
Washington Health Benefit Exchange



**REPORT
TO THE
WASHINGTON
STATE
LEGISLATURE**

*Financing the Washington
Health Benefit Exchange*

December 1, 2012

Washington Health Benefit Exchange

The Washington Health Benefit Exchange (“WHBE” or “Exchange”) was created as a public-private partnership through the passage of SB 5445 in May of 2011. Its duties were defined through the passage of HB 2319 in March of 2012.

The Washington Health Benefit Exchange Board has the following objectives:

- increase access to affordable health plans
- organize a transparent and accountable insurance market – to facilitate consumer choice
- provide an efficient, accurate and customer-friendly eligibility determination process
- enhance health plan competition on value – price, access, quality, service and innovation

Vision:

Redefining People’s Experience with Health Care

Mission:

Radically improving how Washingtonian’s secure health insurance through:

- innovative and practical solutions
- easy-to-use customer experience
- our values of integrity, respect, equity and transparency
- and by providing undeniable value to the healthcare community (patients, providers, plans)

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Retired Executive Director,
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Washington Health Benefit Exchange

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Executive Summary

The Washington Health Benefit Exchange (“WHBE” or “Exchange”) will be an easily accessible, central marketplace for individuals, families and small businesses to buy health insurance with the help of federal subsidies. This one-stop shop will enable residents to:

- Make apples-to-apples comparison between Exchange Qualified Health Plans (“QHP”).
- Check qualifications for tax credits and subsidies.
- Receive assistance finding, selecting and enrolling in a health plan that meets a person’s or business’ specific needs.

Under the Patient Protection and Affordable Care Act of 2010 (the “ACA”), passed by Congress and signed into law by the President in March 2010, state-based health benefit Exchanges must be financially self-sustaining effective January 1, 2015.

The legislature required the Exchange Board (“Board”), under HB 2319, to develop a methodology to ensure the Exchange is self-sustaining after December 31, 2014.

Under the ACA’s simplified eligibility rules (now using modified adjusted gross income, or MAGI) and technological advances, what now takes up to 45 days should be able to be determined within 15 minutes

The Board is required to seek input from health carriers to develop a funding mechanism that fairly and equitably apportions among carriers the reasonable administrative costs and expenses necessary to operate the Exchange and submit its recommendations to the legislature by December 1, 2012. This report is submitted to fulfill this legislative requirement.

The Exchange will serve a broad range of markets and population as a new health insurance marketplace. It is expected to demonstrate substantial economic and social value to Washington, including but is not limited to the following:

- By 2017, it is expected to decrease the number of uninsured Washingtonians from 13% today to less than 5% - a decrease of 8%. In other words, more than 500,000 currently uninsured Washington residents will have health insurance coverage either through the Medicaid Expansion Program or the Exchange’s Qualified Health Plans. The Exchange believes this increase in covered lives will have a positive impact on the overall health of our population.
- The Exchange is projected to serve approximately 280,000 members on January 1, 2015 and is expected to generate premium revenue of roughly \$1.3 billion during 2015 and the premium dollars will be directed to the carriers offering the Qualified Health Plans within the Exchange. By 2018, the Exchange generated



premium revenue is expected to exceed \$2.0 billion annually. The administrative functions, such as marketing/promotion, eligibility verification, premium collection/reconciliation, etc., offered by the Exchange should have a very high intrinsic value to the QHP carriers, consequently lowering their selling costs and enhancing efficiencies for individuals and small group members covered through the Exchange. The Exchange's QHP partners have much to gain in the success of the Exchange.

- Developing and implementing the Exchange is costly -- more than \$150 million in federal grants were awarded during 2012-2014. The on-going operating budget for 2015 is estimated to be about \$50 million. When considering this price tag, the Legislature should consider the annual operating cost of the Massachusetts Health Connector ("Connector"), the only public exchange operating today. During 2011, the Connector had an enrollment base of 240,000, and its operating costs were \$13.48 per member per month ("PMPM"), or \$35 million for the year. **In 2017, WHBE is expected to cost 20% less (\$10.74 PMPM) while offering more value-added benefits to its members (see Appendix B).**

In considering different Self-Sustaining options, the Exchange identified several essential characteristics in evaluating funding mechanisms, including:

- A predictable revenue source to facilitate financial planning,

mitigate risk and meeting budget requirements.

- The relationship between revenue and the Exchange's value proposition.
- The ability of the revenue source to address the Exchange's budget needs in a timely manner.
- The feasibility of collecting revenue using the recommended method.

In light of these considerations, the WHBE Board makes three alternative recommendations to the Legislature in order to be Self-Sustaining by January 1, 2015. The three alternatives are not prioritized, and are as follows:

WHBE is expected to cost 20% less on a PMPM basis and offer more value-added benefits than the currently offered Massachusetts Connector (see Appendix B)

Recommendation A

In accordance with RCW 48.14.0201, the Legislature enacts a premium tax assessment, effective January 1, 2014, totaling half percent (.5%) and, effective January 1, 2015 and thereafter, totaling one percent (1.0%) of all premiums and prepayments for health care services received, to fund the costs to operate the Exchange. (See Appendix A for financial implication)

Recommendation B

In accordance with RCW 48.14.0201 effective January 1, 2014, the Legislature authorizes and apportions to the Exchange the premium tax collected on all

premiums and prepayments for health care services attributable to the Exchange-generated premiums received. Any funding shortfalls shall be augmented by assessing a service charge payable by the Qualified Health Plans in the Exchange to fund the costs to operate the Exchange. (See Appendix A for financial implication)

If either Recommendation A or B is passed, the Exchange Board shall provide a Progress Report to the Legislature on December 1, 2016 to:

- Summarize business metrics, e.g. enrollment & financial performance for 2014-2015
- Evaluate a Sunset Provision of any premium tax assessments
- Quantify and evaluate the incremental premium tax amount from the revenues generated by the Exchange
- Quantify and evaluate the feasibility of assessing Qualified Health Plans in the Exchange for 2018 and beyond as an alternative to the premium tax assessments

Recommendation C

Effective January 1, 2014, assess a service charge payable solely by the Qualified Health Plans in the Exchange to fund the costs to operate the Exchange. (See Appendix A for financial implication)

Introduction

In March 2010, the Patient Protection and Affordable Care Act of 2010 (the “ACA”) was enacted by Congress and signed into law by the President of the United States. The ACA authorizes the creation of state-based and operated Health Benefit Exchanges that will allow consumers in the individual and small group markets to access and evaluate health insurance coverage options from commercial insurers, determine savings on health insurance premiums, and buy coverage of their choice.

The Washington Health Benefit Exchange (“WHBE” or “Exchange”) was established through the passage and signing of SB 5445 in May of 2011. Its duties and responsibilities were further defined with the passage and signing of HB 2319 in March of 2012. The WHBE is a public-private partnership, separate and distinct from the state, governed by an independent Board of Directors (“Board”).

On March 15, 2012 the Board assumed authority for all Exchange functions. Since that time, the WHBE has been working closely with several Federal and State agencies to ensure that the Exchange will be ready to provide health insurance options to residents as of October 1, 2013 for coverage beginning January 1, 2014 as required under the ACA. Once implemented, Washington anticipates the Exchange will serve more than 500,000 individual and small group members by Jan. 1, 2018.

Beginning January 1, 2015, the ACA requires that state-based health benefit exchanges become financially self-sustaining. Prior to that date, Exchange activities can be supported by federal Exchange establishment

grant funding provided by the Center for Medicare and Medicaid Services (“CMS”) through the Center for Consumer Information and Insurance Oversight (“CCIIO”). Federal law allows states considerable flexibility in the manner in which to finance the Exchange.

To identify a funding methodology to support Washington’s Exchange, the legislature required the Board, under HB 2319, to develop a methodology to ensure the Exchange is self-sustaining after December 31, 2014. The Board is required to seek input from health carriers to develop a funding mechanism that fairly and equitably apportions among carriers the reasonable administrative costs and expenses necessary to operate the Exchange. The Board is further required to submit its recommendations to the legislature by December 1, 2012 (see sidebar).

This report is submitted to the Legislature in fulfillment of the requirements outlined in HB 2319 and in order to present the Board’s recommendations in relation to a funding methodology for the WHBE. To put the Board’s recommendations into proper context, the report will also outline the value of the Exchange to various constituencies within Washington; summarize the expected operating expenses and budget requirements for the WHBE; provide an overview of potential funding mechanisms and assessment sources; offer preliminary indications from the other state exchanges currently available publicly and their anticipated self-sustainability funding methodologies currently under consideration. All this was taken into consideration by the WHBE Board in making its recommendation.

The Engrossed Second Substitute House Bill 2319 was approved by Legislation on March 23, 2012 states the following in Section 4 Paragraph 2:

“The exchange board shall develop a methodology to ensure the exchange is self-sustaining after December 31, 2014. The board shall seek input from health carriers to develop funding mechanisms that fairly and equitably apportion among carriers the reasonable administrative costs and expenses incurred to implement the provisions of this chapter. The board shall submit its recommendations to the legislature by December 1, 2012. If the legislature does not enact legislation during the 2013 regular session to modify or reject the board’s recommendations, the board may proceed with implementations of the recommendations.”



Value of the Exchange

The Exchange is a public/private partnership that provides a number of valuable functions and services that benefit a wide range of constituents. Among its required functions¹, the WHBE must perform the following:

- Review and certify issuers and health benefit plans as Qualified Health Plans (“QHPs”)
- Provide customer service support and consumer assistance
- Develop and host a web portal to support individual and employer comparison of health plans and purchase of insurance
- Provide online tools to allow consumers to calculate the tax credit and cost sharing subsidies they may qualify for
- Determine individual eligibility for Medicaid and/or federal tax credits and subsidies
- Develop and maintain a health plan quality rating system
- Enroll individuals and businesses in health insurance coverage
- Oversee and finance a Navigator program
- Engage in targeted and broad-based outreach and education to inform consumers and encourage enrollment
- Provide for the acceptance and adjudication of individual and employer appeals related to program eligibility
- Make determinations related to the ACA’s individual responsibility requirements
- Provide a host of public reporting on health plan quality and Exchange operations
- Develop and maintain a seamless eligibility process that allows for the real-time determination of eligibility across multiple programs
- Administer the distribution of premium tax credits and cost sharing reductions
- Oversee administrative, operational, and consumer support activities specific to the Small Business Health Options Program (“SHOP”)

The WHBE will serve the individual and small group (defined as small businesses under 50 employees) markets and populations, and has both a business value and a public value.

An aspect of the Exchange’s operations includes activities that directly benefit QHP issuers, such as the marketing of health plans, the determination of individual eligibility for federal tax credits and cost sharing subsidies, the required monthly reconciliation and reporting of federal tax credits as well as premium collection activities.

Another aspect involves elements that more broadly benefit the entire health care marketplace, such as the development of a web portal that simplifies the comparison of



¹ List of functions reflected in HHS Funding Opportunity Announcement, Cooperative Agreement to Support Establishment of State-Operated Health Insurance Exchanges, Appendix F: Guidance for Preparing Budget Request by Core Area, November 29, 2011.

carriers and plan designs, along with the provision of tax credits to make insurance more affordable. By making insurance more accessible, especially for the previously under-insured or uninsured, the Exchange will increase health insurance coverage (i.e., reduce the rate of uninsured), benefiting the entire health care market.

Yet a third aspect of the WHBE is to provide services that benefit the general population of Washington. These include discrete functions such as its role in granting certificates of exemption under the individual responsibility requirement, as well as its much more broadly defined value in improving the ability of Washington residents and small businesses to easily and efficiently access affordable health care coverage.

In all of its activities, the WHBE must balance its business-like aspects with those of its public mission and value proposition. At its core, and consistent with the vision of SB 5445 and HB 2319, the WHBE facilitates the purchase of privately-offered health insurance products, the availability of premium tax credits and cost sharing subsidies, and must perform this function efficiently and cost-effectively so that consumers and health insurance carriers will look to the WHBE as a good business partner. In addition to this business-like focus on efficiency and market-appeal, the Exchange must also retain focus on its public mandate to foster efficiency and quality in the health insurance market and expand access to coverage for all Washingtonians.

In evaluating potential revenue models to support the organization's ongoing operations, the Exchange needs to first identify the markets,

populations, and entities that derive value from the Exchange, and determine the specific ways in which these groups will benefit from the activities of the WHBE. To help structure this assessment, the Exchange has divided the constituencies benefitting from the WHBE into three categories: Issuers of QHPs and Medicaid; the Health Care Market; and the Public and the State.

At its core, and consistent with the vision of SB 5445 and HB 2319, the WHBE facilitates the purchase of privately-offered health insurance products, the availability of premium tax credit cost sharing subsidies and must perform these functions efficiently and cost-effectively.

VALUE TO ISSUERS OF QHPs & MEDICAID

The first type of value being provided by the Exchange will accrue to the organization's business partners: issuers of QHPs and the state's Medicaid program. As a direct service provider to these groups, the Exchange will perform a number of critical functions on behalf of these entities, including eligibility determination and enrollment (through technology applied to simplified eligibility criteria now dependent on Modified Adjusted Gross Income "MAGI"); account installation and management; broad-based and targeted marketing; marketing and communications, including collateral material production and web-portal hosting;

customer service and consumer assistance; monthly premium collection and distribution; and ensuring accurate data transmittal for tax credit purposes. The Exchange will simplify processes for new Medicaid enrollees (eligible under the ACA rules), by introducing new technology to simplified eligibility determination criteria, which is expected to reduce a process that currently takes up to 45 days to be completed in 15 minutes.

The value of the Exchange performing these functions is particularly relevant in the small and non-group insurance markets, where administration as a share of total premium cost is highest, due to the high number of transactions for low enrollment yields. Whereas an issuer that closes a single sale in the large group market may yield thousands of new members, it may take that same issuer hundreds of individual sales in the small and individual market – with all of their associated marketing, account set up, and customer service costs – to yield the same level of membership.

The Exchange's role in organizing the market, providing a single web portal, and leveraging its scale efficiencies to perform many of these administrative functions is therefore of particular value to issuers selling in small and non-group insurance market. Because of the scale of enrollment anticipated to move through the Exchange and the type of systems being developed, the WHBE should be able to provide cost efficiencies for issuers of QHPs in the marketing and member installation process.

Beyond the technical and administrative functions provided by the Exchange, **the greatest value**

provided by the Exchange may be the membership opportunity it presents: as the only entity empowered to provide federal premium tax credits and cost-sharing subsidies and the gateway for determining eligibility for Medicaid, the WHBE will be the channel through which Washington residents are able to gain access to affordable coverage.

VALUE TO HEALTH CARE MARKET

The Exchange also provides specific and tangible value to the health care industry as a whole, including both health insurers and health care providers. Most importantly, the Exchange will provide a path for enrollment in 2014 to approximately 140,000 to 410,000 individuals in Washington. Additionally, the Exchange will allow its enrollees to capture federal tax credit dollars as well as individual and employer

contributions, and help distribute these funding streams throughout the health care market. These funds will first be paid to insurers in the form of premium revenue, and then to the provider community as the majority of insurance premium revenue is distributed to pay for medical goods and services.

The ACA has been structured to require that insurers and hospitals make a financial contribution in recognition of the fact that they are anticipated to realize revenue gains as a result of this expanded coverage. These contributions will come in the form of federal premium assessments and reductions in Disproportionate Share Hospital (“DSH”) payments for Medicare and Medicaid. There are differing opinions as to the net impact on these industries from the implementation of the ACA, but the increase in coverage and reduction in uncompensated care should have a net positive financial impact.

The Exchange will perform a number of other functions that benefits this sector. By providing broad-based communication, marketing and outreach programs emphasizing the need for health insurance and the availability of tax credits and subsidies, the Exchange will have a positive impact on expanding coverage beyond the population that enrolls directly through the WHBE, including the new Medicaid expansion population.

The Exchange will also provide a simple-to-use web portal and web-based consumer decision support tools, such as provider search functions and a health care cost calculator. These functions will help healthcare consumers make better purchasing decisions.

Finally, the Exchange will increase transparency in the health care system by providing information and metrics on cost and quality. By providing a source of comparative information, it may also encourage carriers and providers to improve their quality and efficiency both in absolute terms as well as relative to one another through competition for exchange enrollment and the adoption of best practices.

VALUE TO PUBLIC AND THE STATE

The Exchange also provides significant and quantifiable value to the public and to the state of Washington in the form of expanded coverage, greater security in the ability to access affordable coverage when necessary, positive economic impact, portability of their healthcare coverage, greater access to health care information and improved overall population wellness.

Table 1. Exchange Value Proposition by Constituent Type

<u>CONSTITUENCY</u>	<u>SOURCE OF VALUE</u>
I. Issuers of QHPs	Marketing, Enrollment, Account Installation, and Administrative Services Membership Opportunity Premium Aggregation
II. Health Care Market	Increased premium and provider revenue Reduction in hospital charity care and bad debt More widely available consumer information Supporting use of innovative product designs and provider payment methodologies
III. Public and State	Reduction in the number of uninsured residents Enhanced coverage through standardized essential health benefits Comparison of health insurance carriers and benefits Eligibility and mandate appeals administration

The Exchange will provide a convenient destination to purchase affordable coverage and obtain Federal tax credits and cost sharing subsidies for those who qualify.

The WHBE will provide peace of mind to Washington residents who lose or are without health insurance coverage by providing a mechanism that will allow them to obtain coverage that is portable and has a trusted seal of approval through the WHBE QHP certification process. As part of the QHP certification process, the WHBE will offer plan designs that meet minimum coverage standards relative to benefits and cost sharing levels. This will provide additional protection for the residents of Washington by assuring that the insurance products sold by the Exchange meets federal standards, and will provide comprehensive health benefit coverage.

The ripple effects generated by the expansion of health insurance coverage will have a positive effect on fiscal health of the state. The baseline uninsured rate in Washington of 13% is expected to drop by between 8 and 11 percentage points to between 2.3% and 5.0%, by 2017 when ACA is fully implemented in Washington. The number of previously uninsured individuals expected to gain coverage through ACA implementation is estimated to be between 500,000 and 670,000 in total (see *Milliman Report* - link below). While this expansion

of coverage and related increase in insurer and provider revenue is anticipated to aid the state's broader economy, the increased access to health care is expected to have a positive impact on the overall health and wellness of the population.

The Exchange will also provide a valuable service as a trusted, objective source of information about health care generally, and about health insurance carriers specifically. Understanding and interpreting health care terms such as coinsurance, copayments and deductibles, as well as differences between plan designs offered by carriers is extremely difficult for the typical individual or small business looking to purchase health insurance. By bringing best-in-class technology and a deep understanding of the health insurance market, the WHBE will bring order to the current disorder in purchasing health insurance. Due to the significant amount of broad-based marketing and advertising that is expected, the WHBE will likely become a destination site for the general public seeking information about health care reform as well.

Finally, the Exchange will be responsible for administering the ACA-required process for eligibility appeals and is also responsible for granting certificates of exemption to the individual responsibility requirement, i.e. the individual mandate.

The WHBE will also be a valuable state-based asset to assist individuals seeking cost-effective health care options as a result of employment transitions or stitching together part-time employment in which health care is not offered or available.

WHBE Milliman Market Analysis



Exchange Budget Estimates

A key element in assessing revenue model options is to first estimate the level of expenses that must be supported by the chosen revenue stream. WHBE staff have developed a five-year budget estimate covering the years 2013 through 2017. To develop estimated expense levels, staff relied upon actual contracts or known costs when available. For projected expenses, staff utilized a combination of market data, benchmark cost, and industry knowledge to formulate an overall budget estimate. Staff was supported in the development of these budget estimates by Wakely Consulting Group, Inc., (“Wakely”) a consulting firm that has worked with several other states to develop their exchanges’ budget estimates. Wakely conducted a high-level analysis to estimate WHBE spending in late 2011 and early 2012, and also assisted the WHBE in the preparation of the state’s Level II Exchange Establishment Grant application.

Because many of the Exchange’s core operating systems will be fixed versus variable costs based on

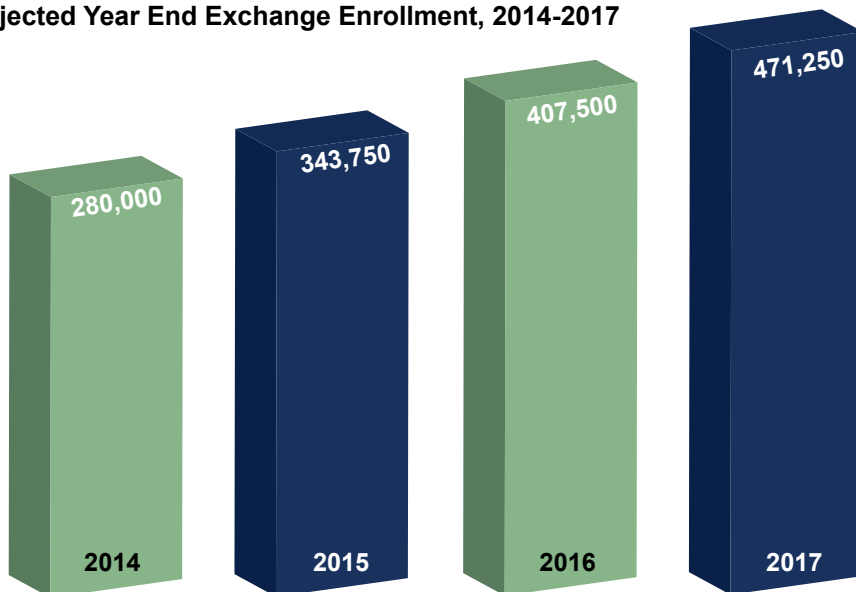
enrollment through the Exchange, an important dimension of the budget development is expected enrollment scale. Total estimated year-end enrollment of the Exchange is anticipated to be between 150,000 and 410,000 in 2014, growing to between 200,000 and 520,000 once reform is fully implemented in 2017. Over the three-year period, 2015 through 2017, the moderate or best-guess estimate yielded year-end membership estimates of 343,750, 407,500, and 471,250 respectively.

Total enrollment is expected to be disproportionately from the individual market, with slightly more than 80% of the total for each of the three years attributable to the non-group market.

Total Exchange spending for the three-year period 2015, 2016 and 2017 is projected to be \$51,078,000, \$53,588,000, and \$55,658,000, respectively.

Expenses on a per member per month (PMPM) basis for 2015, 2016 and 2017 are estimated to be \$13.69,

Projected Year End Exchange Enrollment, 2014-2017



WHBE Projected Key Business Metrics, 2014-2017

	2014	2015	2016	2017
Year End Members	280,000	343,750	407,500	471,250
Total Member Months	2,053,000	3,730,000	4,483,000	5,184,000
Projected FTEs	116	89	95	100
Total Expenses	\$47,213,000	\$51,078,000	\$53,588,000	\$55,658,000
Expenses Per-Member Per-Month	N/A (a)	\$13.69	\$11.95	\$10.74
(a) 2014 is funded by federal grant				

\$11.95, and \$10.74, respectively. The decreasing estimated PMPM cost reflects the increase in membership during this timeframe and underscores the positive cost impact resulting from greater enrollment.

Enrollment will be the most significant factor in operating the WHBE on a cost-effective basis and will be an important variable in refining and updating the budget on a go-forward basis. An additional consideration is the scope of functionality required of the Exchange and the wide range of activities required of the Exchange under the ACA. As contemplated in the ACA and SB 5445, the WHBE is required to perform all of the following: providing a best-in-class, easy-to-use web portal and online decision-support functionality; real-time eligibility determinations; providing outstanding customer service; assisting with complex financial transactions; working with health plans, as well as state and federal partner agencies; and engaging and educating the public on health coverage options. This wide array of required functions requires both a variety of staff experience and expertise, as well as the necessary investment to develop, maintain, and operate the complex technical and operational

infrastructure necessary to support the WHBE's core functions.

When considering the functions required of the WHBE per the ACA and subsequent federal guidance and regulations, the total estimated operating cost on a PMPM basis over the three-year period compares favorably with its peers.

PMPM or unit cost is an important comparative indicator and the best way to compare state Exchange funding. PMPM allows you to compare the cost per-person enrolled and accounts for potential differences related solely to the size of the population served. Because many of the organization's cost

drivers are transactional in nature, the overall cost on a dollar basis will increase with enrollment, meaning an Exchange that enrolls more individuals will cost more to operate in absolute dollar terms.

A more useful benchmark to use when making comparisons to other organizations is therefore the PMPM or total unit cost. While it is difficult to compare directly with benchmark data due to differences in scale and functions, the estimated cost of operating the WHBE appears well in line with estimates of Exchange operating expenses generated by other states currently engaged in Exchange planning. (See comparisons below)

A particularly relevant benchmark considered by WHBE in assessing the reasonableness of the projected operating budget is the actual experience of the Massachusetts Health Connector ("Health Connector").

The Health Connector has been in operation since 2006, when it was created as part of Massachusetts's health care reform initiative and currently enrolls approximately

Peer State Budget Estimates

	MA (2012)	WA (2015 Est.)	CA (2015 Est.)	MD ¹ (2015 Est.)	OR (2015 Est.)
State Population	6.6 Million	6.8 Million	38.0 Million	5.8 Million	3.8 Million
Est. Exchange Expenses	\$34,873,531	\$51,078,000	\$314,937,298	\$34,916,005	\$34,701,742
PMPM	\$13.48	\$13.69	\$17.63	\$16.75	\$11.94
Estimated Member Months	2,587,113	3,730,000	17,863,000	2,084,537	2,905,552
Estimated Membership	240,000	343,750	1,602,100	177,080	281,790

Benchmark Source Information:

MA: Commonwealth Health Insurance Connector Authority, July 12, 2012. www.mahealthconnector.org

CA: Building Covered California: Blueprint Overview and Establishment Grant Comment Draft, November 7, 2012.

OR: Oregon Health Insurance Exchange Corporation, February 2012. www.coveroregon.com

MD: Maryland Health Benefit Exchange, Joint Committee on Exchange Financing, November 2, 2012. www.dhmf.maryland.gov/exchange

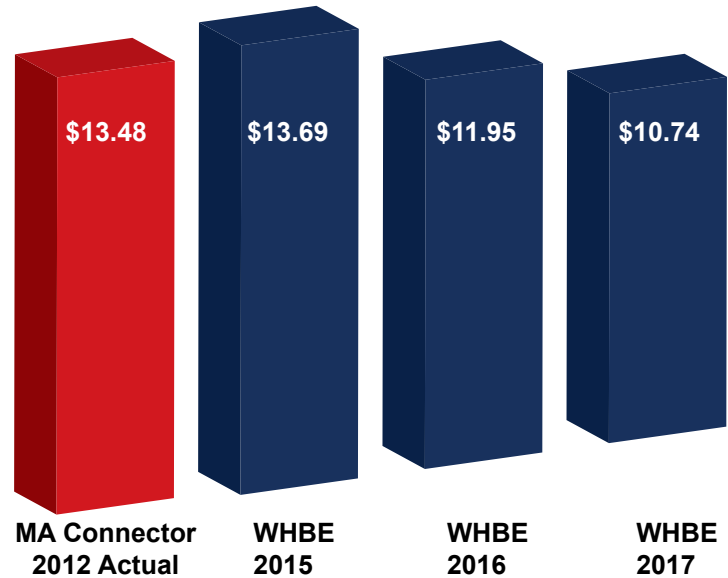
240,000 members in both subsidized and non-subsidized small and non-group coverage.

The Health Connector was the model for ACA-required exchange functionality, and provides the most relevant existing point of comparison for gauging Exchange budget reasonableness in that it is the only currently operating entity performing most functions required of an ACA-required Exchange. (See Page 14 for description on the Massachusetts Health Connector).

As a benchmark, it reflects actual experience rather than estimates or projections. In 2012, the Health Connector’s PMPM cost was \$13.48. In comparison, the WHBE is estimated to operate in a range between \$13.69 and \$10.74 from 2015 to 2017.

When analyzing 2015 detailed spending categories for the Exchange, total cost is primarily concentrated in these spending line items: 1) customer service/call center with approximately 25% of the total estimated spending;

PMPM Cost Comparison – WHBE vs. MA Connector



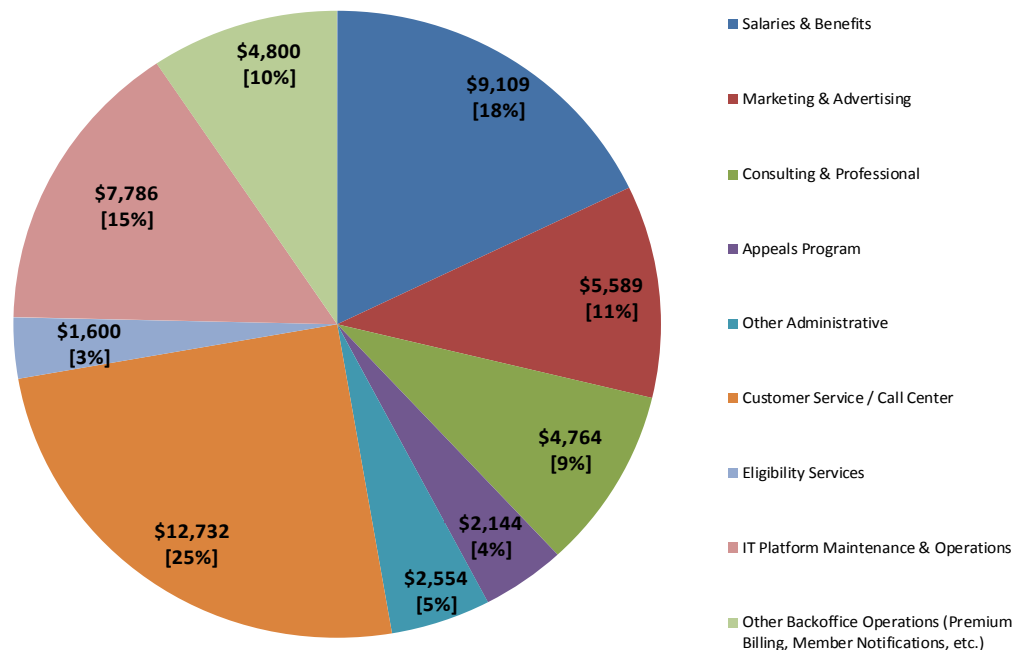
and 2) another 30% attributable to IT Systems/Maintenance and Backoffice costs. (Expenses included in this line item include software, premium billing and collections, the eligibility determination rules-engine, website maintenance, and cost to operate specific functions applicable to the small business health options program for small businesses).

Staffing is expected to remain relatively constant over the three year period, with a hiring plan that

targets 89 full time equivalents (FTE’s) by the end of 2015 or roughly 18% of the budget, growing to 100 FTE’s in 2017.

The 2015 budget estimate also assumes significant use of third-party vendors, meaning that costs for IT Systems & Operations primarily represent vendor costs related to operating and maintaining the primary business, operating, and customer service systems of the WHBE.

Washington Health Benefit Exchange, 2015 Budget Estimate Detail (\$000’s)



The Massachusetts Health Connector, the only insurance exchange operating today, has an enrollment of 240,000 members costing \$13.48 PMPM in 2011. In 2017, WHBE is expected to cost at least 20% less on a PMPM basis and offer more required value-added benefits to its members.

Exchange Revenue Options

This section will highlight the unique characteristics of different approaches in financing the WHBE, and outline the key considerations of each model. Although there are a wide variety of potential revenue models that could support Exchange operations, they can be grouped into the four broad categories: (1) revenue models focused on the insurance market in Washington; (2) revenue models focused on Exchange membership; (3) revenue models focused on the broader health care market (e.g. in self-insured employers and hospital revenue); and (4) broader public funding sources. In addition to the separate models itemized below, the Exchange could also employ a hybrid model or combination of different revenue models to finance its ongoing operations.

The considerations that inform whether a particular revenue stream is appropriate for the needs of the WHBE are multi-faceted, as there are advantages, disadvantages, risks, and trade-offs associated with each model.

In addition to factors such as whether the method can generate sufficient funding, be reasonably predictable, not discourage participation in the Exchange, and align with the Exchange value proposition, there are important considerations related to the timing of cash flows and the ability of the Exchange (or State on behalf of the Exchange) to administer the revenue mechanism.

With respect to cash flow and timing, which are two criteria often overlooked when considering

Exchange revenue options, the Exchange must consider whether incoming cash flow from revenue sources can meet the timing requirements of outgoing cash flow from expenses. In particular, managing the transition from 2014, when the Exchange can rely upon federal funding, to 2015, when it must be self-sustaining, will necessitate careful timeline planning. Providing funds to support the Navigator program in late 2013, before the effective date of health insurance coverage sold by the Exchange, is another important consideration.

In addition, the type of revenue stream selected will affect the Exchange's ability to predict and rely upon the availability of adequate revenue. For example, a broad-based assessment targeted to yield a given amount of funding will provide a greater degree of certainty in the total revenue projections than a transaction-based, membership model that introduces a greater level of uncertainty, especially during the initial years of operations.

INSURANCE PREMIUM ASSESSMENT

This revenue model would place an assessment on health insurance premium revenue, similar to Washington's current 2% tax on insurance premium revenue.

Expanding the assessment base will allow for a lower assessment percentage across a greater pool of revenue. This will also keep the assessment's focus on the health insurance industry that will benefit from growth in health plan

Key Considerations: Insurance Premium Assessment

Reflects the value of the Exchange in bringing additional insured residents into the market and better facilitating the shopping experience.

Reduces the incentive for carrier non-participation by eliminating any potential price or cost advantage to non-participation

Invisible to enrollees; spread across the entire health care market inside and outside the Exchange

Relative to QHP surcharge, allows for greater predictability and stability, as well as lower rate of assessment, by expanding the base for assessment

May allow the state to leverage existing premium tax collection infrastructure, most likely resulting in quarterly collection schedule.

Could be initiated prior to the period of Exchange enrollment (e.g., in 2013), allowing it to finance Navigator grant funding as well as to provide additional start-up or reserve capital to mitigate first-year revenue uncertainty.

Leveraging premium tax would require significant lead time to alter the assessment if changes or updates to the rate are required.

Financial Impact: 1% of fully insured premium revenue



Key Considerations: Leverage Existing Premium Tax

Revenues from Washington's existing 2% premium tax are projected to increase due to increasing enrollment through the Exchange starting in 2014

Capturing a portion of these taxes would partially offset the need for additional revenue to finance Exchange operations

Such a model would be invisible to enrollees, and would not distort the market as it would capture a pre-existing revenue source.

Actual incremental revenue from this source are unpredictable, as actual enrollment growth under ACA is unknown

Revenues from this source alone may not be sufficient to offset total Exchange operating expenses, and would likely need to be supplemented through a secondary revenue source

Allocating a portion of these revenues may place the Exchange in competition with other state spending priorities

Implementing this model would be straightforward, as the tax is already in place

Financial Impact: incremental revenues from this model will vary with insurance take-up; based upon moderate enrollment assumptions, this could yield \$26 million to \$36 million annually from 2015-2017



membership and the distribution of federal subsidies to expand premium revenue.

Broadening the base in this way will also significantly reduce the amount of variability and uncertainty in the underlying exchange revenue estimate relative to a QHP-focused approach. Washington already raises revenue with a 2% tax on insurance revenue, meaning that such a method would be familiar to the industry, and also that the state already possesses the necessary administrative infrastructure to support the WHBE. Adopting such an approach could help minimize challenges associated with creating a new assessment and provide administrative, cash flow, or lead time benefits.

REPURPOSE EXISTING ASSESSMENTS

In addition to the potential to enact new revenue sources to support the Exchange, the Board would like to draw attention to the fact that new enrollment in the Exchange should increase state revenue from the existing 2% insurance premium tax. Enrollment through the Exchange may increase coverage in the fully-insured, non-association market by approximately 7.9% – 24.6%. This increase in enrollment will be paired with an increase in accessible premium revenue and tax collections for the state. At moderate enrollment levels, we estimate that incremental new premium tax revenues to the state resulting from Exchange enrollment will total between \$26,000,000 in 2015 and \$36,000,000 by 2017 (see Appendix A). Thus, without enacting new revenue initiatives or increasing the current assessment percentage, the state will yield significant new

revenues, a portion of which may help offset the cost of operating the Exchange.

Although a potentially attractive funding model, it is unlikely that such an approach would be a viable option to fully fund the Exchange in the short term. One reason has to do with timing. Were such an opportunity to occur, it would become apparent over time as enrollment increased from 2014 and beyond. The Exchange's financing needs, however, are more immediate. The organization cannot wait to evaluate the economic impact of ACA implementation to identify and select a financing opportunity.

QHP ISSUER-BASED REVENUE MODELS

A QHP issuer-based assessment would involve charging a fee to issuers of QHPs, most likely based upon a percent of premium or a flat per-member per-month ("PMPM") amount. This model is narrowly focused on the carriers that most directly benefit from Exchange enrollment. This type of funding mechanism can be viewed as a fee-for-services provided to issuers to offset the value of services provided to them by the Exchange. Specifically, this value includes the marketing, selling, administrative, and account installation functions, premium collections performed by the Exchange, as well as access to additional subsidy-eligible enrollment that is provided exclusively through the Exchange.

Under ACA rating rules, premiums for the same product must be the same inside and outside the Exchange. However, at this point it is unclear how this assessment would be applied by health plans

for products inside and outside the Exchange. Therefore, it is unclear if this assessment will make premiums higher inside the Exchange than they would be outside, further information is being gathered.

OTHER HEALTH CARE MARKET MODELS

Another type of revenue source discussed by the WHBE Board is a broad-based assessment on health care provider revenue. One example of such an assessment would be to assess hospital net patient revenue. As discussed earlier, the Exchange is expected to benefit the provider community by expanding insurance coverage, reducing the level of uncompensated care, and positively impacting total revenue. Currently, hospitals in Washington are required to offer charity care to uninsured or underinsured individuals, but they are not compensated for these services. According to the Washington Department of Health, the value of uncompensated care provided in the state is approximately \$1 billion per year. The expansion of insurance coverage should provide a benefit to hospitals through a reduction in these uncompensated costs. There is a potential offset to hospitals in the form of reductions in Disproportionate Share Hospital (DSH) payments and reductions in payments through Medicare. The Washington State Hospital Association estimates the total reductions over 10 years for hospitals to be at least \$3 billion.

Placing an assessment on provider revenue would also spread the cost of supporting the Exchange over a much broader revenue and population base. The most notable difference between a provider-based funding method and a premium-

based revenue method is that assessing provider revenue would create the opportunity to expand the base beyond the insured market to capture revenue from self-insured employers and public payers. Tapping into revenue from these other payers can potentially greatly expand the base for assessment, allowing a lower overall impact to insurance costs by spreading the assessment more broadly.

On the other hand, establishing a funding method to apply to self-insured groups would expand the reach of the Exchange funding method beyond those most directly benefitting from the Exchange.

BROAD-BASED OR PUBLIC FUNDING

This revenue model would create a broad-based funding stream that is not linked specifically to health industry revenue sources, but would involve broader public support to finance the Exchange's operating costs. As noted previously, the WHBE will create public value for the state of Washington, including an expansion in health insurance coverage, a simpler and more accessible avenue to purchase insurance for individuals and small groups.

Under the ACA, the WHBE will also be required to provide specific services to the residents of Washington, such as its role in granting certificates of exemption to the individual responsibility requirement. Other functions, while not directly attributable to the general public, create value to users who may avail themselves of the services. These functions include: (i) an easy to use web portal for plan comparisons; (ii)

Key Considerations: QHP Issuer Assessment

Places a percentage-based or PMPM assessment on issuers of Qualified Health Plans for Exchange-based membership

Most closely related to Exchange business operations and market relationships

Invisible to enrollees, because issuers must charge the same premiums inside and outside the Exchange

At low levels of Exchange enrollment, the fee as a percent of premium may be high and create market distortion by not incenting issuer participation

Highly sensitive to Exchange enrollment; creates risk of unpredictable and/or variable revenue stream, especially during start-up or in the case of low enrollment

As enrollment grows, may become more predictable, allowing the Exchange to lower the assessment rate over time

Timing of collections would be tied to Exchange membership enrollments; during start-up, may not offset Exchange fixed costs

The Exchange has the ability to quickly change the fee if necessary

Financial Impact: 3% - 4% of gross Exchange premium revenue



Key Considerations: Provider Revenue Assessment

Recognizes the broader value of the Exchange to the health care industry as a whole through its role in expanding coverage and reducing the level of uncompensated charity care

Less direct link to Exchange business relationships and market impact

Retains basis in the health care industry, but further broadens the assessment base to include public and self-insured markets, lowering the overall assessment rate and providing greater stability and predictability to the revenue stream

Could present challenges related to the perception that the assessment increases premium levels for non-Exchange markets, including large employers. To the extent that it is perceived as taxing or regulating self-insured employer benefits, it may be subject to legal challenge

Invisible to enrollees; spread across the entire health care market

Would require significant lead time to establish and alter assessment rates; collections likely annually or quarterly

Financial Impact: 0.3% - 0.4% of 2010 Hospital Net Patient Service Revenue



information regarding individual and small business benefits and obligations under the ACA; (iii) a trust-worthy source of information regarding health insurance; and (iv) information on health insurance carriers cost and quality initiatives.

In light of these public benefits, the Exchange board has also considered the option of recommending a broad-based public financing option, such as a cigarette tax or similar mechanism that would improve the overall health of the population.

FUNDING MODELS IN OTHER STATES

There are limited examples of other state exchange funding methods, as only a handful of states have determined a financing method for their state-based exchanges. These methods have either been established in the states' enabling legislation, or have been established by the exchange board of directors. The states that have determined a funding mechanism include Massachusetts, Oregon, Nevada, West Virginia, and Utah. In other states, including Maryland and Colorado, exchange enabling legislation provides guidelines related to the funding mechanism, but does not indicate a specific funding source. Several other states are actively considering various funding options, but have not reached a final decision or obtained exchange financing legislation.

Of the states that have determined a funding mechanism, three have adopted a QHP assessment that charges a fee to issuers of QHPs for their Exchange membership and/or revenue only; one is authorized to place an assessment on all licensed insurers based on their share of total fully-insured premium revenue,

and one state, Utah, charges a fee to small groups purchasing insurance through the Exchange. It should be noted that Utah's Exchange existed prior to the enactment of ACA market rules and currently only serves small groups. It is unclear whether a similar funding option will be continued if the state exchange comes into compliance with ACA requirements. These methods are discussed below.

QHP ASSESSMENT MODELS

Three states have chosen to finance the Exchange through an administrative fee assessed on participating issuers for their Exchange enrollment as the method to financing the Exchange. These states include Massachusetts, Oregon, and Nevada.

Massachusetts Health Connector

The Massachusetts exchange, called the Health Connector, has been in operation since 2006, and currently enrolls approximately 240,000 members in its subsidized and non-subsidized health plans. The Health Connector performs functions very similar to those required of state-based exchanges under the ACA, and was in fact the primary model, upon which ACA exchange requirements were developed. Additional functions, such as advanced payment of tax credit administration, will be required by the ACA. The Health Connector charges participating issuers a fee based upon a percent of total premium revenue for policies sold through the Exchange. Initially, this fee was established at 5% of premium revenue for both the organization's subsidized program (Commonwealth Care) and its non-subsidized program (Commonwealth Choice). As enrollment in the Health Connector has grown, it has been able to

reduce the administrative fee to approximately 3% for the larger subsidized program, and 3.5% for the smaller non-subsidized program.

Oregon Health Insurance Exchange

The funding method for the Oregon Health Insurance Exchange was established in the state’s enabling legislation, SB 99 passed, in July of 2011. The law stipulates that Exchange operation costs and navigator program costs shall be funded through the establishment of an administrative charge collected from all insurers and state programs participating in the Exchange. The legislation further outlines the allowable level of this administrative charge as a percent of premium revenue, which is adjusted by law based upon overall enrollment through the Exchange as outlined below ranging between 3% and 5% as outlined in the table below. **The legislation further provides that any excess revenues generated above the cost of operating the Exchange may be placed in a reserve fund to offset future losses or reduce its administrative fee.**

Nevada Silver State Exchange

In August 2012, the Nevada Exchange Board of Directors issued its finance and sustainability plan, and identified a per member per month assessment on carriers based upon enrollment within the Exchange as the organization’s primary funding

method for the Exchange.

The board also identified other potential sources of supplementary revenue, such as administrative fees charged for stand-alone vision and dental plans, as well as web-based advertising, as potential revenue sources for the Exchange.

In addition to the financing method ultimately selected, the board’s Finance Committee also considered and elected not to pursue an assessment on total enrollment in issuers of QHPs, as well as an assessment on the entire fully-insured individual and small group major medical markets.

FULLY INSURED MARKET PREMIUM ASSESSMENT MODEL

West Virginia Health Benefit Exchange
West Virginia’s Exchange enabling legislation, SB 408, was signed into law on April 5, 2011. It authorizes the Exchange Board of Directors to assess fees on health carriers licensed in West Virginia, including health carriers that do not participate in the exchange, and empowers the Exchange board to establish the amount of fees assessed as well as the manner of collection. The fees charged are required to be based on health insurer premium volume in the state.

Table 5. Oregon Health Insurance Exchange Allowable QHP Assessment Rate

Exchange Membership Range	QHP Assessment Rate
175,000 or Fewer	5%
175,001 to 300,000	4%
Greater than 300,000	3%

Key Considerations: Broad-based, public financing

Adopting this approach entails recognition of the Exchange’s value as a public good.

Provides broadest revenue base and greatest degree of certainty to the revenue stream

Invisible to enrollees and does not distort market; spread across a specific tax base

Likely the collections would be annually, and will require close coordination with the State Treasurer.

Although the state budgeting and fiscal year basis will require a long lead time in the budget development and justification for funding, this funding mechanism should be administratively easy to implement.

The WHBE will likely be working closely with the state to identify and justify its revenue needs and will develop a payment schedule with the state that will echo the collection frequency of the tax.

Changes to this type of an assessment will be extremely limited and updated on an infrequent basis.

Depending on the appropriation process, the WHBE will be competing with other state needs for this funding source

Financial Impact: Depends upon public funding source



EXCHANGE CUSTOMER USER FEES

Utah Health Exchange

The Utah Health Exchange was created in 2008 to provide non-subsidized insurance options to small businesses in Utah. The functionality for the Utah Exchange, including the web portal, eligibility determination, enrollment, and account installation, are provided through a combination of an administrative services vendor and insurance brokers. Groups purchasing through the Exchange must use a broker. The costs of these administrative functions are paid for through a Per Employee Per Month (“PEPM”) fee charged to groups purchasing through the Exchange. In 2011, these fees were \$6 PEPM for the administrative vendor and \$37 PEPM for broker costs.

It should be noted that while the Utah Health Exchange as it existed prior to the implementation of the ACA complies with some of the required functions of the Small Group Health Options Program (SHOP) Exchange, significant changes or additional functionality will be necessary to comply with the non-group requirements of the ACA. The introduction of ACA rating rules, including the requirement that premiums be the same both inside and outside the Exchange, may impact both the magnitude and structure of the Utah Health Exchange financing model.

HYBRID MODELS

Maryland Health Benefit Exchange (“MHBE”)

Although as of the time of this report Maryland has not selected a specific funding option to finance the Exchange, previous recommendations from the MHBE

Board of Directors as well as recent Exchange-related legislation suggest that the state is considering a hybrid model, potentially including a combination of transaction-based revenue options and more broad-based funding mechanisms.

In its report to the Legislature issued December 23, 2011, the MHBE Board of Directors included the following recommendation: “Because of the significant benefits the Exchange offers to Marylanders, the foundation for the Exchange’s funding should be a broad-based assessment with additional funding coming from transaction fees tied to enrollment within the Exchange.” The subsequent Maryland Health Benefit Exchange Act of 2012 (HB 443) tasks a joint legislative executive committee to identify a funding mechanism for the Exchange, and requires that the committee examine a combination of funding mechanisms for the Exchange, with the goal of developing an approach that will:

- ensure a stable revenue stream;
- allow the Exchange to adjust revenue levels to accommodate fluctuations in enrollment and other factors affecting its fixed and variable costs; and
- rely on (i) a consistent, broad-based assessment that can be adjusted to scale in order to reduce the Exchange’s vulnerability to enrollment fluctuations; and (ii) additional funding from transaction fees.



Board Recommendations

The WHBE Board makes three alternative recommendations to the Legislature. **The three alternatives are not prioritized, and are as follows:**

Recommendation A

In accordance with RCW 48.14.0201, the Legislature enacts a premium tax assessment, effective January 1, 2014, totaling half percent (.5%) and, effective January 1, 2015 and thereafter, totaling one percent (1.0%) of all premiums and prepayments for health care services received, to fund the costs to operate the Exchange. (See Appendix A for financial implication)

Recommendation B

In accordance with RCW 48.14.0201 effective January 1, 2014, the Legislature authorizes and apportions to the Exchange the premium tax collected on all premiums and prepayments for health care services attributable to the Exchange-generated premiums received. Any funding shortfalls shall be augmented by assessing a service charge payable by the Qualified Health Plans in the Exchange to fund the costs to operate the Exchange. (See Appendix A for financial implication)

If either Recommendation A or B is passed, the Exchange Board shall provide a Progress Report to the Legislature on December 1, 2016 to:

- Summarize business metrics, e.g. enrollment & financial performance for 2014-2015
- Evaluate a Sunset Provision of any premium tax assessments

- Quantify and evaluate the incremental premium tax amount from the revenues generated by the Exchange
- Quantify and evaluate the feasibility of assessing Qualified Health Plans in the Exchange for 2018 and beyond as an alternative to the premium tax assessments

Recommendation C

Effective January 1, 2014, assess a service charge payable solely by the Qualified Health Plans in the Exchange to fund the costs to operate the Exchange. (See Appendix A for financial implication)



Glossary of Terms

ACA

Affordable Care Act (ACA) —The Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act)

CCIIO

The Center for Consumer Information and Insurance Oversight (CCIIO) is charged with helping implement many provisions of the Affordable Care Act, the health reform bill that was signed into law March 23, 2010. CCIIO oversees the implementation of the provisions related to private health insurance.

CMS

Centers for Medicare & Medicaid Services (CMS). The federal agency, formerly the Health Care Financing Administration, that administers the Medicare, Medicaid and Child Health Insurance programs.

DSH

Disproportionate Share Hospital (DSH). The United States government provides funding to hospitals that treat indigent patients through the Disproportionate Share Hospital (DSH) programs, under which facilities are able to receive at least partial compensation.

FTE's

Full-time Equivalents

ERISA

The Employee Retirement Income Security Act of 1974 (ERISA) was enacted on September 2, 1974. ERISA is a federal law that establishes minimum standards for pension plans in private industry and provides for extensive rules on the federal income tax effects of transactions associated with employee benefit plans.

HB 2319

House Bill 2319 – 2011-12.
<http://apps.leg.wa.gov/billinfo/summary.aspx?bill=2319&year=2011>

MHBE

Maryland Health Benefit Exchange

MAGI

Modified adjusted gross income

MLR

Medical loss ratio

PEPM

Per-employee-per-month

PMPM

Per-member-per-month

QHP

Qualified Health Plan

SB 5445

Senate Bill 5445-2011-12
<http://apps.leg.wa.gov/billinfo/summary.aspx?bill=5445>

SHOP

Small Business Health Options Program

WHBE

Washington Health Benefit Exchange



Appendix A

EXCHANGE BOARD RECOMMENDATION A: PREMIUM TAX METHOD

In accordance with RCW 48.14.0201, the Legislature enacts a premium tax assessment, effective January 1, 2014, totaling half percent (.5%) and, effective January 1, 2015 and thereafter, totaling one percent (1.0%) of all premiums and prepayments for health care services received, to fund the costs to operate the Exchange.



EXCHANGE BOARD RECOMMENDATION A: PREMIUM TAX METHOD

	<u>Grant Based</u>	<u>Self-Sustainability Based</u>		
	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>
Key Performance Metrics (KPI)				
Members (Y/E)	280,000	343,750	407,500	471,250
Member Months	2,053,000	3,730,000	4,483,000	5,184,000
Aggregate Premiums to QHP's	\$720M	\$1.3B	\$1.6B	\$1.8B
Projected Cash Disbursements				
Salary & Benefits		\$ 9,109,000	\$ 9,382,000	\$ 9,663,000
Marketing & Advertising		5,589,000	4,645,000	3,985,000
Consulting & Professional		4,764,000	3,447,000	2,532,000
IT Infrastructure & Communication		223,000	311,000	311,000
General & Administration		860,000	886,000	912,000
Facilities Related		668,000	672,000	676,000
Appeals Program		2,144,000	2,209,000	2,275,000
HBE Systems Related				
Customer Service / Call Center		12,732,000	14,972,000	16,951,000
Eligibility Related		1,110,000	1,300,000	1,451,000
System Integrator-Related WHBE Variable Costs		7,500,000	8,831,000	10,005,000
Shared System Build / Operation Costs		9,566,000	9,817,000	9,568,000
WHBE Systems Related-Total		30,908,000	34,920,000	37,975,000
WHBE Total Before Adjustments		54,265,000	56,472,000	58,329,000
Medicaid Offset		(3,187,000)	(2,884,000)	(2,671,000)
WHBE Total Expenditures		\$ 51,078,000	\$ 53,588,000	\$ 55,658,000
Self-Sustaining Revenue Source (a)	\$ 25,000,000	\$ 50,000,000	\$ 52,500,000	\$ 55,125,000
Annual Income / Deficit	\$ 25,000,000	\$ (1,078,000)	\$ (1,088,000)	\$ (533,000)
OPERATING RESERVE BALANCE (Y/E)	\$25,000,000	\$23,922,000	\$22,834,000	\$22,301,000

(a) The premium tax on fully insured health plans expected annual revenue base was increased by 5% annually



PRO FORMA PREMIUM TAX FUNDING EXCHANGE BOARD RECOMMENDATION A

Tax Year 2011 Taxable Premiums (a)	\$ 7,929,591,000
Prospective 2014/2015 Annual Taxable Premium Base Used In WHBE Financial Pro Formas (b)	\$ 5,000,000,000
Additional 1% Premium Tax for Annual WHBE Funding Purposes (Per Recommendation A)	\$ 50,000,000

(a) Obtained from Insurance Commissioner's Office

(b) WHBE utilized around a 35% discount factor to project the baseline taxable premium to be conservative in its pro forma financial analysis. There are unknown healthcare industry factors which are not yet clearly defined which may have a negative impact on the amount of fully-insured taxable premiums going forward, such as the undeniable migration of fully-insured employer groups opting to self-insure.



EXCHANGE BOARD RECOMMENDATION B: HYBRID METHOD

In accordance with RCW 48.14.0201 effective January 1, 2014, the Legislature authorizes and apportions to the Exchange the premium tax collected on all premiums and prepayments for health care services attributable to the Exchange-generated premiums received. Any funding shortfalls shall be augmented by assessing a service charge payable by the Qualified Health Plans in the Exchange to fund the costs to operate the Exchange.



EXCHANGE BOARD RECOMMENDATION B: HYBRID METHOD

	<u>Grant Based</u>	<u>Self-Sustainability Based</u>		
	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>
<u>Key Performance Metrics (KPI)</u>				
Members (Y/E)	280,000	343,750	407,500	471,250
Member Months	2,053,000	3,730,000	4,483,000	5,184,000
Aggregate Premiums to QHP's	\$720M	\$1.3B	\$1.6B	\$1.8B
<u>Projected Cash Disbursements</u>				
WHBE Total Expenditures	N/A	\$ 51,078,000	\$ 53,588,000	\$ 55,658,000
<u>Self-Sustainability Revenue Source</u>				
WHBE-Generated Premium Tax - 2% (a)	\$ -	\$ 26,000,000	\$ 32,000,000	\$ 36,000,000
QHP Assessments (b)	\$ 28,742,000	\$ 25,078,000	\$ 21,588,000	\$ 19,658,000
Total WHBE Revenue	\$ 28,742,000	\$ 51,078,000	\$ 53,588,000	\$ 55,658,000
<u>Exchange QHP Assessment (PMPM)</u>				
QHP Assessment-PMPM (c)	\$14.00	\$6.72	\$4.82	\$3.79
QHP Assessment-% of Revenue (c)	4.0%	1.9%	1.3%	1.1%

- (a) There will be no cash receipts in calendar year 2014 since there were no premiums generated in 2013
 (b) 2014 PMPM assessment set at \$14.00/PMPM & retained in reserve --- rates will be lowered in subsequent years
 (c) Represents mutually exclusive alternative assessment methods



EXCHANGE BOARD RECOMMENDATION C: EXCHANGE ONLY METHOD

Effective January 1, 2014, assess a service charge payable solely by the Qualified Health Plans in the Exchange to fund the costs to operate the Exchange.



EXCHANGE BOARD RECOMMENDATION C: EXCHANGE ONLY METHOD

	<u>Grant Based</u>	<u>Self-Sustainability Based</u>		
	<u>2014</u>	<u>2015</u>	<u>2016</u>	<u>2017</u>
<u>Key Performance Metrics (KPI)</u>				
Members (Y/E)	280,000	343,750	407,500	471,250
Member Months	2,053,000	3,730,000	4,483,000	5,184,000
Aggregate Premiums to QHP's	\$720M	\$1.3B	\$1.6B	\$1.8B
<u>Projected Cash Disbursements</u>				
WHBE Total Expenditures	N/A	\$ 51,078,000	\$ 53,588,000	\$ 55,658,000
<u>Self-Sustainability Revenue Source</u>				
QHP Assessments (a)	\$ 28,742,000	\$ 51,078,000	\$ 53,588,000	\$ 55,658,000
<u>Internal Exchange Assessment (PMPM)</u>				
QHP Assessment-PMPM (b)	\$14.00	\$13.69	\$11.95	\$10.74
QHP Assessment-% of Revenue (b)	4.0%	3.9%	3.3%	3.1%

(a) 2014 PMPM assessment set at \$14.00/PMPM & retained in reserve

(b) Represents mutually exclusive alternative assessment methods



OTHER KEY COMPONENTS OF RECOMMENDATIONS

If either Recommendation A or B is passed, the Exchange Board shall provide a Progress Report to the Legislature on December 1, 2016 to:

- Summarize business metrics, e.g. enrollment & financial performance for 2014-2015
- Evaluate a Sunset Provision of any premium tax assessments
- Quantify and evaluate the incremental premium tax amount from the revenues generated by the Exchange
- Quantify and evaluate the feasibility of assessing Qualified Health Plans in the Exchange for 2018 and beyond as an alternative to the premium tax assessments



Appendix B

MASSACHUSETTS HEALTH CONNECTOR

- Established in 2006 as part of MA Health Care Reform; currently enrolls approximately 240,000 members
- Provides a range of health plan and carrier options to individuals and small groups via two main programs:
 - Commonwealth Care – subsidized coverage for adults <300% of the FPL not eligible for Medicaid, provided through private health plans
 - Commonwealth Choice – non-subsidized coverage for individuals, families, and small groups from commercial carriers in MA
- The Connector was the model for ACA-required Exchange Functionality, and provides the most relevant existing point of comparison for gauging Exchange budget reasonability
 - Additional requirements for ACA

MASSACHUSETTS HEALTH CONNECTOR

Functions currently performed or overseen by the Connector mirror those required of Exchanges under the ACA.

(Un-subsidized)

40,000
Members

Commonwealth Choice (Non-Subsidized Small and Non-Group)

- Market plans to individuals and small groups through easy-to-use, consumer-friendly website
- Organize plans into actuarial value tiers for plan comparison (Gold, Silver, Bronze, etc.)
- Collect premiums and remit to participating health plans
- Operate call center and functions specific to small groups
- Interface with and compensate insurance brokers
- Conduct annual plan selection and qualification process
- Conduct both targeted and broad-based outreach and education

0 – 300%
FPL

(Subsidized)

200,000
Members

Commonwealth Care (Subsidized Individual Coverage for Adults)

- Determine individual subsidy eligibility based upon income
- Eligibility/Enrollment integrated with Medicaid (Single Entry Point, similar to ACA)
- Operate call center, perform premium billing
- Draw down subsidy dollars from MA Treasury (federally-matched); reconcile with enrollee premium collections
- Conduct annual plan selection and qualification process
- Conduct both targeted and broad-based outreach and education
- Perform risk-adjustment and reinsurance functions (closed risk pool)
- Accept and adjudicate eligibility appeals and hardship waivers

COMPARISON OF FUNCTIONS

Required Functions	MA Connector	WA HBE
1. Governance and Oversight	✓	✓
2. Internal Administration and Human Resources	✓	✓
3. Financial Management and Accounting	✓	✓
4. Program Integrity (Privacy, Security, External Reporting)	✓	✓
5. Eligibility Determination	✓	✓
6. Enrollment	✓	✓
7. Premium Billing and Reconciliation	✓	✓
8. Advanced Payment of Tax Credit Administration		✓
9. Premium Tax Credit and Cost Sharing Subsidy Calculator		✓
10. Website (and Decision Support Tools)	✓	✓
11. Customer Service (Call Center)	✓	✓
12. SHOP Functions (Rating, Eligibility, Enrollment, Billing, Service)	✓	✓
13. Outreach & Marketing	✓	✓
14. Navigator Program		✓
15. Broker Program	✓	✓
16. QHP Certification and Plan Management	✓	✓
17. Plan Quality Rating System		✓
18. Risk Adjustment and Reinsurance	✓	
19. Mandate Determinations & Appeals	✓	✓

MASSACHUSETTS CONNECTOR FY 2012 ACTUAL BUDGET

	Total Cost	PMPM Cost
Customer Service/Billing*	\$14,231,221	\$5.50
Enrollment/Elig	\$6,879,284	\$2.66
Website	\$1,191,638	\$0.46
Sub Total Systems/Back Office Operations	\$22,302,143	\$8.62
Salary & Benefits	\$4,559,452	\$1.76
Appeals Program	\$348,980	\$0.13
Communications	\$1,060,255	\$0.41
Consulting & Professional Support	\$4,237,171	\$1.64
Other Administrative, Special Projects	\$2,365,525	\$0.91
Sub Total Other Operating Expenses	\$12,571,383	\$4.86
Total Exchange Expenses	\$34,873,531	\$13.48

*Estimate approximately 70% of this line item, or \$10 million, is for Customer Service

COST COMPARISON – MASSACHUSETTS HEALTH CONNECTOR

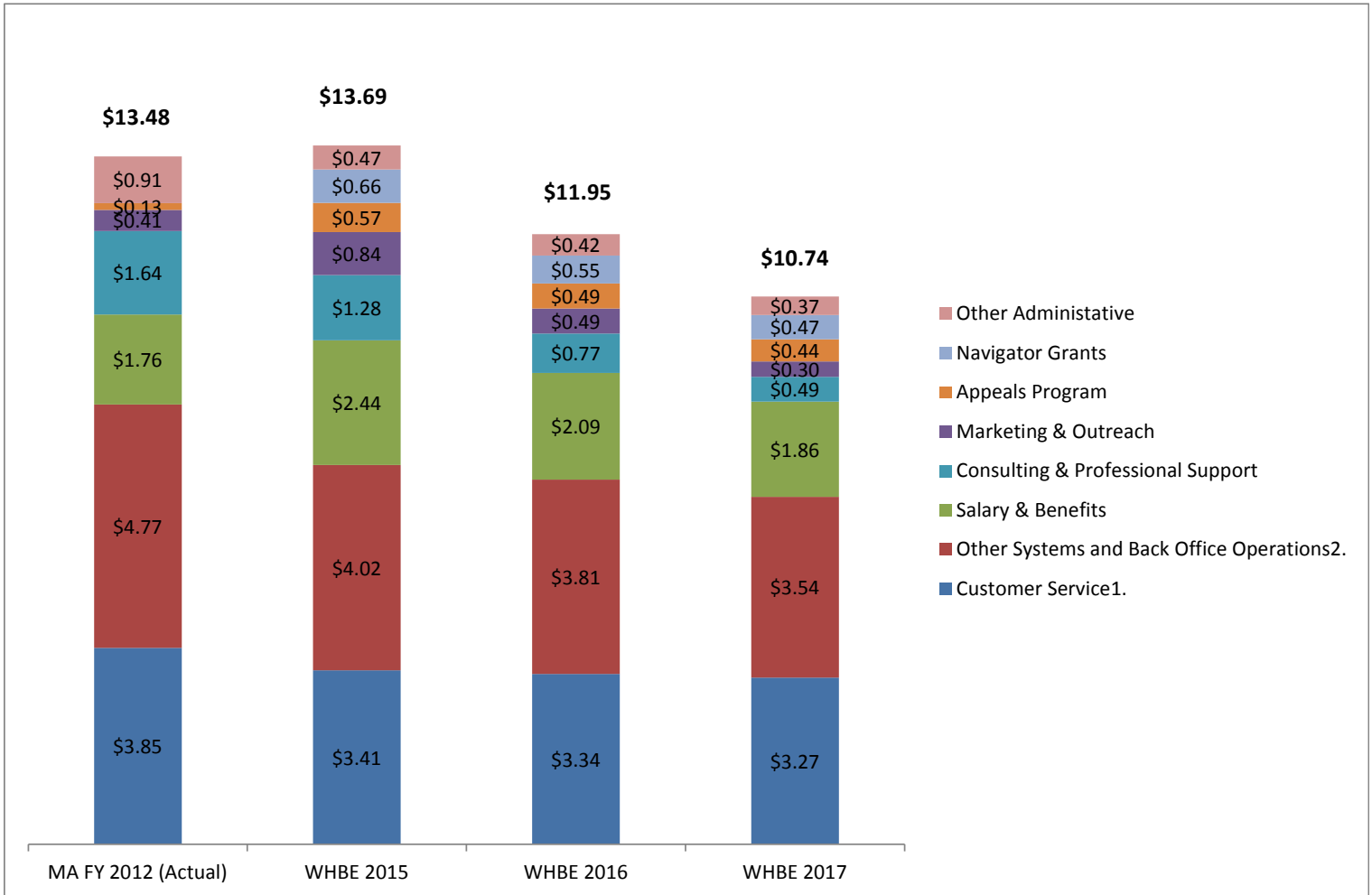
- The Washington HBE is expected to be 25% - 75% larger than the MA Connector on a membership basis
- Because many Exchange functions are transaction-based (call center, billing, eligibility), larger scale is expected to result in greater total cost
- On a per-member per-month, or unit cost basis, the WA HBE is expected to cost less than the MA Connector over time

	MA Connector	Washington HBE Estimated, 2015 - 2017		
	FY 2012 Actual	2015	2016	2017
Member Months	2,587,113	3,730,000	4,483,000	5,184,000
Total Cost Estimate	\$34,873,531	\$51,078,000	\$53,588,000	\$55,658,000
Per-Member Per-Month Cost Estimate	\$13.48	\$13.69	\$11.95	\$10.74

PMPM COST COMPARISON MASSACHUSETTS HEALTH CONNECTOR

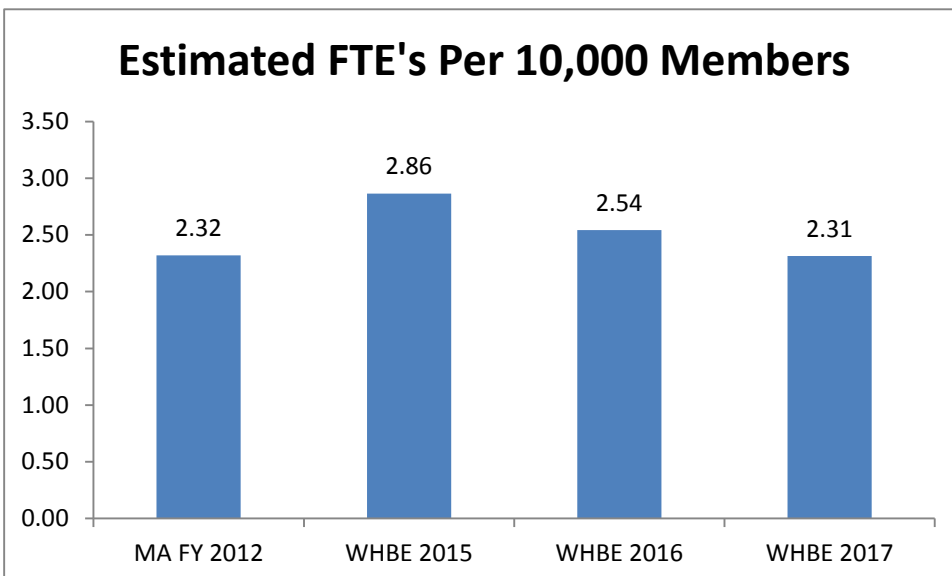
	MA Connector	WA HBE Estimated		
	FY 2012	2015	2016	2017
Member Months	2,587,113	3,730,000	4,483,000	5,184,000
Total Cost Estimate	\$34,873,531	\$51,078,000	\$53,588,000	\$55,658,000
Systems and Back Office Operations	\$ 8.62	\$ 7.43	\$ 7.15	\$ 6.82
Salary & Benefits	\$ 1.76	\$ 2.44	\$ 2.09	\$ 1.86
Other	\$ 3.10	\$ 3.82	\$ 2.71	\$ 2.06
Total	\$13.48	\$13.69	\$11.95	\$10.74

MASSACHUSETTS HEALTH CONNECTOR/ WHBE DATA COMPARISON



Notes:

1. Massachusetts contracts for customer service and premium billing jointly. For comparison purposes, it is estimated that 70% of the contract value is dedicated to Customer Service and is reflected here. The remainder is included in Other Systems and Back Office Operations.
2. This line includes costs associated with IT solution maintenance and operations, premium billing, eligibility, enrollment, web portal, and other fixed and variable costs associated with core Exchange operational functions.



Note: MA FTE's based upon 2010 budget information. Updated data for 2012 not available.

Peer State Budget Estimates

	MA (2012)	WA (2015 Est.)	CA (2015 Est.)	MD ¹ (2015 Est.)	OR (2015 Est.)
State Population	6.6 Million	6.8 Million	38.0 Million	5.8 Million	3.8 Million
Est. Exchange Expenses	\$34,873,531	\$51,078,000	\$314,937,298	\$34,916,005	\$34,701,742
PMPM	\$13.48	\$13.69	\$17.63	\$16.75	\$11.94
Estimated Member Months	2,587,113	3,730,000	17,863,000	2,084,537	2,905,552
Estimated Membership	240,000	343,750	1,602,100	177,080	281,790

Benchmark Source Information:

MA: Commonwealth Health Insurance Connector Authority, July 12, 2012. www.mahealthconnector.org

CA: Building Covered California: Blueprint Overview and Establishment Grant Comment Draft, November 7, 2012.

OR: Oregon Health Insurance Exchange Corporation, February 2012. www.coveroregon.com

MD: Maryland Health Benefit Exchange, Joint Committee on Exchange Financing, November 2, 2012. www.dhmf.maryland.gov/exchange

Financial Benefit To State

	2014	2015	2016	2017	Total
Enrollment Forecast	280,000	343,750	407,500	471,250	
Newly Created Premium Revenue	\$720 million	\$1.3 billion	\$1.6 billion	\$1.8 billion	\$5.4 billion
New State Premium Tax Revenue (2%)	\$14 million	\$26 million	\$32 million	\$38 million	\$110 million
Health Insurance Tax Credit for Individuals	\$700 million	\$860 million	\$1 billion	\$1.2 billion	\$3.8 billion