty of different aspects of their shopping experience (Exhibit 3). Fifty-six percent responded that finding an affordable plan was "very difficult," and 26 percent said that it was "somewhat difficult." Employers found comparing premiums less difficult than other tasks, but 38 percent reported that even that comparison was "very" or "somewhat" difficult.

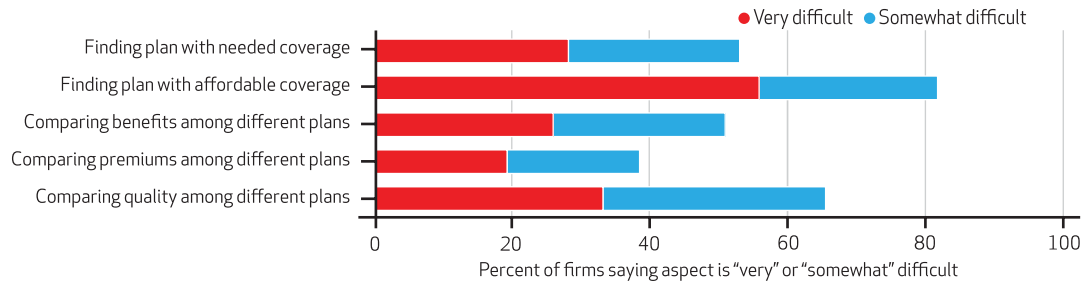
We asked small firms offering coverage, "How important would each of the following items be in making the process of providing health benefits easier, less expensive, and a better value?" (Exhibit 4). The most highly rated item was "ability to compare plans by cost, benefits, physicians in the network, and other features," which was rated "very important" by 68 percent of respondents.

APPEAL OF SELECTED SHOP FEATURES We asked small employers that offered coverage about their interest in a number of features that the SHOP exchanges will have and about various scenarios that could occur if they used a SHOP exchange. The survey questions did not specifically mention SHOP exchanges, instead describing their characteristics broadly.

Fifty-six percent of respondents said that they were more interested in "offering workers a choice of plans, with the employer paying a fixed amount, and the employee paying any extra cost for choosing a more expensive plan" (the "employee model") than in "offering workers one

EXHIBIT 3

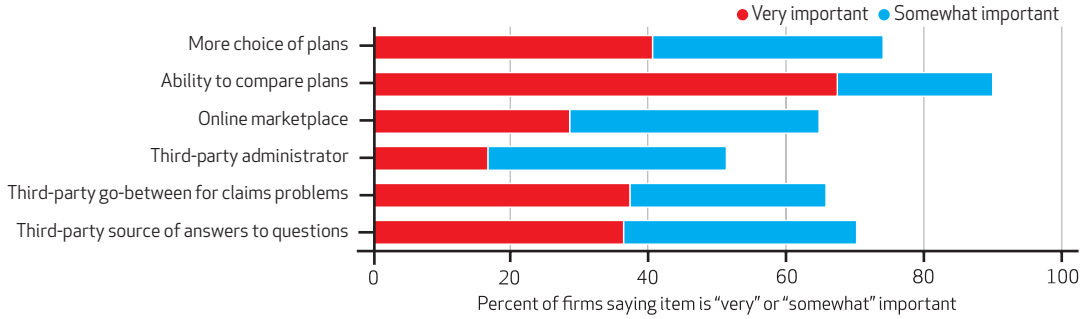
Difficulty Of Various Aspects Of Shopping For Benefits, Among Small Firms That Offer Benefits Or Bought Or Shopped For Benefits In The Past Five Years, 2013



SOURCE Commonwealth Fund/NORC 2013 Survey of Small Employers.

EXHIBIT 4

Small Offering Firms' Views On The Importance Of Various Items For Improving Health Benefits, 2013



SOURCE Commonwealth Fund/NORC 2013 Survey of Small Employers.

plan with less administrative work for your firm" (the "employer model"). Thirty-six percent preferred the employer model. In a related question, respondents were asked about their interest in the following scenario: Employees would be offered a choice of plans, with no change in cost to the firm, which would pay a fixed amount. Twenty-two percent said they would be very interested, and 45 percent would be somewhat interested.

When asked what is more important to their firm and its employees, being able to buy coverage from the dominant carrier in the state or having a "broader" (more extensive) choice of plans, 66 percent of respondents said that broader choice mattered more.

Small employers showed an interest in narrow-network plans, if using such plans would reduce costs. The survey defined *narrow-network plans* as those contracting with 25 percent of the doctors and hospitals in the community. If using a narrow network instead of a broad network—one with 80 percent of the doctors and hospitals in the community—would lower premiums by 5 percent, 57 percent of the respondents said they would opt for the narrow network. If the premiums were 10 percent lower, 77 percent would choose the narrow network, and with 20 percent lower premiums, 82 percent would do so.

One feature of the SHOP exchanges that has broad appeal is "getting one bill and writing one check each month." Seventy percent of employers indicated they would be "very interested" in such an approach.

If dental, vision, and other benefits such as disability insurance were part of an online marketplace, a sizable segment of small employers expressed interest in shopping for them. Thirty-two percent indicated they would be "very interested," and 36 percent would be "somewhat interested." Twenty-two percent said they would be "very interested" in shopping for wellness benefits through an online marketplace, but 40 percent would be "somewhat interested."

Impact On Small Employers To Date

Although most of the provisions of the Affordable Care Act take effect in 2014, the law has already affected many small employers in a number of ways. Half of all small firms were aware of provisions offering tax credits for small employers with substantial numbers of lower-income workers (those earning $50,000 or less per year). Small firms with large numbers of lower-income workers were no more likely to be aware of the tax credits than were small firms with fewer lower-income workers.

About one in six nonoffering firms that were aware of the tax credit considered offering health insurance because of it. Among all small firms that were aware of the tax credit, 61 percent had determined whether or not they were eligible for it. Firms with a relatively high percentage of older workers (those age fifty or older) were more likely than others to have made such a determination.

When asked if the firm's insurer had changed its benefit package because of the Affordable Care Act, 44 percent of employers said yes, 22 percent said no, and 34 percent said they didn't know. In fact, provisions that went into effect in 2010—such as prohibiting lifetime maximum benefits and requiring coverage of adult children up to age twenty-fix—have affected all plans.

Seventeen percent of small employers reported receiving a rebate from insurers. Seventy percent said they had not received one, and 13 percent were unable to answer the question. These rebates are a result of the medical loss ratio

review provisions in the health care law. The medical loss ratio is the average portion of earned premiums an insurance company spends on medical benefits and quality improvements, as opposed to administrative activities. Under the law, in the small-group market this portion must be at least 80 percent, and an insurer must give its subscribers a rebate for the difference should its medical loss ratio fall below that level.

As a result of Affordable Care Act provisions, 22 percent of small employers offering coverage reported having at least one adult child (up to age twenty-six) enrolled in their health plan who would not have been eligible before health reform. On average, these firms covered two adult children. Based on survey findings, an estimated 725,000 adult children were covered by small employers because of the act.

Self-Insurance

An unintended consequence of the Affordable Care Act is that it may make self-insurance attractive for small firms. Even prior to health reform, there were many advantages to self-insurance. For example, self-insured plans were not subject to state-mandated benefits, state premium taxes, consumer protections, reserve requirements, and other state regulatory requirements. An employer with a young and healthy workforce could have lower premiums with self-insurance than with coverage obtained as part of a pool of employers. Currently, only 8 percent of firms with 3–50 workers self-insure.[5]

The major drawback to self-insuring has been the financial risk of having a covered person experience a catastrophic illness or injury, and the subsequent substantial increase in the cost for stop-loss coverage that would ensue. Stop-loss coverage is a form of reinsurance that limits the amount of money that employers must pay out for a claim or group of claims.

But self-insurance may become more attractive as the Affordable Care Act takes effect. Because the act eliminates medical underwriting, if one or more insured workers or dependents at a small firm were to incur catastrophic costs in a given year, the next year the firm could move into the fully insured community-rated market on or off the SHOP exchange.

We asked small employers using brokers if their brokers had discussed with them the possibility of self-insurance, and 26 percent said yes. (Firms with relatively older workers were more likely to respond positively, as were firms with relatively more high-earning workers.) For firms not using brokers, only 1 percent considered self-insuring. Among firms whose brokers had discussed self-insuring, or firms not using brokers but considering self-insuring, 9 percent said they were "very likely" to self-insure, and 14 percent were "somewhat likely." In all, roughly 5 percent of small firms offering coverage are either "very" or "somewhat likely" to move from full to self-insurance in the next few years.

One clear message from employers is that the cost of coverage is by far the most important factor in their purchasing decisions.

22%

Covered an adult child

As a result of the Affordable Care Act, 22 percent of small employers offering coverage reported having at least one adult child enrolled in their plan who would not have been eligible before health reform.

Discussion

This survey of 604 small employers provides information on the current state of the small-group market during the year before the SHOP exchanges become operational. We found that just 57 percent of employees were eligible for coverage through their employer, and only 41 percent of employees obtained that coverage (Exhibit 1). The cost of a single policy now exceeds $6,000 a year—about 42 percent of the pretax earnings of a minimum-wage worker working full time.

The Affordable Care Act has already affected many small employers. Sixteen percent of them have received rebates from their insurers, and 725,000 adult children are covered by their parents' policies who would not have been eligible before the act's passage. About half of employers were aware of tax credits for small employers, and 60 percent of them had determined whether or not they were eligible for the credits.

The survey findings also provide information on aspects of the SHOP exchanges that may and may not appeal to small employers. One clear message from employers is that the cost of coverage is by far the most important factor in their purchasing decisions. The majority of employers not offering coverage identified price points (the highest premium amount they would consider) that were substantially lower than prices in the current market.

However, a sizable segment of nonoffering firms are close to purchasing health benefits: Nearly one-fourth of these firms reported price

The exchanges must obtain a strong buy-in from brokers while demonstrating superior value over what already exists in the small-group market.

points that were in the range of current plan prices. If tax credits were factored into the price of coverage, a larger segment of nonoffering small employers would have price points within that range. Moreover, 37 percent of nonoffering firms have shopped for coverage in the past five years.

Employers displayed their price sensitivity in other ways. Eighty-two percent of nonoffering firms indicated that it would be "very important" in their decision to buy health insurance for their workers if costs were lower than they are today. A majority of employers offering coverage were willing to select a plan with a narrow network of providers instead of one with a broad network if by doing so they could save 5 percent of their costs. If they could save 20 percent, 82 percent would select the narrow-network plan.

Many facets of the SHOP exchanges were very appealing to small employers. The most attractive feature was "getting one bill and writing one check each month." Seventy percent of small employers said they would be "very interested" in such an arrangement. About two-thirds believed that the process of offering health benefits would be "easier, less expensive, and better value" if they could compare costs, benefits, and physicians in networks among plan offerings. Substantial percentages of employers indicated that it would be "very important" to have a greater choice of plans than they do now and to have a third party that would act as a go-between in handling claims disputes.

Interestingly, having an online marketplace was not so highly rated. This may reflect the late Steve Jobs's observation that "customers don't know what they want until we've shown them."[6]

Small employers showed strong preferences for the "employee model" over the "employer model," even if the former involved higher administrative expenses than the latter. As noted above, seventeen of the eighteen state-based SHOP exchanges have chosen the employee model.[7] However, federally run exchanges will not offer that model until 2015.

Conclusion

We conclude by identifying two formidable challenges facing the SHOP exchanges. First, as states and the federal government implement them, it is imperative that the exchanges obtain a strong buy-in from brokers while simultaneously demonstrating superior value over what already exists in the small-group market.

Eighty percent of small employers use brokers, and these brokers perform most of the functions of a benefit manager, including selecting a plan, enrolling employees, and handling disputes over claims. The SHOP exchanges will perform many of the same functions, and with superior technology and economies of scale they will be able to do so at a lower cost than brokers can offer. This would suggest that brokers' fees would be reduced, leading brokers to oppose the exchanges. Historically, without broker buy-in, small-group exchanges tend not to succeed.[8]

Second, the survey quantified a much-discussed unintended consequence of the Affordable Care Act: a movement to self-insurance, which poses a threat not just to SHOP exchanges but to the entire small-group market. Under the act, self-insured firms do not have the same plan design requirements as fully insured firms. For example, self-insured plans do not have to meet essential benefit requirements of their state. Consequently, some brokers have suggested to small employers that they self-insure and purchase stop-loss coverage at attachment points as low as $10,000. (Attachment points are the dollar amount where stop-loss insurance begins paying for medical expenses.)

Moreover, should a small firm self-insure and incur catastrophic costs, instead of facing prohibitive stop-loss premiums the following year, it could simply move into the fully insured market through a SHOP exchange, where premiums are community rated (with adjustments for age of the workforce and geographic location). Among firms using a broker, 26 percent reported that their broker had already discussed the possibility of self-insuring in 2014.

Our calculations based on survey data suggest that 5 percent of firms are "very likely" and 7 percent "somewhat likely" to move from self-insured to fully insured status in "the next few years." These figures may underestimate the likely growth of self-insurance. After a few years of

converting to self-insurance, the small-group market could reach a tipping point that would leave the fully insured markets with greater risks, higher premiums, and eventually a so-called death spiral—in which costs become prohibitive for most people, so few people enroll except the sick, making per enrollee costs even higher. Based on the Urban Institute's Health Insurance Policy Simulation Model, without regulation of the stop-loss coverage market, the differences in premiums for fully and self-insured firms might reach 25 percent for single and 19 percent for family policies.[9]

To prevent this potential erosion of insurance, states need to reform their stop-loss markets so that stop-loss coverage is not de facto health insurance. Alternatively, if and when Congress is ready to make technical improvements in the Affordable Care Act, it should prohibit the sale of stop-loss coverage to small firms. If a tipping point were reached, then the many appealing features of the SHOP exchanges would be lost, and the small-group market would revert to the risk-based market it was prior to health reform. ■

The authors thank the Commonwealth Fund for the financial support (Grant No. 20110556) that made this work possible. The authors especially acknowledge the contributions of Sara Collins, whose ideas greatly shaped the study. The authors thank Tim Jost, Terry Gardiner, and Jon Kingsdale for their contributions to the questionnaire, and Tracy Garber for her assistance throughout the project. [*Published online October 16, 2013*].

NOTES

1 The average number of workers per firm is from the survey whose results we report here. The number of firms with 3–50 workers is derived from Dun and Bradstreet's electronic database of businesses in the United States.

2 James J. Health Policy Brief: Small business insurance exchanges. Health Affairs [serial on the Internet]. 2012 Feb 9 [cited 2013 Sep 20]. Available from: http://www.healthaffairs.org/healthpolicybriefs/brief.php?brief_id=62

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4 Kaiser Family Foundation, Health Research and Educational Trust. Employer health benefits: 2013 annual survey [Internet]. Menlo Park (CA): KFF; 2013 [cited 2013 Oct 8]. Section 2:37. Available from: http://kaiserfamilyfoundation.files.wordpress.com/2013/08/8465-employer-health-benefits-20131.pdf

5 Authors' calculation from Kaiser Family Foundation and Health Research and Educational Trust 2013 survey data (see Note 4).

6 Quoted in: Isaacson W. Steve Jobs. New York (NY): Simon and Schuster; 2011. p. 328–9.

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9 Buettgens M, Blumberg LJ (Urban Institute, Washington, DC). Small firm self-insurance under the Affordable Care Act [Internet]. New York (NY): Commonwealth Fund; 2012 Nov [cited 2013 Sep 23]. (Issue Brief). Available from: http://www.commonwealthfund.org/~/media/Files/Publications/Issue%20Brief/2012/Nov/1647_Buettgens_small_firm_self_insurance_under_ACA_ib.pdf

Getting the Word Out on Marketplaces

OCTOBER 2, 2013

An Analysis of Education and Outreach Efforts Across States' Health Insurance Marketplaces

KidsWell
Building a Legacy of Healthy Children

KidsWell is powered by Manatt Health Solutions on behalf of The Atlantic Philanthropies.
Click here to subscribe to the KidsWell Weekly Update.

What is KidsWell?

KidsWell is a national advocacy campaign focused on successful health care reform implementation on behalf of children and families.

The KidsWell team tracks health care reform activity at the state and federal levels and summarizes the most newsworthy information into a weekly newsletter and summary reports like this one. Click here to subscribe to the weekly newsletter and receive updates on state activity.

For more information on KidsWell, go to www.kidswellcampaign.org or email info@kidswellcampaign.org.

The 101 on Marketplaces

The Health Insurance Marketplace offers a "one stop shop" for consumers to compare health insurance plans, apply for coverage (with or without financial assistance), and enroll. Each state may establish its own Marketplace (a State-Based Marketplace), partner with the federal government (a Partnership Marketplace), or allow the federal government to run the Marketplace on the state's behalf (the Federally-Facilitated Marketplace).

Open enrollment for Marketplaces runs from October 1, 2013 to March 31, 2014. This is the time that folks can start to compare and enroll in plans that best fit their needs.

A national snapshot of Marketplace development across states is available on KidsWell.

Introduction

With states preparing for the start of open enrollment on October 1st, the KidsWell team analyzed the education and outreach campaigns of 16 State-Based Marketplaces (SBMs) and 2 State Partnership Marketplaces (SPMs). While states differ in their approaches to publicizing the Marketplaces, they have a common mission of educating consumers about their coverage options. Many of the campaigns utilize creative and innovative strategies that move beyond typical government outreach efforts and target populations that are hard-to-reach and/or have high rates of uninsurance. While not exhaustive, this analysis reflects examples of state marketing efforts based on publicly available information as of September 2013. The KidsWell team will continue to monitor and track states' efforts.

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Arkansas Health Connector

Click to watch a television ad for the Arkansas Health Connector, the entity that conducts plan management and consumer assistance functions for Arkansas' partnership Marketplace. The ad highlights that the Marketplace will open for enrollment on October 1st and will provide a variety of affordable coverage options, even for those with pre-existing conditions. The Arkansas Health Connector also released a television ad targeted specifically to families, which notes that plans offered in the Marketplace will cover doctor's visits, prescriptions, and emergency visits.

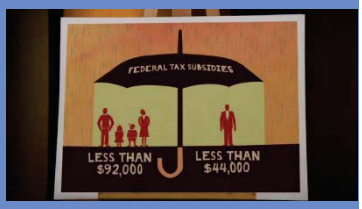
OVERVIEW: ARKANSAS HEALTH CONNECTOR OUTREACH & MARKETING EFFORTS

The Arkansas Health Connector launched an outreach and marketing campaign to generate awareness of its partnership Marketplace. The campaign includes television, radio and print ads, as well as billboards and promotional signage at 100 gas stations around the state. The Connector will also place ads on Pandora and conduct outreach through social media. In addition, the Connector has held town halls at the University of Arkansas to answer questions about the Marketplace.

- **Kick-Off Date:** 6/24/2013
- **Target Populations:** Uninsured, families, small businesses
- **Estimated Marketplace Enrollment:** 500,000
- **Notable Partnerships:** University of Arkansas
- **Marketing Funding:** $24 million
- **Marketing Vendor:** *Mangan Holcomb Partners*

More information on Arkansas' efforts can be found on the KidsWell State Overview Page.

Covered California



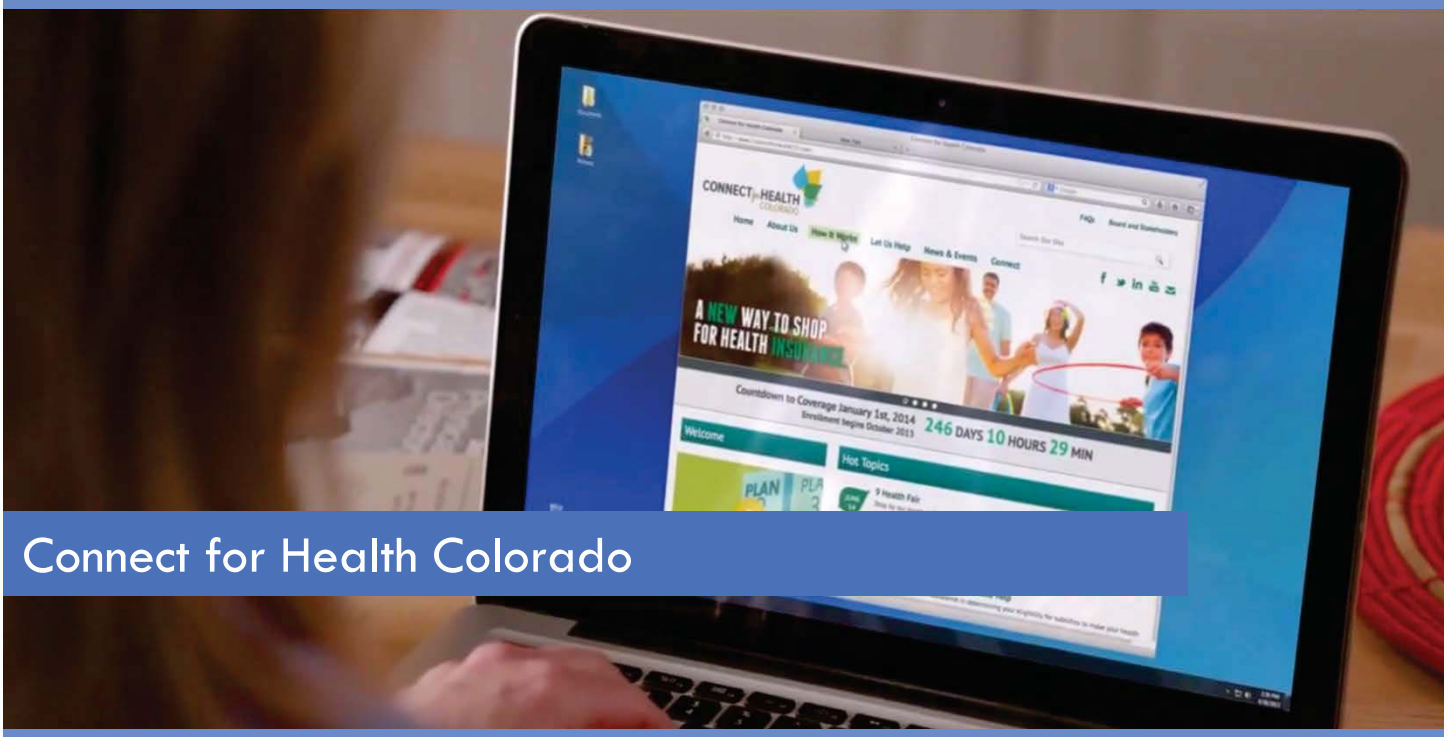
Click to watch "Signs," the first television ad for Covered California, California's state-based Marketplace. The ad informs consumers that the Marketplace will soon be opening and will offer coverage to residents across the state, regardless of pre-existing conditions. In addition to the television ad, Covered California released a video on YouTube called "The Boil It Down Guy," which provides a short overview of the changes coming to the state's health care system as a result of the Affordable Care Act.

OVERVIEW: COVERED CALIFORNIA'S OUTREACH & MARKETING EFFORTS

Covered California's broader marketing effort began in August, which includes television and radio ads, digital and social media, an updated website with a shop and compare tool, and online informational videos. The ads will run in select markets until October, when they will be distributed statewide. The initial marketing campaign is funded through federal grants and will extend through December 2014.

- **Kick-Off Date:** 8/29/2013
- **Target Populations:** General population, minorities (particularly African American, Hispanic, and Asian)
- **Estimated Marketplace Enrollment:** 2.6 million subsidy-eligible Californians
- **Notable Partnerships:** The California Endowment, Univision, Telemundo, impreMedia
- **Marketing Funding:** $45 million budgeted through March 2014, with an additional $35 million budgeted for April to December 2014
- **Marketing Vendor:** *Weber Shandwick*

More information on California's efforts can be found on the KidsWell State Overview Page.



Connect for Health Colorado

Click to watch Connect for Health Colorado's "World Series," "Triple Crown" and "Vegas" television ads, which highlight how consumers win as a result of increased competition among insurers in the Marketplace. In addition to the television ads, Connect for Health Colorado also released informational videos on YouTube for targeted populations, such as self-employed individuals, small business owners, and families.

OVERVIEW: CONNECT FOR HEALTH COLORADO'S OUTREACH & MARKETING EFFORTS

Colorado was the first state to launch a marketing and outreach campaign to promote the launch of the Marketplace. The campaign includes television and radio ads, as well as digital and print ads. The Marketplace will also conduct in-person outreach at festivals, libraries, churches, and fairs to increase awareness. To capture young adults, the Marketplace is running ads during broadcasts of Colorado Rockies baseball games.

- **Kick-Off Date:** 5/8/2013
- **Target Populations:** Uninsured, low-income populations, young adults, small businesses, self-employed individuals, families
- **Estimated Marketplace Enrollment:** 136,000
- **Notable Partnerships:** King Soopers Pharmacy
  Marketing Funding: $21 million
- **Marketing Vendor:** *Pilgrim*

More information on Colorado's efforts can be found on the KidsWell State Overview Page.

Access Health CT

CHANGE IS HERE

CHANGE IS VALUABLE

Click to watch a television ad titled "Change is Surprising" for Access Health CT, Connecticut's state-based Marketplace. The ad emphasizes changes to health care including new coverage options, a ban on denial of coverage due to pre-existing conditions, and lower costs. Access Health CT also created a television ad targeted toward small businesses, which emphasizes that small business owners can offer their employees coverage through the Marketplace and may be eligible for tax credits.

OVERVIEW: ACCESS HEALTH CT'S OUTREACH & MARKETING EFFORTS

Access Health CT launched a marketing and outreach campaign to raise awareness about the state's Marketplace and increase enrollment among uninsured populations. The campaign includes television, radio and print ads, as well as brick-and-mortar locations where Marketplace staff will be available to answer questions. In addition, Access Health CT launched a television series on Univision titled "Mercado de Salud," which will inform Latinos about the Marketplace.

- **Kick-Off Date:** 6/24/2013
- **Target Populations:** Uninsured, minorities (including Latinos), small businesses
- **Estimated Marketplace Enrollment:** 100,000
- **Notable Partnerships:** Univision
- **Marketing Funding:** $15 million
- **Marketing Vendor:** *Pappas MacDonnell*

More information on Connecticut's efforts can be found on the KidsWell State Overview Page.

Choose Health Delaware

Click to watch a television ad titled "Questions" for Choose Health Delaware, Delaware's partnership Marketplace. The ad features common questions about the Marketplace, including when coverage begins, whether coverage is guaranteed regardless of your health, gender, or other factors, and whether coverage and enrollment assistance will be free. Choose Health Delaware also released a television ad titled "Mistakes," which portrays various common accidents and the costs associated with subsequent care without health insurance.

OVERVIEW: CHOOSE HEALTH DELAWARE'S OUTREACH & MARKETING EFFORTS

The Choose Health Delaware marketing and outreach campaign is focused on educating consumers about the Marketplace and encouraging them to enroll into coverage. The campaign includes television, radio and print ads, billboards, and social media. In addition, the Marketplace will conduct in-person grassroots outreach in stores, barbershops, churches, libraries and community centers.

- **Kick-Off Date:** 9/2/2013
- **Target Populations:** 18-29 year-olds and 30-64 year-olds
- **Estimated Marketplace Enrollment:** 35,000 in 2014
- **Notable Partnerships:** Not available
- **Marketing Funding:** Not available
- **Marketing Vendor:** *AB+C Creative Intelligence*

More information on Delaware's efforts can be found on the KidsWell State Overview Page.

DC Health Link

DC Health Link plans to advertise the District's state-based Marketplace through television ads, but no ads or videos are currently publicly available.

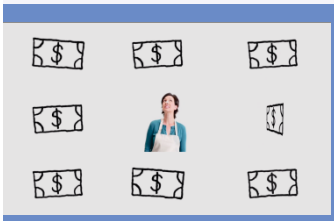
OVERVIEW: DC HEALTH LINK'S OUTREACH & MARKETING EFFORTS

D.C. Health Link plans to launch a marketing campaign to encourage District residents to buy insurance through the Marketplace. During the six month campaign, planners expect to utilize the city's buses, bus stops, Metro stops, and billboards, targeting areas where insurance coverage lags. In addition, the campaign will feature television, radio and print ads to generate awareness of the Marketplace among city residents.

- **Kick-Off Date:** 10/1/2013
- **Target Populations:** Uninsured, young adults, Hispanics, LGBT communities, small business owners and employees
- **Estimated Marketplace Enrollment:** 42,000
- **Notable Partnerships:** D.C. United Soccer Team, CVS Pharmacy, Restaurant Association of Metropolitan Washington, DC Chamber of Commerce, Greater Washington Hispanic Chamber of Commerce
- **Marketing Funding:** $2 million
- **Marketing Vendor:** *Sawyer Miller and GMMB*

More information on the District's efforts can be found on the KidsWell State Overview Page.

Hawaii Health Connector



Click to watch a television ad titled "Kimo" for the Hawaii Health Connector, Hawaii's state-based Marketplace. The ad focuses on individuals who need to purchase coverage and notes that the Marketplace will feature affordable coverage options for individuals and their families. In addition, the Hawaii Health Connector also released a television ad titled "Lisa," which focuses on small business owners and their coverage options in the Marketplace. The ad notes that premiums may be lower and that small business owners may be eligible for tax credits.

OVERVIEW: HAWAII HEALTH CONNECTOR'S OUTREACH & MARKETING EFFORTS

The Hawaii Health Connector launched a public awareness campaign to inform Hawaiians about their coverage options available on the state's health insurance Marketplace. The campaign includes online, print, and broadcast advertisements, as well as participation in community outreach and events. The campaign highlights the benefits available to individuals and small businesses.

- **Kick-Off Date:** 9/20/2013
- **Target Populations:** Uninsured, small businesses
- **Estimated Marketplace Enrollment:** 300,000
- **Notable Partnerships:** Pacific Business News
- **Marketing Funding:** $1.13 million
- **Marketing Vendor:** *MVNP*

More information on Hawaii's efforts can be found on the KidsWell State Overview Page.

Kynect

Click to watch a television ad for Kynect, Kentucky's state-based Marketplace. The animated ad provides an overview of several health care issues people face that the Marketplace seeks to address, such as affordability, denial of coverage due to pre-existing conditions, and access to care. Kynect also released a longer version of the ad on YouTube, which highlights these issues in more detail. The longer version also notes that individuals might be eligible for tax credits through the Marketplace.

OVERVIEW: KYNECT'S OUTREACH & MARKETING EFFORTS

Kentucky undertook a branding and marketing effort to build support for the Marketplace in the state. Kynect's marketing strategy includes television ads, social media, and appearances at state fairs. In addition, Kynect also plans to partner with local college football teams to generate awareness of the Marketplace among young adults.

- **Kick-Off Date:** 5/15/2013
- **Target Populations:** Single parents, young and older adults, minorities
- **Estimated Marketplace Enrollment:** 600,000
- **Notable Partnerships:** College sports teams
- **Marketing Funding:** Not available
- **Marketing Vendor:** *Doe Anderson*

More information on Kentucky's efforts can be found on the KidsWell State Overview Page.

Maryland Health Connection

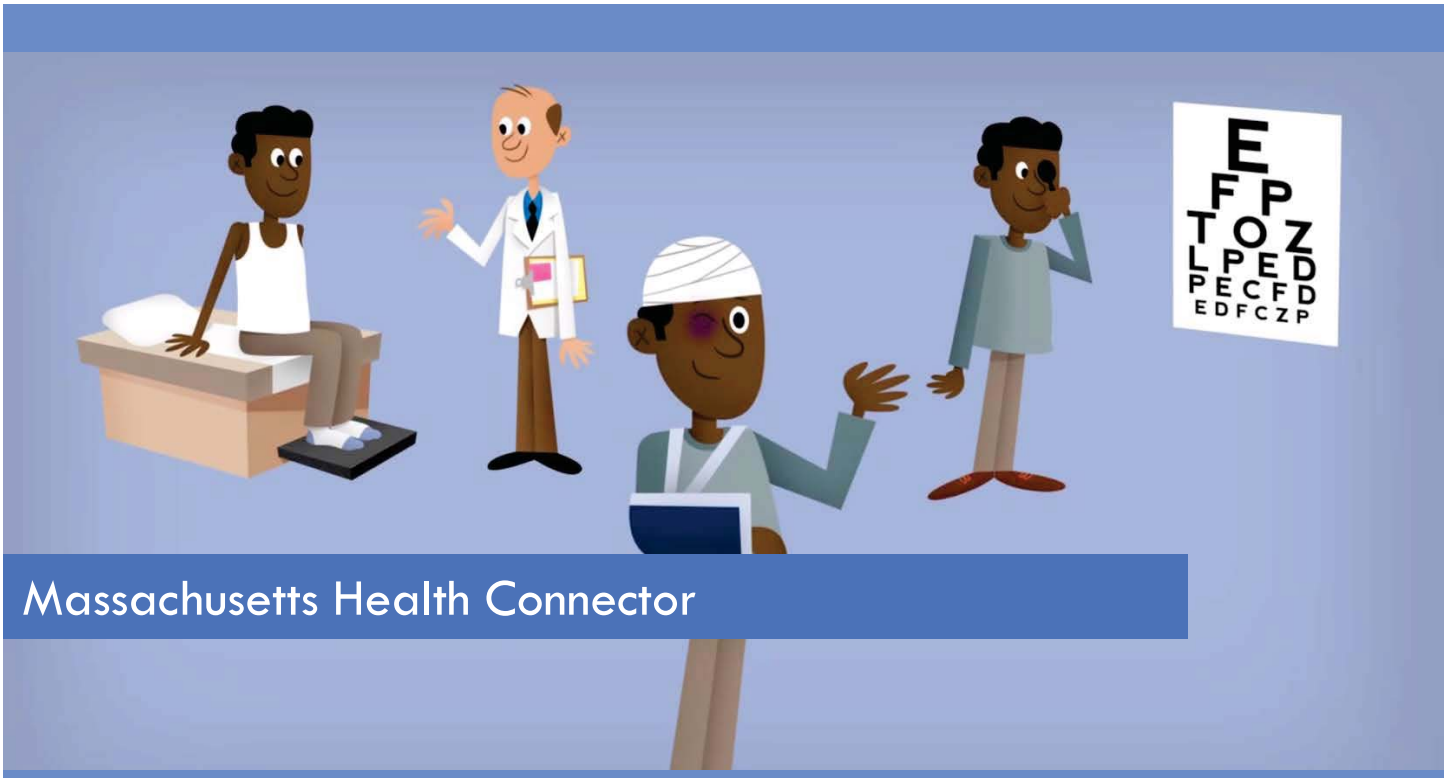
Click to watch a television ad for Maryland Health Connection, Maryland's state-based Marketplace. The ad features a jingle that describes the convenience of getting coverage online through the Marketplace, while graphics indicate the October 1st enrollment date and that individuals may be eligible for subsidies. In addition to the television ad, Maryland Health Connection also released an overview video on YouTube, which discusses how individuals can compare benefits and prices across plans.

OVERVIEW: MARYLAND HEALTH CONNECTION'S OUTREACH & MARKETING EFFORTS

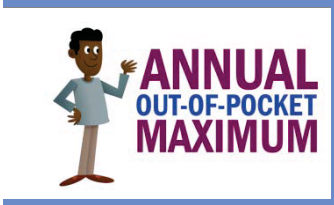
The Maryland Health Connection's outreach and marketing campaign is designed to maximize education and enrollment in the Marketplace. The campaign includes television, radio and print advertisements, as well as digital and social media. The campaign also features partnerships with large retail companies and sports teams across the state.

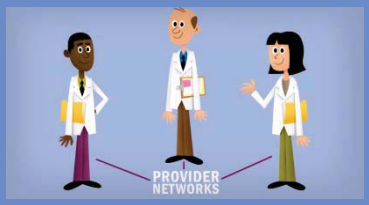
- **Kick-Off Date:** 9/3/2013
- **Target Populations:** Uninsured individuals, Medicaid-eligible populations, young adults, women, minorities (particularly African American and Hispanic populations), and small business owners.
- **Estimated Marketplace Enrollment:** 800,000
- **Notable Partnerships:** Baltimore Ravens, CVS Pharmacy, Giant Food
- **Marketing Funding:** $2.5 million
- **Marketing Vendor:** Weber Shandwick

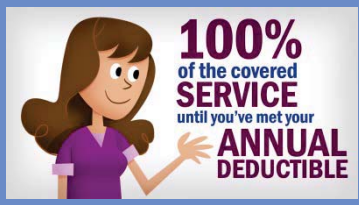
More information on Maryland's efforts can be found on the KidsWell State Overview Page.



Massachusetts Health Connector







Click to watch informational videos for the Massachusetts Health Connector, Massachusetts' state-based Marketplace, which cover a variety of issues, including: maximum out-of-pocket costs, annual deductibles, co-insurance, and provider networks. In addition, the Health Connector released a video targeted toward small business owners, which highlights the savings employers can achieve through providing health insurance to their employees through the Marketplace.

OVERVIEW: MA HEALTH CONNECTOR'S OUTREACH & MARKETING EFFORTS

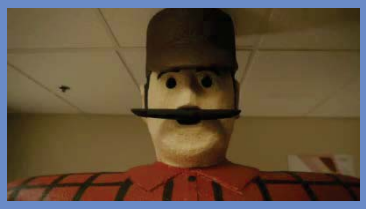
Since the Massachusetts Health Connector opened in 2006, its marketing and branding efforts are well established. However, the Connector has undergone upgrades to conform with new ACA requirements and is engaging in an extensive marketing effort known as "Health Connector 2.0." The Connector's marketing efforts include television, radio and print ads, direct mail and email, social media, an outbound calling campaign, and road shows.

- **Kick-Off Date:** June 1, 2013
- **Target Populations:** 215,000 current and newly eligible Health Connector members
- **Estimated Marketplace Enrollment:** Not available
- **Notable Partnerships:** Boston Red Sox
- **Marketing Funding:** $7 million
- **Marketing Vendor:** *Weber Shandwick*

More information on Massachusetts' efforts can be found on the KidsWell State Overview Page.

MNsure






Click to watch "Minnesota, Land of 10,000 Reasons to Get Health Insurance," an ad featuring Paul Bunyan for Minnesota's state-based Marketplace, known as MNsure. The state also produced an overview video titled "Welcome to MNsure," which walks through the functions of the Marketplace and the various types of coverage options available to consumers.

OVERVIEW: MNSURE'S OUTREACH & MARKETING EFFORTS

MNsure's broader marketing campaign features television and radio advertisements, community ad placements on buses and light rail, digital and traditional billboards, skyway panels, and posters placed throughout select areas in the state. In addition, MNsure is also coordinating an on-the-ground outreach program, which includes booths at fairs to educate residents about the Marketplace and their coverage options.

- **Kick-Off Date:** 8/18/2013
- **Target Populations:** General population/consumer, minority populations, small business owners
- **Estimated Marketplace Enrollment:** By 2016, 300,000 individuals, 150,000 small businesses and employees, 880,000 Medicaid beneficiaries.
- **Notable Partnerships:** Minnesota Timberwolves and Minnesota Lynx
- **Marketing Funding:** $9 million
- **Marketing Vendor:** *BBDO Proximity*

More information on Minnesota's efforts can be found on the KidsWell State Overview Page.

Nevada Health Link

Click to watch a television ad for Nevada Health Link, Nevada's state-based Marketplace. The ad notes that the Affordable Care Act requires that individuals have health insurance and that Nevada Health Link can help individuals purchase "state-approved" health plans beginning in October. Nevada Health Link released four other ads that also highlight the individual mandate and the coverage options available in the Marketplace.

OVERVIEW: NEVADA HEALTH LINK'S OUTREACH & MARKETING EFFORTS

Nevada Health Link's outreach and marketing campaign is designed to generate awareness about the Marketplace and persuade individuals to enroll into coverage once open enrollment begins. The campaign includes television, radio and print ads, digital media, billboards, transit ads, and event ads. In addition, the Marketplace plans to partner with churches, civic groups, and tribal councils to help educate consumers.

- **Kick-Off Date:** 7/15/2013
- **Target Populations:** Low-income populations, including Hispanics, young families with children, and young adults (predominately male)
- **Estimated Marketplace Enrollment:** 118,000
- **Notable Partnerships:** Churches, civic groups, tribal councils
- **Marketing Funding:** $8.2 million
- **Marketing Vendor:** *KPS3*

More information on Nevada's efforts can be found on the KidsWell State Overview Page.

nmhix
New Mexico Health Insurance Exchange
BE WELL.

New Mexico Health Insurance Exchange (NMHIX)

Television ads for the New Mexico Health Insurance Exchange, New Mexico's state-based Marketplace, are expected to begin airing on October 1st.

OVERVIEW: NMHIX'S OUTREACH & MARKETING EFFORTS

The New Mexico Health Insurance Exchange launched a marketing campaign titled "Be Well New Mexico" that is designed to educate consumers across the state about the Marketplace. The campaign includes television, radio and print ads, billboards, and social media. The campaign kick-off event included a performance of the "Be Well New Mexico" song, performed by local musicians. The song will be featured in radio ads across the state.

- **Kick-Off Date:** 9/17/2013
- **Target Populations:** Uninsured, minorities (including Hispanic and Native American populations)
- **Estimated Marketplace Enrollment:** 72,000 in the individual market, 8,400 in the small group market
- **Notable Partnerships:** Association of Commerce and Industry, Albuquerque Hispano Chamber of Commerce, Las Cruces Hispano Chamber of Commerce
- **Marketing Funding:** $7 million
- **Marketing Vendor:** *BVK, Inc.*

More information on New Mexico's efforts can be found on the KidsWell State Overview Page.

NY State of Health

Click to watch a video for NY State of Health, New York's state-based Marketplace. The video depicts places and people around the state and describes how New Yorkers will soon have access to affordable health coverage through the Marketplace. The video concludes by noting that individuals and small business can go to the NY State of Health website to learn more.

OVERVIEW: NY STATE OF HEALTH'S OUTREACH & MARKETING EFFORTS

NY State of Health's marketing campaign will launch when the Marketplace's open enrollment period begins on October 1st. While a short video featuring the Marketplace is already available on YouTube, the full campaign will include television, radio, print and transit ads designed to generate awareness of the Marketplace.

- **Kick-Off Date:** 10/1/2013
- **Target Populations:** Low-income individuals, childless adults, parents with CHIP-enrolled children, small business owners and employees
- **Estimated Marketplace Enrollment:** 558,000 in the individual market and 432,000 in the SHOP exchange
- **Notable Partnerships:** Advocacy organizations, industry and professional associations
- **Marketing Funding:** $40.2 million
- **Marketing Vendor:** *DDB Worldwide*

More information on New York's efforts can be found on the KidsWell State Overview Page.

Cover Oregon

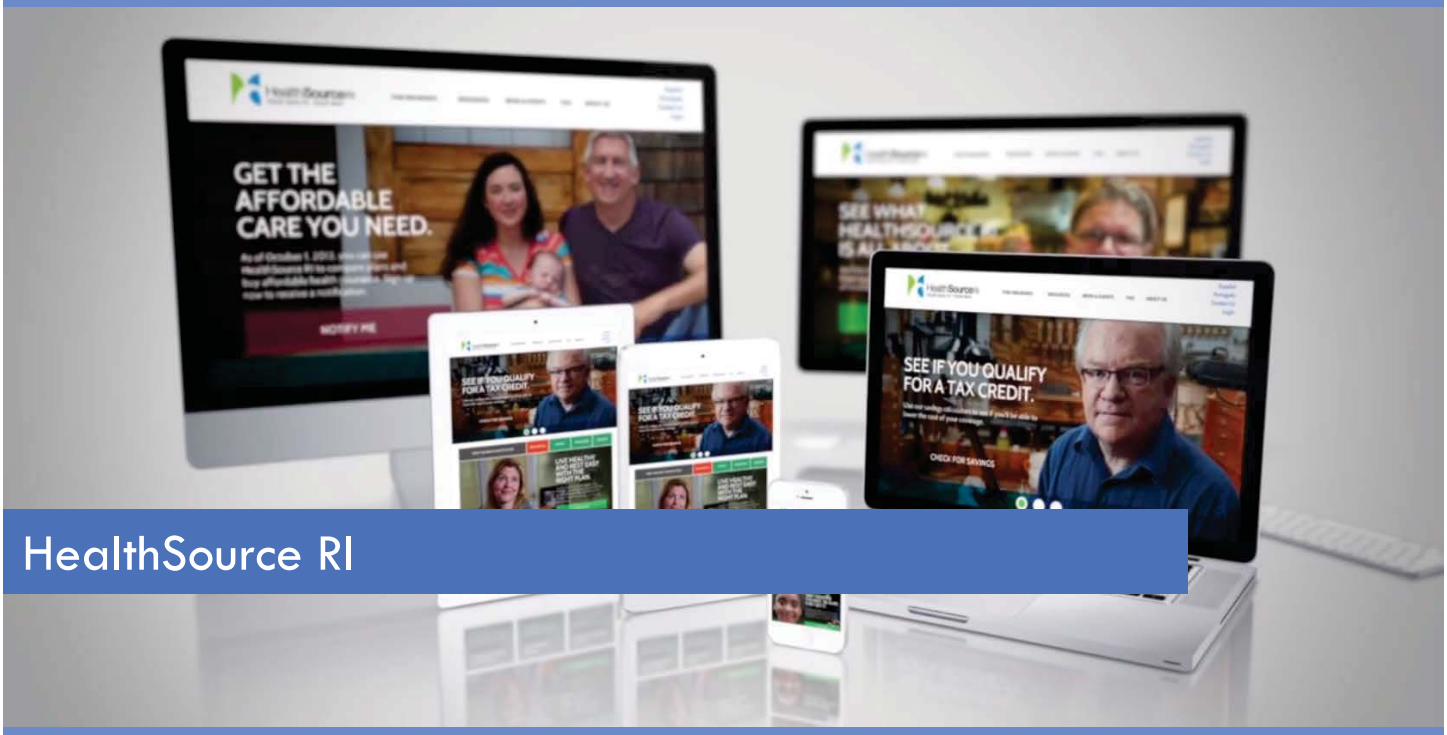
Click to watch "Live Long In Oregon," a television ad for Cover Oregon, the state's state-based Marketplace. The ad is one among a few ads that feature popular Oregonian musicians and artists. Other ads include a rap video titled "Live Your Life," a folk song titled "Long Live Oregonians," and an animated video titled "Fly With Your Own Wings." Other videos discuss the Marketplace's features more explicitly, including videos titled "Compare," "Save" and "Covered."

OVERVIEW: COVER OREGON'S OUTREACH & MARKETING EFFORTS

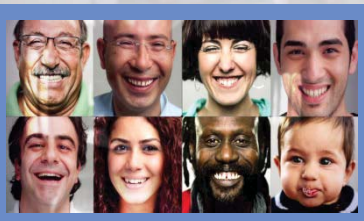
Cover Oregon conducted extensive research to inform its outreach and marketing campaign, known as "Long Live Oregonians". The campaign is designed to educate a large portion of the state's population about the Marketplace and coverage options. The campaign includes television, radio and print ads, social media, in-person events, and grassroots partnerships. In addition, Cover Oregon also solicited artwork from local artists that is used in posters and digital ads.

- **Kick-Off Date:** 7/1/13
- **Target Populations:** Uninsured, Medicaid-eligible individuals, minorities, young adults, rural populations, small employers
- **Estimated Marketplace Enrollment:** 201,770 in 2014, 281,790 in 2015 (includes individual and small group markets)
- **Notable Partnerships:** Local musicians and artists
- **Marketing Funding:** $20 million
- **Marketing Vendor:** *North and Metropolitan Group*

More information on Oregon's efforts can be found on the KidsWell State Overview Page.



HealthSource RI



Click to watch an overview video for HealthSource RI, Rhode Island's state-based Marketplace. The video highlights common concerns about health insurance and how the Marketplace will help individuals and small businesses compare and choose plans. In addition, the video notes that consumers will be able to learn about providers and read the latest health care news on the Marketplace website.

OVERVIEW: HEALTHSOURCE RI'S OUTREACH & MARKETING EFFORTS

HealthSource RI launched a marketing campaign to educate residents in the state about the Marketplace and health reform overall. The campaign includes a website to educate consumers, an overview video of the Marketplace, social media outreach, and appearances at farmers' markets and other local events throughout the state.

- **Kick-Off Date:** 8/1/2013
- **Target Populations:** Uninsured, Medicaid-eligible populations, and small business owners and employees
- **Estimated Marketplace Enrollment:** 70,000 to 100,000 in the first 18 months of operation
- **Notable Partnerships:** YMCA
- **Marketing Funding:** $5.1 million
- **Marketing Vendor:** *Nail Communications*

More information on Rhode Island's efforts can be found on the KidsWell State Overview Page.

Vermont Health Connect

Click to watch a television ad titled "For Vermonters, By Vermonters" for Vermont Health Connect, Vermont's state-based Marketplace. The ad showcases a variety of individuals across the state and notes that Vermont Health Connect will be a new way for residents to purchase health insurance. In addition to the television ad, Vermont Health Connect also produced overview videos on qualified health plans, getting help selecting a plan, and resources for small businesses.

OVERVIEW: VERMONT HEALTH CONNECT'S OUTREACH & MARKETING EFFORTS

Vermont Health Connect launched a marketing campaign titled "For Vermonters, By Vermonters", which is designed to educate residents about health reform and the state's Marketplace. The campaign includes, television, radio and print ads, and appearing at fairs and local events. The Marketplace will also utilize digital advertising, including buying ads on social media platforms. The state ran an initial series of ads earlier this year to publicize regional informational forums.

- **Kick-Off Date:** 8/29/2013
- **Target Populations:** Uninsured and Medicaid-eligible individuals and families, young adults, parents of school-aged children, small business owners
- **Estimated Marketplace Enrollment:** 100,000
- **Notable Partnerships:** Vermont Chamber of Commerce
- **Marketing Funding:** $9.5 million
- **Marketing Vendor:** *GMMB*

More information on Vermont's efforts can be found on the KidsWell State Overview Page.

Washington Healthplanfinder




Click to watch a television ad titled "No More Surprises" for the Washington Healthplanfinder, the state's state-based Marketplace. The premise of the ad, as well as another ad titled "Gambling Man," is to show the chance people take when they don't have health insurance. The ads also highlight how the Marketplace will offer low-cost plans for individuals. In addition to the television ads, Washington Healthplanfinder also posted an overview video on YouTube, which highlights the types of plans and benefits consumers can expect in the Marketplace.

OVERVIEW: WASHINGTON HEALTHPLANFINDER'S OUTREACH & MARKETING EFFORTS

Washington Healthplanfinder launched its marketing campaign to raise awareness of the state's Marketplace and inform residents of changes resulting from health reform. The campaign includes television, radio and print ads, billboards, and online videos. The state is also providing an outreach toolkit for stakeholders on its website, which includes brochures, postcards, posters, and window signs that stakeholders can use to educate consumers about the Marketplace.

- **Kick-Off Date:** 8/19/2013
- **Target Populations:** Uninsured individuals, minorities (including African Americans), non-English speaking communities (including Chinese, Vietnamese, Korean, Spanish and Russian)
- **Estimated Marketplace Enrollment:** 130,000 by the end of 2013 and 280,00 by the end of 2014
- **Notable Partnerships:** Not available
- **Marketing Funding:** $26.3 million
- **Marketing Vendor:** *GMMB*

More information on Washington's efforts can be found on the KidsWell State Overview Page.

AN INTRODUCTION TO

HEALTH IN ALL POLICIES

A Guide for State and Local Governments

Health in All Policies: A Guide for State and Local Governments was created by the Public Health Institute, the California Department of Public Health, and the American Public Health Association in response to growing interest in using collaborative approaches to improve population health by embedding health considerations into decision-making processes across a broad array of sectors. The Guide draws heavily on the experiences of the California Health in All Policies Task Force and incorporates information from the published and gray literature and interviews with people across the country.

WHY DO WE NEED HEALTH IN ALL POLICIES?

Health in All Policies is based on the recognition that our greatest health challenges—for example, chronic illness, health inequities, climate change, and spiraling health care costs—are highly complex and often linked. Promoting healthy communities requires that we address the social determinants of health, such as transportation, education, access to healthy food, economic opportunities, and more. This requires innovative solutions, a new policy paradigm, and structures that break down the siloed nature of government to advance collaboration.

A MESSAGE FROM THE AMERICAN PUBLIC HEALTH ASSOCIATION

The environments in which people live, work, learn, and play have a tremendous impact on their health. Responsibility for the social determinants of health falls to many non-traditional health partners, such as housing, transportation, education, air quality, parks, criminal justice, energy, and employment agencies. Public health agencies and organizations will need to work with those who are best positioned to create policies and practices that promote healthy communities and environments and secure the many co-benefits that can be attained through healthy public policy.

This guide follows in that tradition: We believe it will be of great value as the implementation of Health in All Policies expands and evolves to transform the practice of public health for the benefit of all.

Adewale Troutman, MD, MPH, MA, CPH
President

Georges C. Benjamin, MD
Executive Director

WHAT IS HEALTH IN ALL POLICIES?

Health in All Policies is a collaborative approach to improving the health of all people by incorporating health considerations into decision-making across sectors and policy areas.

The goal of Health in All Policies is to ensure that decision-makers are informed about the health, equity, and sustainability consequences of various policy options during the policy development process. A Health in All Policies approach identifies the ways in which decisions in multiple sectors affect health, and how better health can support the goals of these multiple sectors. It engages diverse governmental partners and stakeholders to work together to promote health, equity, and sustainability, and simultaneously advance other goals such as promoting job creation and economic stability, transportation access and mobility, a strong agricultural system, and educational attainment. There is no one "right" way to implement a Health in All Policies approach, and there is substantial flexibility in process, structure, scope, and membership.

FIVE KEY ELEMENTS OF HEALTH IN ALL POLICIES

Promote health, equity, and sustainability. Health in All Policies promotes health, equity, and sustainability through two avenues: (1) incorporating health, equity, and sustainability into specific policies, programs, and processes, and (2) embedding health, equity, and sustainability considerations into government decision-making processes so that healthy public policy becomes the normal way of doing business.

Support intersectoral collaboration. Health in All Policies brings together partners from the many sectors that play a major role in shaping the economic, physical, and social environments in which people live, and therefore have an important role to play in promoting health, equity, and sustainability. A Health in All Policies approach focuses on deep and ongoing collaboration.

Benefit multiple partners. Health in All Policies values co-benefits and win-wins. Health in All Polices initiatives endeavor to simultaneously address the policy and programmatic goals of both public health and other agencies by finding and implementing strategies that benefit multiple partners.

Engage stakeholders. Health in All Policies engages many stakeholders, including community members, policy experts, advocates, the private sector, and funders, to ensure that work is responsive to community needs and to identify policy and systems changes necessary to create meaningful and impactful health improvements.

Create structural or process change. Over time, Health in All Policies work leads to institutionalizing a Health in All Policies approach throughout the whole of government. This involves permanent changes in how agencies relate to each other and how government decisions are made, structures for intersectoral collaboration, and mechanisms to ensure a health lens in decision-making processes.

The Healthy Community Framework was developed by the California Health in All Policies Task Force, based upon discussion with community, government, and public health leaders in response to the question, "What is a healthy community?"

A Healthy Community provides for the following through all stages of life:

HEALTHY COMMUNITY FRAMEWORK

Meets basic needs of all

- Safe, sustainable, accessible, and affordable transportation options
- Affordable, accessible and nutritious foods, and safe drinkable water
- Affordable, high quality, socially integrated, and location-efficient housing
- Affordable, accessible and high quality health care
- Complete and livable communities including quality schools, parks and recreational facilities, child care, libraries, financial services and other daily needs
- Access to affordable and safe opportunities for physical activity
- Able to adapt to changing environments, resilient, and prepared for emergencies
- Opportunities for engagement with arts, music and culture

Quality and sustainability of environment

- Clean air, soil and water, and environments free of excessive noise
- Tobacco- and smoke-free
- Green and open spaces, including healthy tree canopy and agricultural lands
- Minimized toxics, greenhouse gas emissions, and waste
- Affordable and sustainable energy use
- Aesthetically pleasing

Adequate levels of economic and social development

- Living wage, safe and healthy job opportunities for all, and a thriving economy
- Support for healthy development of children and adolescents
- Opportunities for high quality and accessible education

Health and social equity

Social relationships that are supportive and respectful

- Robust social and civic engagement
- Socially cohesive and supportive relationships, families, homes and neighborhoods
- Safe communities, free of crime and violence

California Health in All Policies Task Force. (2010, December 3). Health in All Policies Task Force Report to the Strategic Growth Council. Retrieved from: http://sgc.ca.gov/hiap/docs/publications/HiAP_Task_Force_Report.pdf. Used with permission.

WHAT'S IN *HEALTH IN ALL POLICIES: A GUIDE FOR STATE AND LOCAL GOVERNMENTS*?

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http://www.apha.org/hiap

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The California Endowment

APHA American Public Health Association

CDPH California Department of PublicHealth

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ALLIANCE FOR HEALTH REFORM

Robert Wood Johnson Foundation

The Employer Mandate of the Patient Protection Affordable Care Act

An Alliance for Health Reform Toolkit
Produced with support from the Robert Wood Johnson Foundation
Compiled and researched by Bara Vaida
October 4, 2013
www.allhealth.org

Fast Facts

- Employers with more than 50 full-time employees (those who work 30 or more hours a week) must offer insurance to workers beginning in 2015 or pay a $2,000 per employee penalty, if any worker gets a coverage subsidy through a state health insurance exchange.[1]
- Employer-provided insurance coverage must be affordable and cost no more than 9.5 percent of the employee's income.[2] If it is more, the employee may seek coverage on the exchange and the employer will pay a $3,000 penalty for each of those workers.[3]
- The mandate was originally scheduled for implementation in 2014, but the Obama administration in July 2013 delayed it for one year to give employers more time to comply with the law.[4]
- Small employers (those with fewer than 50 workers) are exempt from the penalties.[5]
- The percentage of individuals with employment-based coverage was 55.1 percent in 2011, down from 55.3 percent in 2010, 56.1 percent in 2009, and 65.1 percent in 2000.[6]

Most employers in the United States offer health insurance benefits to their workers. In 2013, 99 percent of companies with 200 or more employees, and 57 percent of firms with 3 to 199 employees, offered coverage.[7]

Many employers started offering coverage to employees during World War II as a way to recruit and retain workers. And not only can employers deduct health benefits for their employees from their taxes,[8] the cost of those benefits is excluded from workers' incomes. This exclusion is the nation's largest tax expenditure, totaling $177 billion in fiscal year 2011.[9]

While employer coverage levels remain high, an increasing number of firms have cut health insurance because of rising costs. In 2011, more than 170 million individuals had employment-based health benefits (55.1 percent of the population), but that is down 11.8 million from 2000, when employers covered 65.1 percent of the population.[10]

In 2013, the average annual premium for employer-based family coverage was $16,351, which is 4 percent higher than the previous year and about twice as high as in 2002.[11]

The Patient Protection and Affordable Care Act (ACA) contains an incentive for employers to offer affordable health benefits. Starting in 2015, employers with more than 50 full-time employees are required to offer health coverage or pay a $2,000 fee per full-time employee, if any employee receives a subsidy through the state insurance exchange. The first 30 employees are excluded from the calculation of the fee.[12]

Employers don't have to pay a penalty for employees who work fewer than 30 hours per week, but they still have to consider them to determine if they fall under the insurance mandate. For example, if a firm employs 40 full timers who work 30 or more hours a week and 20 part timers who put in 15 hours a week, those part timers may push the company over the 50-employee threshold, making the firm subject to the mandate.[13]

The law also requires that the insurance be affordable. The plan must pay for at least 60 percent of typical health expenses. Further, if an employee has to pay more than 9.5 percent of his income for the plan's premium, then he has the option of looking for subsidized coverage through the state-based exchange. If the employee does so, his employer will be assessed a $3,000 penalty. The penalty applies only if one or more workers receive subsidized coverage through an exchange.[14]

Originally, the ACA required the employer mandate to begin in 2014, but the Obama administration in July of 2013 delayed the requirement for one year until 2015. Administration officials said that they wanted more time to simplify reporting requirements, at the request of employers.[15]

Critics of the employer mandate say that, rather than being an incentive to keep coverage, the policy will instead drive employers to drop coverage. They say the expense of health insurance and changes in tax law will make it cheaper to send employees to the health exchanges and pay the penalty, rather than pay for insurance.[16] Proponents of the law counter that surveys show little evidence that employers plan to drop coverage.[17] A June 2013 Mercer survey of companies with 500 or more employees found that 7 percent plan to stop offering medical benefits.[18]

Critics have also said the mandate will cost millions in jobs because company funds that could have paid salaries will instead have to be used to finance insurance.[19] Further, they say it will cause companies to turn full-time positions into part-time slots to avoid the mandate. The state of Virginia, for example, recently told part-time state employees that their hours would be cut to ensure they don't hit the full-time threshold.[20]

RESOURCES

Explanation of the Employer Mandate

You Ask, We Answer: Here's how Obamacare's employer mandate works

Kliff, Sarah. *The Washington Post*, April 15, 2013
http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/15/you-ask-we-answer-heres-how-obamacares-employer-mandate-works/
This story explains the employer mandate through a series of questions from readers about how the employer mandate may impact their business.

Health Care Changes
Business USA, Aug. 1, 2013
http://business.usa.gov/healthcare
This website, launched in conjunction with the White House, explains to businesses how the employer mandate works. The White House describes this site as "a web-based tool that allows employers to get tailored information on how the health law may affect them based on their business' size, location, and plans for offering health benefits to their workers next year."

Employer Responsibility Under the Affordable Care Act
Kaiser Family Foundation, July 13, 2013
http://kff.org/infographic/employer-responsibility-under-the-affordable-care-act/
This is a clear graphic illustrating how the employer mandate works and which companies fall under the mandate. It includes information about penalties for companies that don't comply with the law.

Implementing Health Reform: The Employer Mandate
Jost, Timothy. *Health Affairs*, December 29, 2012
http://healthaffairs.org/blog/2012/12/29/implementing-health-reform-the-employer-mandate/
This post explains the employer mandate and links to the multiple IRS guidance papers and proposed regulations for complying with the law. It explains the definition of a full time employee and affordable coverage. It also outlines the penalties.

Proposed Rule Clarifies Employer Mandate Calculations
Miller, Stephen. Society for Human Resource Management, July 3, 2013
http://www.shrm.org/hrdisciplines/benefits/articles/pages/employer-mandate-proposed-rule.aspx
This document provides guidance to employers about how to implement the employer mandate and determine if a company is subject to the requirement. The author poses a set of questions and answers, published by the Internal Revenue Service, and addresses such details as requirements regarding seasonal workers.

Summary of the New Health Reform Law

Kaiser Family Foundation, 2010
www.kff.org/healthreform/8061.cfm
This document provides an easy-to-understand explanation of all of the requirements and timetables under the health care law, including mandates that impact small, medium and large employers.

Impact of the Employer Mandate on Workers

Health care law is tied to new caps on work hours for part-timers.
Somashekhar, Sandhya. *The Washington Post,* July 23, 2013
http://articles.washingtonpost.com/2013-07-23/national/40737111_1_health-law-health-insurance-health-care-law
In this story, the reporter interviews part-time employees impacted by the health law and examines the overall impact of the employer mandate and its delay on the labor market. The story determines that the law is hurting some part-time employees' ability to obtain more work.

Definition of Full-Time Becomes A Sticking Point In Obamacare
Rovner, Julie. Kaiser Health News and National Public Radio, July 31, 2013
http://capsules.kaiserhealthnews.org/index.php/2013/07/definition-of-full-time-becomes-a-sticking-point-in-obamacare/
The author looks into the definition of full-time employment and how proponents and opponents of the law have opposing views on the definition. The report explains why the definition is important and its impact on employment.

The White House Claim That Obamacare Is Not Reducing Full-Time Employment
Kessler, Glenn. *The Washington Post,* July 22, 2013
http://www.washingtonpost.com/blogs/fact-checker/post/the-white-house-claim-that-obamacare-is-not-reducing-full-time-employment/2013/07/21/e67a4254-f240-11e2-8505-bf6f231e77b4_blog.html#pagebreak
This article delves into the Obama administration's assertion that the employer mandate isn't hurting jobs growth as critics of the law argue. The reporter looks at the economic data and talks to economists to determine whether the administration is accurate. The bottom line is that it remains difficult to discern if the law is having negative impact or not.

Will Companies Stop Offering Health Insurance Because of the Affordable Care Act?
Thurm Scott. *The Wall Street Journal,* June 16, 2013
http://online.wsj.com/article/SB10001424127887323582904578488781195872870.html

This article conducts a question and answer with several economists and labor market analysts to get a sense of what employers are thinking about the employer mandate and whether it will impact their decision to offer health benefits. The article looks at what happened in Massachusetts when the state imposed an employer mandate, which increased the number of people getting employer-sponsored benefits.

Job Creation and the Affordable Care Act
Bernstein, Jared. On the Economy: Facts, Thoughts and Commentary by Jared Bernstein, July 3, 2013
http://jaredbernsteinblog.com/job-creation-and-the-affordable-care-act-have-little-to-do-with-each-other/
The author, a senior fellow at the Center for Budget and Policy Priorities and former economic advisor to Vice President Joe Biden, analyzes economic data and jobs market data and concludes that the employer mandate has not had an impact on the jobs market.

Employer Mandate Penalties In The New Healthcare Law
National Federation of Independent Business, November 15, 2011
http://www.nfib.com/research-foundation/cribsheets/employer-mandate
In this document, the small business lobbying group analyzes the employer mandate and concludes that it will discourage business growth because money will need to be spent on accountants to comply with the law, rather than on building business.

CBO and JCT's Estimates of the Effects of the Affordable Care Act on the Number of People Obtaining Employment-Based Health Insurance
Congressional Budget Office, Joint Committee on Taxation, March 2012
http://www.cbo.gov/publication/43082
In this analysis, the Congressional Budget Office and Joint Committee on Taxation project the impact of the employer mandate on employment-based health coverage. The analysts predicted a small decrease in the number of those obtaining employee-based benefits as a result of the law, and they explain in detail how they reach that conclusion.

The IRS Interprets the Employer Mandate, and Businesses Have Questions
Mandelbaum, Robb. *The New York Times*, July 23, 2013
http://boss.blogs.nytimes.com/2013/07/23/the-i-r-s-interprets-the-employer-mandate-and-businesses-have-questions/?_r=0
This story looks at the IRS's efforts to explain and detail the regulations related to the employer mandate and how to implement it correctly and notes there are still plenty of questions about how the law works.

Are CBO Estimates on the Future of Employment-Based Coverage Under PPACA Moving Toward the Herd Mentality?

Fronstin, Paul. Employee Benefit Research Council. March 30, 2012
https://ebriorg.wordpress.com/2012/03/30/starting-small/
This blog post explains the March 2012 CBO/JCT findings above and gathers information and analysis from other surveys of employers on how they are responding to the employer mandate. The surveys suggest that while most have no plans to drop insurance, they might consider doing so if other companies start to discontinue their coverage.

Broken Promise: Why ObamaCare Will Force Americans to Lose the Health Care Coverage They Have And Like
Camp, Rep. David. House Ways and Means Committee Majority Staff, May 1, 2012
http://waysandmeans.house.gov/uploadedfiles/fortune_100_report_5_1_12.pdf
Staff of this key House committee reached out to 100 top executives at Fortune 500 companies. Of the 71 who responded, 85 percent said that they expected health care costs to keep rising and indicated that they could save billions of dollars by dropping their employer-sponsored insurance. The committee concluded that the law provides a perverse incentive for employers to drop their coverage.

The Labor Market Impact of Employer Health Benefit Mandates: Evidence From San Francisco's Health Care Security Ordinance
The National Bureau of Economic Research and the Robert Wood Johnson Foundation.
Colla, Carrie, et al. July 2011
http://www.rwjf.org/content/dam/web-assets/2011/07/the-labor-market-impact-of-employer-health-benefit-mandates-
This paper looks at the labor market impact of an employer mandate requiring businesses in San Francisco to provide health insurance or pay into a public fund if they choose not to do so. The study found that the mandate had more of an impact on consumer prices for services than on the labor market itself.

Employer Sponsored Health Insurance, Down But Not Out
Christianson, Jon B., et al. Center for Studying Health System Change. October 2011
http://2fwww.newpublichealth.org/content/dam/web-assets/2011/10/employer-sponsored-health-insurance
This study, based on interviews with employers across the country, discusses the impact of the recession and the expected 2014 implementation of the health care law on businesses. Companies spoke of shifting health costs to employees and projected that responses to the mandate would vary depending upon state implementation of the health law and local labor market conditions.

Health Reform Law 101: Employer Mandate
U.S. Chamber of Commerce

http://www.uschamber.com/health-reform/employer-mandate
This well-known business lobbying group details how the employer mandate works and provides several scenarios to help illustrate which businesses would need to comply and which would not and how much the mandate could cost. This webpage includes links to articles that conclude that the health care law will cost jobs.

Delaying the Mandate

Continuing to Implement the ACA in a Careful, Thoughtful Manner
Mazur, Mark J. Treasury Notes, U.S. Department of the Treasury, July 2013
http://www.treasury.gov/connect/blog/Pages/Continuing-to-Implement-the-ACA-in-a-Careful-Thoughtful-Manner-.aspx
This is the official blog post from the U.S. Treasury Department delaying the employer mandate for one year. The delay "will allow us to consider ways to simplify the new reporting requirements consistent with the law [and] … provide time to adapt health coverage and reporting systems while employers are moving toward making health coverage affordable and accessible for their employees," according to the post.

It's No Contest: The ACA's Employer Mandate Has Far Less Effect on Coverage and Costs Than The Individual Mandate
Blumberg, Linda, et al. Urban Institute, July 2013
http://www.urban.org/UploadedPDF/412865-ACA-Employer-Mandate.pdf
This report considers the Obama administration decision to delay the employer mandate by one year and its impact on the uninsured and concludes that because so many people already work at large companies that offer insurance, the impact will be minimal. It also found that if the government also delayed the individual mandate, the impact would be huge and many fewer people would seek insurance.

A Misleading Obamacare Poll Courtesy of the U.S. Chamber of Commerce and Harris Interactive
Kessler, Glenn. *The Washington Post*, July 31, 2013
http://www.washingtonpost.com/blogs/fact-checker/post/a-misleading-obamacare-poll-courtesy-of-the-chamber-of-commerce-and-harris-interactive/2013/07/30/26e5f51c-f94a-11e2-8e84-c56731a202fb_blog.html
The reporter examines a poll that has been widely used by congressional Republicans to argue that despite the delay in the employer mandate, at least a quarter of small businesses are already cutting hours and jobs in response to the health law. A closer look of the poll shows that 83 percent of small businesses expected to feel no impact from the law and just 4.5 percent to 8.5 percent of small businesses expected to reduce staff and hours.

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Government
Agency for Healthcare Research and Quality http://www.ahrq.gov
Bureau of Labor Statistics http://www.bls.gov/
Business USA http://business.usa.gov/healthcare
Congressional Budget Office http://www.cbo.gov
Congressional Research Service http://www.loc.gov/crsinfo/
Department of Health and Human Services www.dhhs.gov
Department of Labor www.dol.gov
General Accountability Office www.gao.gov
House Budget Committee http://budget.house.gov/
House Education and the Workforce Committee http://edworkforce.house.gov/
House Ways and Means Committee http://waysandmeans.house.gov/
Internal Revenue Service: http://www.irs.gov/
Joint Committee on Taxation https://www.jct.gov/
Senate Budget Committee http://www.budget.senate.gov
Senate Finance Committee http://www.finance.senate.gov/
Senate Health, Education, Labor and Pensions Committee http://www.help.senate.gov/

Other

Employee Benefit Research Institute: www.ebri.org
BenefitsLink: www.benefitslink.com
Council on Employee Benefits: http://www.ceb.org/
International Foundation of Employee Benefit Plans: www.ifebp.org
National Business Coalition on Health: www.nbch.org
U.S. Chamber of Commerce: www.uschamber.org

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manatt

September 30, 2013

HHS Proposes Basic Health Program Regulations

On Friday, September 20th, the Department of Health and Human Services (HHS) released the long anticipated proposed rule on the Basic Health Program (BHP)[1] implementing Section 1331 of the Patient Protection and Affordable Care Act (ACA). Section 1331 provides states with the option to establish a BHP for certain low-income individuals who would otherwise be eligible for coverage through the Exchange. The rule follows a 2011 Request for Information seeking stakeholder comments on the program, and provides the first implementing guidance for states considering adoption of a BHP. The proposed rule addresses: (1) state administration; (2) consumer eligibility and enrollment; (3) health plan benefits and participation; (4) financing; and (5) oversight. Details on payment will be issued separately. The proposed rule was published in the *Federal Register* on September 25th; comments will be accepted until November 25th.

Executive Summary

The ACA provides states with the option to establish a BHP for individuals with incomes between 133% and 200% of the Federal Poverty Level (FPL) who would otherwise be eligible for coverage through the Exchange. States electing to operate a BHP will receive federal funding equal to 95% of the amount of premium tax credits and cost-sharing reductions that would have been available had the eligible individual obtained coverage through the Exchange. States may operate BHP as early as January 1, 2015 and the proposed rule highlights policy and operational considerations for states pursuing this programmatic option.

- **To the extent possible, HHS aligns BHP rules with existing rules governing coverage through the Medicaid, CHIP, and Exchange.** The proposed regulations specify where states must follow Exchange rules or Medicaid/CHIP rules and where states have flexibility to choose. (The appendix to this summary, reviews these requirements.) In addition, the proposed regulations mandate coordination across the continuum of Insurance Affordability Programs (IAPs) – Medicaid, CHIP, Exchange, and BHP. HHS leverages existing Medicaid, CHIP and Exchange policies and procedures to promote coverage coordination and administrative simplicity.

- **HHS recognizes challenging implementation timeframes.** HHS makes special exceptions to, or allows a phase-in period for compliance with, several policies for states seeking January 2015 implementation.

- **HHS addresses states' need for fiscal predictability.** Recognizing that fiscal impact and sustainability are key to state decisions whether to implement a BHP, HHS proposes to determine the amount of federal funding a state will receive on a prospective basis and lays out an annual payment notification process. HHS advises that a proposed payment notice specifying the funding methodology and data requirements for the first year of BHP operations will be issued shortly by HHS. We summarize the major funding provisions in the proposed rule below.

[1] "Basic Health Program: State Administration of Basic Health Programs; Eligibility and Enrollment in Standard Health Plans; Essential Health Benefits in Standard Health Plans; Performance Standards for Basic Health Programs; Premium and Cost Sharing for Basic Health Programs; Federal Funding Process; Trust Fund and Financial Integrity," CMS-2380-P, Published on September 25, 2013 at *78 Fed Reg 59121*, Accessed at: https://federalregister.gov/a/2013-23292.

BHP Establishment and Certification Standards

Borrowing the approach for establishment of Health Insurance Exchanges (Exchanges), HHS proposes states develop a BHP Blueprint that must be approved by the HHS Secretary to certify readiness for BHP operations.

BHP Blueprint and Funding Plan (42 CFR 600.110)

Under the proposed rule, the BHP Blueprint must describe how the state will operationalize its BHP consistent with all program requirements and must also include a funding plan. Specifically, the BHP Blueprint must address how the state will:

- Assure inclusion of essential health benefits under the BHP;
- Use a competitive process to contract with "standard health plans" serving the BHP;
- Incorporate standard contract requirements in its standard health plan contracts;
- Enhance the availability of standard health plan coverage;
- Ensure and promote coordination with other insurance affordability programs, with a plan for enrollment, disenrollment, and verification to eliminate gaps for transitioning individuals;
- Assure that premiums and cost-sharing will not exceed amounts BHP enrollees would have paid in the Exchange;
- Handle BHP disenrollment and non-payment of premiums;
- Determine BHP eligibility;
- Set fiscal policies and accountability procedures;
- Appoint BHP trust fund trustees;
- Ensure program integrity; and
- Assess operational readiness.

The funding plan must describe "the enrollment and cost projections for the first 12 months of operation and the funding sources, if any, beyond the BHP trust fund."

BHP Blueprint Submission Process and Timeline (42 CFR 600.115)

The BHP Blueprint must be signed by the Governor or a delegated official and identify the agency and agency officials responsible for program administration, operations and financial oversight. Similar to the Exchange Blueprint, HHS proposes that states must allow for public comment. However, other than federally-recognized tribes, HHS proposes to maintain flexibility for states to identify particular stakeholders to be consulted in the public comment period.
The preamble acknowledges that timing issues may arise for states preparing a Blueprint for certification prior to finalizing plan contracts or receiving federal funding notification. HHS proposes that states may submit certain BHP Blueprint sections in draft form to receive "certification in principle, pending submission of final Blueprint provisions" and seeks comments on this approach.

BHP Blueprint Certification and Revisions (42 CFR 600.115; 600.120; 600.125; 600.135; 600.155)

- ***Certifying the BHP Blueprint.*** Under the proposed rule, the date of the Secretary's signature serves as the effective date of BHP Blueprint certification, before which a state may not implement its BHP. The date of implementation is the first day that the BHP may provide eligible enrollees with BHP coverage or receive federal payments. The certified BHP Blueprint remains in effect until the Secretary approves a state's revised BHP Blueprint or a state terminates its BHP; or the Secretary withdraws a state's BHP Blueprint certification.

- ***Revising the BHP Blueprint.*** Before making significant changes to its BHP, a state must submit and receive HHS approval for amending its BHP Blueprint. The preamble suggests that significant changes include those that directly impact the enrollee experience in a BHP or program funding. A state must allow public comment prior to submitting a revised BHP Blueprint that significantly alters core BHP operations.

- ***Timing of HHS action for BHP Blueprint certification.*** The proposed rule holds HHS accountable for acting "in a timely manner" to respond to a state's BHP Blueprint certification and revision requests.

BHP Operating Standards (42 CFR 600.145)

The proposed rule requires states to operate their BHP in accordance with a certified BHP Blueprint and to perform core operating functions including the following:

- Eligibility determinations;
- Eligibility appeals;
- Contracting with standard health plan offerors;
- Oversight and financial integrity;
- Consumer assistance;
- Extending protections to American Indian and Alaska Natives and complying with nondiscrimination provisions;
- Data collection and reporting; and,
- Program termination procedures, if necessary.

BHP Withdrawal and Termination Procedures (42 CFR 600.130; 600.140; 600.142)

The proposed rule describes the circumstances under which a state may elect to withdraw or terminate its BHP, and the HHS Secretary may withdraw a state's BHP Blueprint certification and terminate a state's BHP.

- ***State elects to withdraw its BHP.*** Prior to enrolling eligible individuals and regardless of whether a state's BHP Blueprint was certified, a state may withdraw its BHP Blueprint from further consideration.

- ***State elects to terminate its BHP.*** Should a state elect to terminate its BHP after enrolling eligible individuals, the state must submit notice to HHS at least 120 days prior to the proposed termination date; obtain the Secretary's approval of a transition plan; provide notice to BHP standard health plan offerors and enrollees consistent with Exchange accessibility and readability standards; and fulfill all contractual, data reporting, and financial requirements.

- ***HHS withdraws BHP Blueprint certification and terminates a BHP****.* Under the proposed rule, the Secretary may withdraw certification of a state's BHP Blueprint, after notice and a hearing, should it no longer meet certification standards based on an annual or program review, or other evidence. The earliest date for termination must be at least 120 days following the finding of noncompliance.

Transparency and Information Disclosure (42 CFR 600.110; 600.150)

The proposed rules require states to make their Blueprint available online. States also must provide accurate, easily understood information about the BHP coverage option and about other insurance affordability programs. Participating standard health plans must make the names and locations of network providers publicly available, provide accessible and clear information on premiums, covered services, cost-sharing, and other data consistent with Exchange rules.

Application of Exchange Protections for American Indian and Alaskan Natives (42 CFR 600.160)

The proposed rule adopts the same protections for American Indian and Alaskan Natives (AI/AN) as would apply to those applicants and enrollees under the Exchange.

Application of Exchange Nondiscrimination Standards (42 CFR 600.165)

The state's BHP and its participating standard health plans must comply with all applicable nondiscrimination statutes, including those applicable to the Exchange and recipients of federal assistance.

Annual Reporting and Oversight

Annual Reporting Standards (42 CFR 600.170)

The proposed rule requires that States submit annual reports to HHS 60 days prior to operational year end. The report must include any evidence of program fraud, waste or abuse, and a detailed data-driven review of compliance with requirements related to eligibility verification, use of federal funds, collection of quality and performance measures, and any additional requirements specified by the Secretary. The preamble indicates that HHS intends to issue additional guidance on quality and performance measures to align, to the maximum extent possible, BHP, Exchange, Medicaid, and CHIP measures. HHS seeks comment on whether it should adopt this approach.

Federal Compliance Reviews *(42 CFR 600.200)*

Drawing from administrative standards established for other IAPs, the proposed rule allows for HHS review of state administration of the BHP, as needed, but no less than once a year. Though the review may utilize a state's submitted annual report, HHS may also directly analyze a state's policies and procedures, review agency operations, sample case records, and review other data, as necessary. The HHS Office of the Inspector General (OIG) also may audit a state's BHP operations and standard health plan practices, as consistent with Medicaid processes.

Findings of noncompliance may require a state to submit to HHS another annual report addressing the findings no later than 120 days after HHS issues its compliance review, and, if not resolved, may be the basis for withdrawal of BHP certification. A state must resolve findings of improper use of the BHP trust fund by either substantiating proper use of the trust fund or correcting procedures to ensure proper use of the trust fund and restoring improperly used funds.

Eligibility and Enrollment

HHS models BHP eligibility requirements after Exchange and Medicaid rules, and in some cases states may choose which standards to apply. Where states are given a choice between the Exchange or Medicaid, they must adopt all the applicable standards.

Eligible Individuals (§600.305)

The proposed rule codifies the ACA statutory eligibility requirements. Specifically, to be eligible for the BHP an individual:

- Must be a state resident not eligible for Medicaid coverage consisting of at least the essential health benefits;
- Must have household income between 133% FPL and 200% FPL, or be under 200% FPL and a lawfully-present non-citizen ineligible for Medicaid due to their non-citizen status;
- Must not be eligible to enroll in affordable minimum essential coverage
- May be eligible for or enrolled in Medicaid or CHIP coverage that is not minimum essential coverage or for Employer Sponsored Insurance that is unaffordable;
- Must be under 65;
- Must be a citizen or lawfully present; and
- Must not be incarcerated.

States may not impose conditions of eligibility other than those identified above, including restrictions related to geographic location, enrollment caps or waiting periods. If an individual is enrolled in both BHP and Medicaid coverage that is not minimum essential coverage, Medicaid must be the secondary payer.

Application (§600.310)

The proposed rule requires the use of the single streamlined IAP application for the BHP. The rule adopts Medicaid standards of 45 days for timely review of the application.

Authorized Representatives and Certified Application Counselors (§600.310–315)

States may permit authorized representatives to assist with applications and have the option to certify application counselors for the BHP. If a state chooses to take up these options, it must adopt either the Exchange or Medicaid rules.

Determination of Eligibility for and Enrollment in BHP (§600.320)

The proposed rule clarifies that states can choose to determine eligibility directly or allow any governmental entity that determines Medicaid or Exchange eligibility to determine BHP eligibility. States also have the option of following either Medicaid or Exchange rules for eligibility effective dates and enrollment periods. Medicaid policies provide more generous parameters for BHP individuals, such as retroactive coverage and the ability to enroll any time during the year. Under Exchange policies, BHP individuals' coverage would not be effective until at least the first of the following month and they would be limited to open and special enrollment periods.

Coordination with Other Insurance Affordability Programs (§600.330)

To ensure coordination between BHP and other IAPs, BHP eligibility determinations must use modified adjusted gross income (MAGI) standards. The proposed rule incorporates both Exchange and Medicaid standards for IAP coordination. As with Exchange determinations, Medicaid may choose to accept BHP determinations of Medicaid eligibility, or Medicaid may reserve the ability to make final eligibility determinations. The proposed rule requires that BHP, the Exchange, Medicaid, and CHIP have an agreement in place delineating responsibilities between agencies and ensuring timely eligibility

determinations and enrollment. Coordinated and combined notices must be provided to BHP enrollees, consistent with Exchange and Medicaid requirements.

Appeals (§600.335)

Noting that there is no statutory basis for permitting federal appeals of BHP determinations, as is required for the Exchange, the proposed rule requires states to administer appeals of BHP eligibility through state Medicaid processes. In states that have delegated Medicaid appeals to the Exchange, individuals would not be afforded a federal level of appeal for BHP eligibility determinations or a "second level" appeal as is available in the Medicaid process. In general, eligibility determinations must include a notice on the right to appeal and must be accessible to those with limited English proficiency and disabilities.

Periodic Renewal of BHP Eligibility (§600.340)

Consistent with both Exchange and Medicaid requirements, the proposed rule would require a redetermination of BHP eligibility every 12 months. Enrollees must report changes that would affect their eligibility for BHP within 30 days, in accordance with the Exchange rules, and redeterminations must be based on verified information received or on updated information from available data sources. Upon redetermination, a state must retain a BHP enrollee's enrollment in his or her current standard health plan, unless the individual acts to select a different plan.

Eligibility Verification (§600.345)

Under the proposed rule, States have the option to follow either Exchange or Medicaid verification requirements. The commentary notes that a State may choose to verify additional factors and specify those factors for which self-attestation will be accepted.

Privacy and Security of Information (§600.350)

BHP must follow Exchange standards on the use and disclosure of personally identifiable information.

Enrollee Premiums and Cost-Sharing

Premiums (§600.505)

States must assure that monthly premiums do not exceed what an otherwise qualified enrollee would have paid in premiums had they secured coverage through the Exchange. The BHP Blueprint must include all proposed enrollee monthly premium amounts, the collection method, the procedures for making payments, and the consequences for nonpayment.

Cost-sharing Protections (§600.510, 520)

Consistent with CHIP and Exchange standards, cost sharing cannot be higher for lower income BHP enrollees than it is for higher income enrollees. In addition, BHP plans for individuals with incomes below 150% of the FPL must have an actuarial value of at least 94%; for individuals between 150% and 200% of the FPL, BHP plans must meet an actuarial value of 87%. The preamble notes that HHS considered basing cost sharing amounts for BHP plans on a selected model gold or platinum plan available under Exchange, but did not propose that option. Consistent with the Exchange and Medicaid guidance, preventive health services are exempt from cost sharing. The BHP Blueprint must identify the groups subject to cost sharing and the amount of cost-sharing.

Public Schedule of Enrollee Premium and Cost-sharing (§600.515)

Consistent with requirements for Exchanges, states must publish information on premiums and cost sharing for a specific item or service under the standard health plan that would apply at different income levels. States must also make available information on the implications of nonpayment of premiums..

Disenrollment Procedures and Consequences for Nonpayment of Premiums (§600.525)

The proposed rule requires BHP to assure compliance with Exchange disenrollment procedures for nonpayment of premiums overall – including the requirement to provide a premium payment grace period – but then specifies when Exchange and Medicaid policies apply. If a state chooses to align its BHP enrollment policy with that of the Exchange, the state must follow Exchange policy requiring a three month premium grace period and may not restrict re-enrollment beyond the next open enrollment period, or, if applicable, next special enrollment period. If the state chooses to align its BHP enrollment policies with that of Medicaid, the state must provide a 30-day grace period; may not impose a lockout period for failure to pay premiums of more than 90 days or after an enrollee has paid past due premiums; and, may not collecting past due premiums as a condition of eligibility upon expiration of the lockout period.

Standard Health Plans

The ACA provides that BHP coverage is delivered through "standard health plans" and outlines eligible offerors, plan coverage standards, and plan procurement process. The proposed rule codifies and expands upon these requirements.

Eligible Offerors (42 CFR 600.415)

The ACA authorizes standard health plans to be offered by licensed HMOs, licensed health insurance insurers, or networks of providers. HHS proposes to include "non-licensed HMOs participating in Medicaid and/or CHIP" to provide states with flexibility to contract with Medicaid or CHIP managed care organizations that may not meet Qualified Health Plan (QHP) issuer standards.

Coverage Standards (42 CFR 600.405)

HHS adopts both Exchange and Medicaid standards for coverage, noting its "goal to create coordination across all insurance affordability programs, promote efficiencies and reduce administrative costs." With respect to ensuring EHBs in standard health plans, states may select more than one base benchmark option – the approach permitted in ensuring EHBs for Medicaid alternative benefit plans – and must comply with Exchange standards for substitution and supplementation of benefits, non-discrimination in benefit design, and segregation of funds for abortion coverage. Consistent with Exchange and Medicaid standards, substitution of prescription drug benefits is not permitted. If the standard health plan is offered by is a health insurance issuer, the coverage must also comply with the 85% medical loss ratio standard.

Plan Procurement (42 CFR 600.410-425)

- ***Competitive Contracting.*** The ACA requires that states use a "competitive process" for contracting with standard health plans, which includes negotiation of premiums, cost-sharing, and benefits and consideration of innovative features such as care coordination and incentives to encourage the use of preventive services and appropriate utilization of health services. , In

the preamble discussion, HHS notes the competitive contracting process is a "unique feature to BHP" and – while striving to align with Exchange, Medicaid and CHIP standards – an area of new policymaking. States are permitted to employ any state procedures consistent with 45 CFR 92.36. HHS acknowledges that states may have interest in joint procurements with Medicaid or other state health programs and wish to leverage existing Medicaid managed care contracts for "efficient and quick implementation of BHP" in the first program year. HHS proposes to permit states to seek an exception from the competitive contracting process in 2015 so long as it can demonstrate its timeline and process to comply in 2016. HHS solicits comments on this approach.

- ***Plan Contract Requirements.*** States must develop health plan contracts tailored to their BHP. At a minimum, the proposed rule requires that contract provisions address network adequacy, service provision and authorization, enrollment procedures, noticing, appeals, quality and performance, and privacy and security of information. HHS intends to release future guidance but advises in the preamble discussion that it will provide a "safe harbor" for states that apply Medicaid or Exchange requirements until the next contract cycle after the issuance of guidance.

- ***Coordination with Other Insurance Affordability Programs***. Reinforcing the goal of a coordinated and seamless consumer experience when transitioning across programs in the coverage continuum, the proposed rule requires states to implement policies to promote continuity of care. Example policies include: ensuring individuals undergoing a course of treatment can continue to receive such treatment and provider access through the duration of the prescribed treatment and promoting access to provider networks and benefits through coordinated provider enrollment and plan procurement procedures.

- ***Availability of Plans***. The proposed regulations specify states must ensure at least two standard health plan options are available to BHP applicants and enrollees.

BHP Financing

Payment Methodology (42 CFR 600.600-615)

The statute requires that HHS transfer federal funds to a state's BHP trust fund each fiscal year. The funding amount is 95% of the premium tax credit and cost-sharing reductions that would have been provided to the enrollee had she or he been enrolled in QHP coverage through an Exchange. The statute further directs HHS to take into account factors such as age, income, health status and geographic rating differences in calculating BHP payments to states. In the proposed rule, HHS outlines a payment approach with rates determined on a calendar year basis and amounts calculated prospectively and adjusted retrospectively. In crafting this approach, for which HHS seeks comment, the Department highlights its attempt to address concerns raised by states and other stakeholders on state budget predictability.

- ***CSRs in BHP Payment Amount***. The proposed rule clarifies that HHS will include 95% of both the premium amount and cost sharing reductions when calculating the BHP payment to states.

- ***Payment Calculation on Quarterly Prospective Basis with Retrospective Adjustment***. HHS actuaries will determine payment amounts on a state-specific, quarterly basis, multiplying payment rates by projected BHP enrollment. This calculation would take into account different payment rates for different groups of enrollees based on the payment factors noted above. Sixty

days after the close of the quarter, payment amounts would be adjusted based on actual enrollment. Additional payments would be deposited into the state's BHP trust fund and reductions would be applied to the state's prospective payment in the upcoming quarter.

- ***Risk Adjustment, Reinsurance and Risk Corridors.*** HHS weighed two options for risk adjustment: developing a risk adjustment factor to include in the BHP funding methodology, or incorporating BHP plans in the risk adjustment and BHP enrollees and plans in the individual market risk pool. Citing potential differences between BHP and Exchange benefit packages and noting that insurance market reform rules may not apply to some standard health plan offerors, HHS proposes to follow the first approach. HHS further proposes to apply risk adjustment on a prospective annual basis – rather than applying the current year's experience retrospectively to premiums as in the individual market – to "improve predictability for states in the amount of federal funding they will receive in a given fiscal year." Retrospective corrections would only be made in the event of incorrect enrollment data used as the basis for payments or mathematical errors in applying the methodology. ACA reinsurance and risk corridor programs will not apply to the BHP.

- ***Annual Payment Notice.*** Consistent with its practice for Exchange and CHIP payment, HHS proposes to develop and publish annual federal BHP payment notices in the *Federal Register.* HHS will publish a proposed notice each October describing the methodology to calculate the payment rates for the next federal fiscal year and soliciting data on BHP payment factors from states for the calculation of the federal payment amount. HHS will then publish a final notice each February describing the final payment methodology, payment factors, and the federal payment amount. For January 1, 2015 implementation date, HHS expects to publish the proposed payment notice in the fall of 2013 and final payment notice concurrently with the final BHP rule.

Trust Fund (42 CFR 600.700-715)

States must establish a trust in which to deposit federal BHP payments. HHS proposes that the trust fund must exist as an independent entity, or as a subset account within the state general fund, and include trustees who are vested with authority to withdraw and oversee funds. States are authorized to apply unspent trust funds to reduce premiums and cost-sharing or provide additional benefits for BHP enrollees. Notably, the proposed rule prohibits BHP trust funds from being used for BHP program administration. HHS also proposes to permit states to carryover unexpended BHP trust funds from year-to-year.

HHS also proposes a number of policies relating to fiscal accountability of the BHP trust fund. These include maintenance of accounting records; annual certification by BHP trustees or state's chief financial officer; independent audit of trust fund expenditures every three years; and annual reporting on use of funds.

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Appendix: Alignment of BHP, Medicaid, CHIP and Exchange Policies

BHP Feature	Approach Adopts or Consistent With:	Comments
Establishment and Certification Standards		
Blueprint	Exchange	Leverages Exchange Establishment approach but state flexibility in identifying stakeholders for public comment
Information Disclosure by Standard Health Plans	Exchange	
Quality and Performance Standards	Exchange, Medicaid, CHIP	Intent is to align with QHP quality rating and consumer satisfaction surveys and Medicaid/CHIP efforts in future guidance
Nondiscrimination	Exchange	
OIG Audit of State Operations and Standard Health Plan Practices	Medicaid	Consistent with purpose and processes of Medicaid audits
Eligibility and Enrollment		
Single, Streamlined Application	Exchange, Medicaid, CHIP	
Application Processing Timeline	Medicaid	
Authorized Representatives	Exchange or Medicaid	States may choose whether to allow authorized representatives and which approach to follow
Certified Application Counselors	Exchange or Medicaid	States may choose whether to certify application counselors and which approach to follow
Eligibility Verification	Exchange or Medicaid	States may choose to add additional standards
Eligibility Effective Date	Exchange or Medicaid	States may choose first of following month or retroactive eligibility
Enrollment Period	Exchange or Medicaid	States may choose open enrollment/SEP or continuous enrollment
AI/AN Special Enrollment Period	Exchange	
Eligibility Determination Notices	Exchange and Medicaid	
Electronic Notices	Medicaid	Only difference between Exchange and Medicaid requirements is effective date of 1/1/15 for Medicaid
Eligibility Appeals	Medicaid	Excludes second level of review and federal review if Medicaid delegates to Exchange

BHP Feature	Approach Adopts or Consistent With:	Comments
Eligibility Redeterminations	Exchange or Medicaid	States may choose but must require changes to be reported within Exchange standard of 30 days
Privacy and Security of Information	Exchange	
Interagency Coordination Agreements	Exchange and Medicaid	
Enrollee Premiums and Cost Sharing		
General Cost Sharing Protections	Exchange and CHIP	
Premium Levels	Exchange	
Out-of-Pocket Cost Sharing Maximums	Exchange	
AI/AN Premiums and Cost-sharing Protections	Exchange (similar to Medicaid/CHIP)	
Disenrollment Due to Non-Payment of Premiums	Exchange	
Premium Grace Periods	Exchange or CHIP	States must apply consistent Exchange or CHIP program policy based on selected approach for enrollment period
Reenrollment Standards	Exchange or CHIP	States must apply consistent Exchange or CHIP program policy based on selected approach for enrollment period
Standard Health Plans		
Essential Health Benefits Definition	Exchange and Medicaid	
Essential Health Benefits Benchmark Selection	Medicaid	States may select more than one benchmark option
State-mandated Benefits	Exchange	
Nondiscrimination	Exchange	
Abortion Coverage	Exchange	
Plan Contract Provisions	Exchange and Medicaid	States may use Exchange and Medicaid plan contracts under a safe harbor provision
Financing		
Annual Payment Notice	Exchange and CHIP	