Civis Analytics Application Test
Background Materials

This bundle contains six documents for you to reference in your answer to one question of the test.

We recommend you begin by reading the introductory document, which contains a glossary of key terms and a basic overview of how the Affordable Care Act will affect the insurance market.

Contents:

1. Slides – Overview of the ACA and Insurance Exchanges
2. Chart – Colorado Individual Silver Plans
3. Article – Blue Cross-Blue Shield Bets Big on Obamacare Exchanges
4. Article – Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues
5. Article – Obamacare's Challenge: Persuading Young and Healthy to Buy Insurance
6. Biography – Preston Tucker, a fictional CEO referenced the test question

The ACA and Insurance Exchanges

Engagement Analyst Exam

Glossary

Employer Mandate – An ACA provision going into effect in 2015 that requires employers with more than 50 employees to offer health insurance to their full time workers. There is a tax penalty for those who do not comply.

Health Insurance Exchange (Marketplace) – A state-level entity created by the ACA for the individual insurance market that will come into existence October 1, 2013. Each exchange will contain a set of standardized health insurance plans that individuals may purchase.

Individual Mandate – An ACA provision going into effect in 2014 that legally requires an individual to have health insurance, either through their employer or through the exchanges. There is a tax penalty for those who to not comply. There are subsidies to purchase health care for individual who cannot afford the full price.

Medicaid Expansion – An ACA provision that increased the minimum eligibility requirements for Medicaid, increasing the number of individuals who qualify for the program. States have the ability to opt-out of this expansion.

Patient Protection and Affordable Care Act of 2010 (ACA) – A law passed by Congress and signed by President Obama that made significant regulatory changes to the healthcare and insurance industries and increased the government's role in both. Importantly, the ACA [1] removes the ability for an insurer to reject applicants based on their health conditions, [2] strictly limits the ability to which insurers can charge different prices to different people for the same plan.

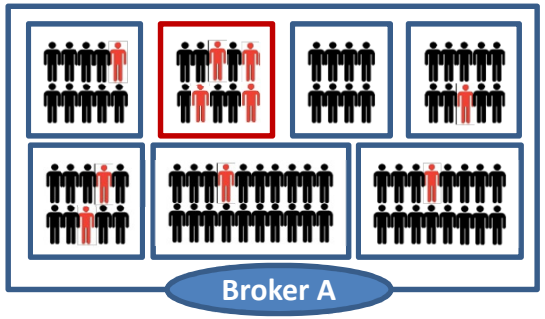
Premium – The monthly cost of an insurance plan.

Risk – A measure of the expected cost for an insurance company to insure an individual. High-risk individuals often are identified through unhealthy behaviors and are expected to cost more to an insurance company than low-risk individuals.

The current health insurance market is heavily weighted towards employer-based insurance

Current Healthcare system

Employer-based 49%

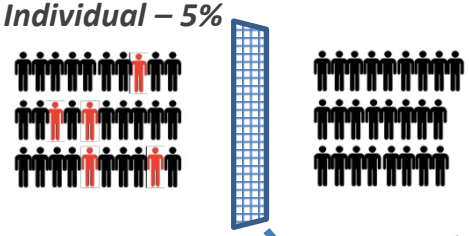


High risk individual

High risk company

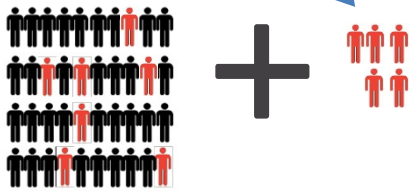
- Broker brings in multiple companies
- Risk of individuals within a company and of the company on a whole is mitigated by bundling many companies together

Individual – 5%



- Risk is managed by filtering out individuals with pre-existing conditions. Only low-risk individuals currently end up with insurance on the individual market

Uninsured – 16%



- No need to manage risk
- Potential missed opportunity to manage overall risk pool of the insured by leaving low-risk individuals out of the process

Medicare/Medicaid – 30%

- Government assumes risk

Market breakdown: Kaiser Family Foundation. Data for 2011

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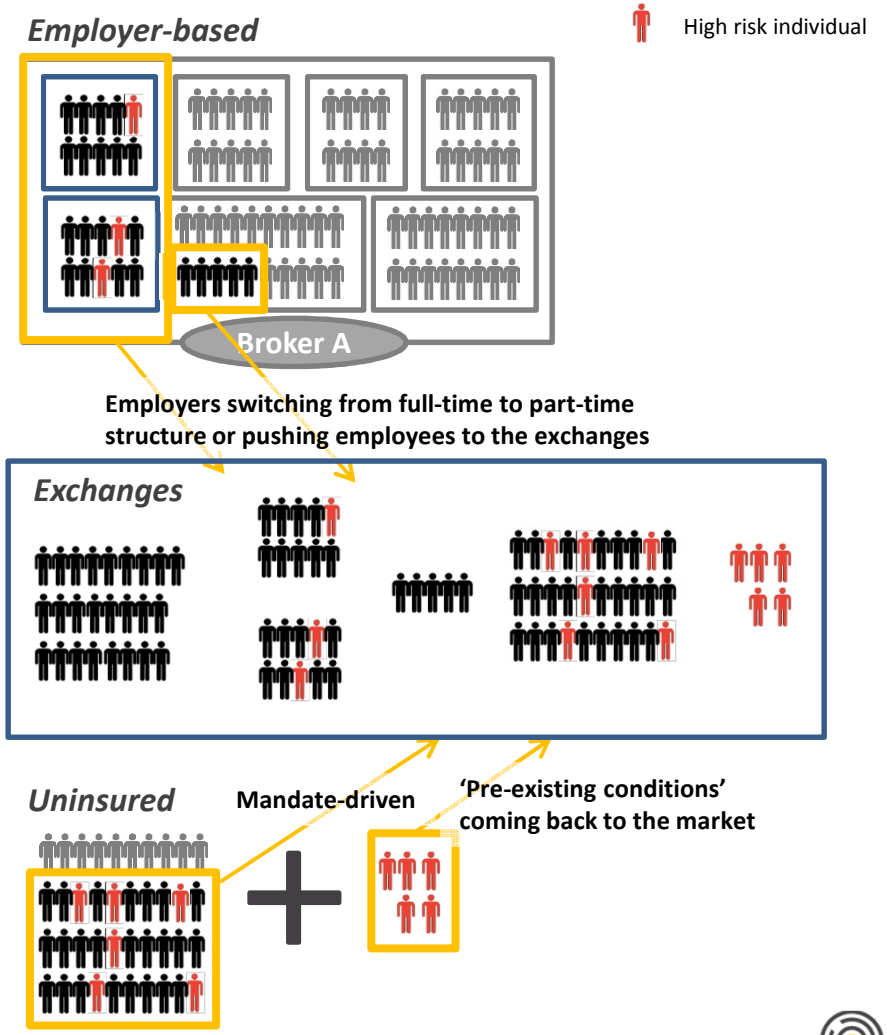
The ACA will increase the size of the individual market while eliminating that market's traditional 'risk mitigation' system

Movement to the Exchanges under ACA

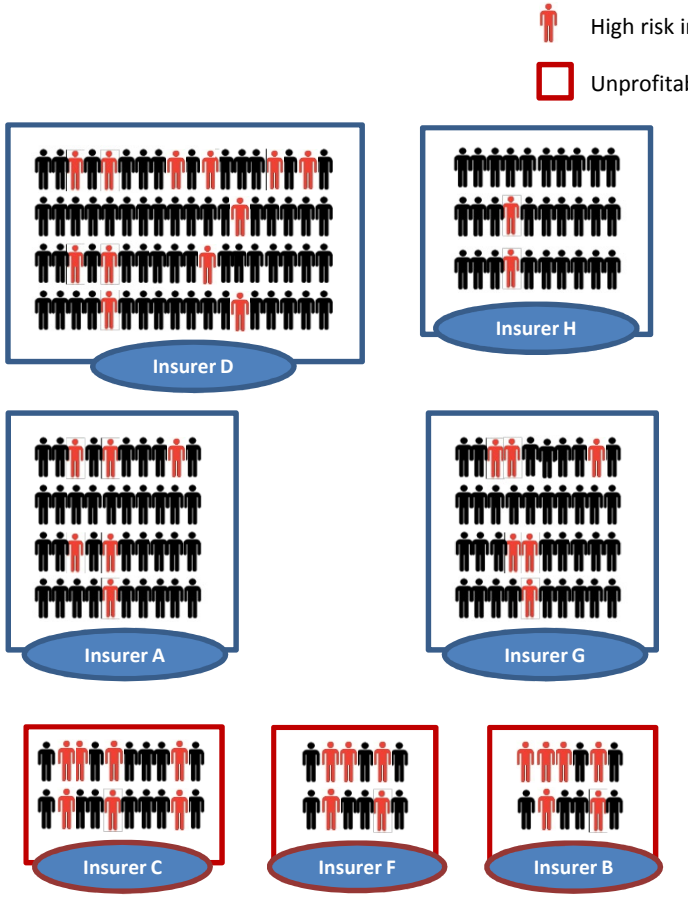


Changes in the Individual Market

- The individual market will increase as some employees push employees to the Exchanges, and as the individual mandate comes into effect. Predicted size estimates vary.
  - US Gov Office of Budget and Management estimates 25M people on the Exchanges by 2022
- The individually-insured will likely become on-average riskier, as it is no longer possible to reject on pre-existing conditions
- Greater competition pressures insurers to lower premiums

There will be winners and losers among the companies providing individual coverage on the exchanges

Exchange-insured individuals, by insurer



Blue Cross-Blue Shield Bets Big On Obamacare Exchanges

TOPICS: INSURANCE, MARKETPLACE, STATES, HEALTH REFORM

By Jay Hancock
KHN Staff Writer
JUN 21, 2013

This KHN story was produced in collaboration with The Washington Post

At a closed White House meeting in April, President Barack Obama told corporate insurance bosses "we're all in this together" on implementing his signature health law. But some insurance companies seem to be more in than others.

At least five Blue Cross and Blue Shield executives sat at the table of about a dozen CEOs with the president, according to those knowledgeable about the session, first reported by the New York Times. Just as significant is who wasn't there: chiefs of the country's biggest and third-biggest health insurers, UnitedHealth Group and Aetna.

Those two and most other non-Blue insurers "seem to be proceeding cautiously" in the online marketplaces expected to cover to millions, said David Windley, who follows the industry for Jefferies & Co., an investment firm. "They are evaluating markets state by state and in some cases region by region within the state to assess the viability of all the different pieces."

Not the Blues. They're expected to offer health-exchange plans nearly everywhere, ensuring at least a minimum choice for individuals seeking subsidized coverage when the marketplaces open Oct. 1. It also makes them an undeclared Obama ally in implementing the health law.

"The Blues will definitely participate," said Ana Gupte, an insurance stock analyst for Dowling & Partners. "If there is an exchange I'm sure there will be the Blues."

The exchanges are online marketplaces that will operate in all 50 states, offering insurance plans for individuals and small businesses. The individual market has long been a high-risk, unstable business that some insurers never sought. The health law – with its mandate that could bring younger, healthier people into the pool and its subsidies – seeks to stabilize the individual market. But if few other insurers follow the Blues into those markets, consumers in those states may not see the same kind of competitive pricing of premiums that states like Oregon have reported.

Still, it's not just that Blues will offer coverage in places other carriers may avoid. In states where Republican governors oppose the health law, Blues may be the single biggest factor in educating consumers and recruiting them into Obamacare.

In Louisiana, where Gov. Bobby Jindal has flatly said "we are not implementing the exchange," the local Blues plan has organized community nonprofits, churches, chambers of commerce and food banks to get out the word on what will be a federally run marketplace there.

BlueCross BlueShield of Louisiana "is the driving force" behind the Louisiana Healthcare Education Coalition, launched in March, said Nebeyou Abebe, who works on consumer engagement at the Louisiana Public Health Institute. "I can't think of any other entity in Louisiana that's developing a massive campaign to educate people."

Founded by hospitals and doctors before World War II, the Blues are a loose federation of nonprofit and for-profit plans with a history of selling coverage directly to individuals and families.

The Concerns Of Insurers

The Affordable Care Act requires exchange plans to cover anybody, no matter how sick, at regulated prices and often with large government subsidies.

Despite the prospect of millions of new customers and measures to cushion insurers with disproportionately high claims in the early years, carriers worry that the sick will be first to sign up while the healthy stay away. Fears grew after claims came in far higher than expected for temporary "high risk pools" that had been established by the law to cover the chronically ill until the full law took effect in 2014. The shortfall prompted the plans to close enrollment early.

"Insurance companies, very suddenly in my estimation, are getting very conservative and hesitant about being in the exchanges," said Robert Laszewski, a Virginia-based consultant and former insurance executive. "All along everybody, including the companies, assumed they would be in a lot of exchanges."

Carriers also fear Democrats will blame them if government-run online marketplaces suffer technical failures or run into other problems, Laszewski said.

UnitedHealth Group's recent disclosure that it would offer plans in only a dozen state exchanges marked new disappointment for those hoping the exchanges will generate vigorous competition and new insurance for millions. Previously United had said it would sell on as many as 25 exchanges.

The company will "watch and see" how exchanges work, "approaching them with some degree of caution," UnitedHealth Group CEO Stephen Hemsley told analysts last month.

Aetna plans to offer individual exchange policies in 14 states and may reduce that if some states look unprofitable or unprepared, CEO Mark Bertolini said on a conference call in late April. On June 17 Aetna disclosed it would stop selling individual insurance in California, the most populous state.

For its part, Cigna will focus on making exchange plans work well in five states rather than spreading efforts more thinly, said Ray Smithberger, who's in charge of the company's individual business.

"What you see in the general market is just a hesitancy" over whether states will be technologically ready, he said in an interview. "With condensed time frames, it's important that we provide the right connectivity to ensure we're providing the best experience for the customer."

Although not every state has announced online marketplace participants, the Blues characterize their approach very differently. "We expect Blue Cross Blue Shield plans will have a strong, reliable presence in the new exchanges," said Alissa Fox, a senior vice president at the Blue Cross and Blue Shield Association. "We've been in this market for more than 80 years and we've been providing coverage in every zip code to everybody. We imagine we will continue to do that."

Five Blues executives attended the meeting with Obama on April 12 to coordinate exchange implementation: Scott Serota, CEO of the Blue Cross and Blue Shield Association; Florida Blue CEO Patrick Geraghty; Chet Burrell, CEO of CareFirst BlueCross BlueShield, with plans in Maryland and D.C.; Patricia Hemingway Hall, CEO of Health Care Service Corp., with Blues plans in four states; and WellPoint CEO Joseph Swedish. WellPoint is the No. 2 health insurer and operates Blues plans in 14 states.

The White House declined to release the full list of attendees. Nor does it comment "on the role of one company or provider" in implementing the health act, a spokeswoman said.

Protecting Their Business

Blues aren't the only alternative to national commercial insurers. In many states there are regional nonprofits such as Group Health Cooperative in the Northwest or Presbyterian Health Plan in New Mexico. But for health coverage sold directly to consumers -- the kind that will be offered on the exchanges — Blues have the most members in a large majority of states.

Protecting that business is why Blues have little choice but to offer plans in the online marketplaces, analysts said. If they abstain, they risk losing those members. Once in the game, they need to recruit as many customers as possible to avoid signing a disproportionate share of the sick.

Florida Blue, which owns about half the market in that state for individual insurance, intends to use its 11 recently opened retail centers to get out the word and will rent temporary storefronts in key neighborhoods, said Jon Urbanek, senior vice

president of commercial markets for the company. Florida Blue will double the size of its call center to 200 employees as October approaches, he said.

"In campaign terms, it's a get-out-the-vote type of approach," said Michelle Riddell, vice president of community investment for BlueCross BlueShield of Texas.

Like the Louisiana Blues, the Texas Blues are educating and recruiting exchange customers with little cooperation from the state. Texas and Louisiana are among 33 states leaving exchange implementation to the federal government amid questions about whether it has the resources to educate a broadly ignorant public.

The Texas insurer's Be Covered Texas team includes Habitat for Humanity, diabetes groups, churches, social services nonprofits, the NAACP and community clinics — all putting out the Obamacare word in the state with the highest percentage of uninsured people in the country.

The campaign includes a Web site, a texting campaign and community events planned through the rest of the year. A Blues official recently spoke to the Houston congregation of Windsor Village United Methodist Church, which has more than 16,000 members. Food bank grocery bags bear printed information about health insurance. Barber shops are seen as health information hubs.

Be Covered Texas doesn't mention Blue Cross, presenting itself as a grass-roots program. Health Care Services Corp., the parent of the Texas Blues, hasn't disclosed how much it is spending on the Texas effort and similar outreach by its Blues plans in New Mexico, Illinois and Oklahoma, a spokesman said.

"I view this as a three-year project," said Bert Marshall, president of BlueCross BlueShield of Texas. "I think the education piece is going to last well beyond this enrollment and well beyond the next."

With his company holding more than half of the Texas individual insurance market, Marshall believes an early and extended campaign is a good investment. His competitors seem to have a different view.

"The Blue Cross plans… are going to be in the exchanges because it's part of their DNA," said Laszewski. "But the rest of the marketplace, if you go look at their block of individual business, it's small, and it's probably losing money."

THE COMMONWEALTH FUND
A Private Foundation Working Toward a High Performance Health System

Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues

July 15, 2010

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Health Insurance Exchanges Under the Affordable Care Act: Key Policy Issues

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Overview

Health insurance exchanges are the centerpiece of the private health insurance reforms of the Patient Protection and Affordable Care Act of 2010 (ACA). If they function as planned, these exchanges will expand health insurance coverage, improve the quality of such coverage and perhaps of health care itself, and reduce costs. Previous attempts at creating health insurance exchanges, however, produced only mixed results. This report identifies the earlier attempts' problems, enumerates the key issues that are critical for overcoming those problems, analyzes in detail the ACA's provisions addressing these issues, and discusses further policy options.

Executive Summary

Health insurance exchanges are the centerpiece of the private health insurance reforms of the Affordable Care Act of 2010 (ACA). If they function as planned, these exchanges will expand health insurance coverage, improve the quality of such coverage and perhaps of health care itself, and reduce costs. Previous attempts at creating health insurance exchanges, however, enjoyed only mixed results. As part of successfully implementing the new exchanges, the U.S. Department of Health and Human Services (HHS) and the states must address issues that undermined the earlier attempts. These issues are:

- *Adverse selection.* It is absolutely necessary that exchanges be protected against adverse selection (the disproportionate purchase of health insurance by the least healthy individuals)—especially because, under the ACA, small-group and nongroup insurance options remain available outside the exchanges. However, a number of provisions of the ACA level the playing field inside and outside the exchange, and weaken incentives for adverse selection. These protections can also be enhanced by the states.
- *Numbers of participants.* Exchanges that include large numbers of enrollees, as well as a high percentage of the total number of enrollees who are participating in the entire insurance market, offer greater market power, economies of scale, more stable risk pools, and stronger protection against adverse selection. The ACA offers opportunities for expanding risk pools, which should be fully exploited.
- *Market coverage and structure*. The ACA permits both the combination and separation of small-group and nongroup risk pools and exchanges. It also allows the creation of regional or subsidiary exchanges. The advantages and disadvantages of pursuing these options must be carefully weighed.
- *Choice without complexity.* The exchange model created by the ACA presents consumers with structured choices. An important implementation decision will be whether to further structure choices or, alternatively, to offer maximum choice and flexibility within the constraints of the ACA.
- *Transparency and disclosure.* The ACA contains numerous provisions designed to maximize transparency and disclosure. Putting these requirements into operation will be one of the Act's most important implementation tasks.
- *Competition.* The exchanges are intended to increase competition among insurers and focus that competition on value and price. A number of provisions of the ACA should help to facilitate this objective.
- *Administrative costs.* The ACA requires exchanges to fulfill a number of administrative functions that will add to their costs. Exchanges must find ways to reduce such internal costs, as well as the administrative costs to insurers and employers, if they are to offer better value to enrollees.
- *Market or regulator?* The ACA delegates to exchanges a number of regulatory responsibilities. Exchanges must certify health plans for participation and can exercise regulatory authority through this power. An important implementation choice will be whether exchanges should, on the one hand, maximize plan participation by minimizing certification requirements or, on the other hand, use their certification authority to limit exchange participation to high-value plans.
- *Administering subsidies and mandates*. The exchanges will play important roles in establishing insurance affordability, administering cost-sharing subsidies, and serving as a gateway to other public programs. It is particularly important that exchanges coordinate seamlessly with other public programs because participants will often move back and forth between an exchange, Medicaid, and the Children's Health Insurance Program (CHIP).
- *State, regional, or national exchanges?* Although the ACA favors the creation of state exchanges, it also confers authority to create a federal exchange as well as a multistate insurance program, and it provides for the possibility of regional exchanges. Important policy choices will need to be made concerning which avenues particular states should pursue and how the federal

government should react to state action—or inaction.

- *Governance*. The ACA provides very little guidance as to how exchanges should be governed. HHS and the states must carefully consider how the entities that govern exchanges should be structured and how they relate to other state and to federal institutions.
- *Relationships with employers.* Although exchanges must be employer-friendly if they are to succeed, the ACA offers little guidance in this regard. Such relationships nevertheless need to be a major focus of implementation efforts.
- *Cost control.* Exchanges have been sold as a mechanism for moderating the growth of health insurance costs. Achieving this objective will only be possible if exchanges are implemented so as to maximize competition, choice, and participation and to minimize administrative cost and adverse selection.

Citation

T. S. Jost, Health Insurance Exchanges and the Affordable Care Act: Key Policy Issues, The Commonwealth Fund, July 2010.

Obamacare's challenge: Persuading young and healthy to buy insurance

By Kelli Kennedy, Associated Press

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In this Wednesday, June 19, 2013 photo, Emily Nicoll smiles for a photo in Coppell, Texas. For millions of unemployed and underemployed 20-somethings, health care has been out of reach. Now sweeping federal health laws are promising to make coverage more affordable, but the big question remains_ will it be affordable enough? Nicoll says sheÃll skip other luxuries and pay for the insurance because sheÃs always worried about the "what if." (AP Photo/LM Otero) (LM Otero)

MIAMI (AP) - Dan Lopez rarely gets sick and hasn't been to a doctor in 10 years, so buying health insurance feels like a waste of money.

Even after the federal health overhaul takes full effect next year, the 24-year-old said he will probably decide to pay the $100 penalty for those who skirt the law's requirement that all Americans purchase coverage.

"I don't feel I should pay for something I don't use," said the Milwaukee resident, who makes about $48,000 a year working two part-time jobs.

Because he makes too much to qualify for government subsidies, Lopez would pay a premium of about $3,000 a year if he chose to buy health insurance.

"I shouldn't be penalized for having good health," he said.

Persuading young, healthy adults such as Lopez to buy insurance under the Affordable Care Act is becoming a major concern for insurance companies as they scramble to comply with the law, which prohibits them from denying coverage because of pre-existing conditions and limits what they can charge to older policy holders.

Experts warn that a lot of these so-called "young invincibles" could opt to pay the fine instead of spending hundreds or thousands of dollars each year on insurance premiums. If enough young adults avoid the new insurance marketplace, it could throw off the entire equilibrium of the Affordable Care Act. Insurers are betting on the business of that group to offset the higher costs they will incur for older, sicker beneficiaries.

The nonpartisan Congressional Budget Office estimates that about six million people of various ages will pay the tax penalty for not having insurance in 2014, the first year the law championed by President Barack Obama will be fully implemented.

It's hard to estimate how many of those will be the young and healthy adults insurers are trying to reach, but that subgroup makes up a very small portion of the overall market. Even though it's small, experts say it could be enough to throw the system's financing off-kilter.

About 3 million 18-24 year-olds in the U.S. currently purchase their own insurance. Many pay high prices for scant benefits, with high deductibles and co-pays because they make too much to qualify for Medicaid and have no coverage options from their employers or parents. The Urban Institute estimates that the majority of adults in their 20s will qualify for government subsidies under the Affordable Care Act.

Premium hikes could be a disincentive for young people weighing their options. Premiums

Premium hikes could be a disincentive for young people weighing their options. Premiums for people aged 21 to 29 with single coverage who are not eligible for government subsidies would increase by 42 percent under the law, according to an analysis by actuaries at the consulting firm Oliver Wyman. By comparison, an adult in his or her early 60s who would see about a 1 percent average increase in premiums under new federal health rules.

Insurers including America's Health Insurance Plans and The Blue Cross and Blue Shield Association recently wrote to federal health officials warning that they feared low enrollment by young adults and proposed beefed up penalties for opting out. Insurers worry the $100 penalty might not be a strong enough deterrent. The penalties jump to $695 or 2.5 percent of taxable income - whichever is more - by 2016.

"The key to keeping health care affordable is you really want to balance the pool, where you have enough young and healthy people to balance off the care of the older, sicker people who are likely to utilize much more health care services," said Justine Handelman, the Blue Cross and Blue Shield Association's vice president for legislative and regulatory policy.

She said younger people use about a fifth of the services that older beneficiaries do.

Jonathan Gruber, an economics professor at the Massachusetts Institute of Technology who helped craft that state's law, said he thinks the first-year federal penalty should be higher.

The penalty under the Massachusetts law, which served as the model for Obama's

overhaul, was $218 the first year in 2007. Gruber said that amount proved effective.

"People hate paying money and getting nothing for it," he said.

Roughly 40,000 of about 6 million Massachusetts residents paid the penalty the first year, he said.

Many young adults have chosen relatively bare-bones health plans before the Affordable Care Act, but the new law requires all plans to offer a minimum set of benefits, thus raising the price for coverage.

The cost of health coverage is difficult to estimate because it includes so many factors, but a 27-year-old making $30,000 a year in 2014 will have a $3,400 premium and will be eligible for subsidies that cover about 26 percent of the bill. That person would end up paying $2,509, or about $209 a month. That does not include deductibles, co-pays and other variables which can vary widely.

The estimates come from the nonpartisan Kaiser Family Foundation's online Health Reform Subsidy Calculator.

Francois Louis, a 20-year-old college student in South Florida who works part-time, can't remember the last time he went to the doctor and gets by on over-the-counter medication whenever he's sick. He'd love to get a check-up, but says it's too expensive on his income of less than $15,000 a year.

"I probably would do the $100 fine because it's just cheaper and you don't have to worry about paying off monthly costs," said Louis, a student at Broward Community College near Fort Lauderdale.

Louis would get a $2,718 tax credit and have to pay $300 toward his premium, according to the calculator.

Health advocates note that many people who have difficulty affording health insurance now will qualify for federal subsidies. The assistance will go to those making less than $43,000 a year who cannot get affordable coverage through their job.

That description fits 27-year-old Emily Nicoll of Dallas, who makes $20,000 a year working in customer service for a sports team.

She said she pays a lot of money for basic health benefits, including $80 a month for two

prescriptions and a $100 co-pay for each doctor's visit. But the memory of being in a car accident in high school lingers, so she will continue to pay for health insurance once the new law takes effect.

"That's the fear that makes me pay out that $151 a month," said Nicoll, who says most of her friends do not have insurance.

She would receive a $2,100 tax credit under the Affordable Care Act and pay about $83 a month for her premium.

While Nicoll stands to save money on health insurance under the new law, many young people who make more money would not.

The potential for skyrocketing prices caught the attention of a Democratic state lawmaker in New Jersey, Assemblywoman Celeste Riley. She is so worried about the cost for young people that she helped pass legislation to remove a requirement that students at two-year colleges have health insurance to attend class. The bill is awaiting action by the governor.

Riley said the low-cost, limited plans currently offered to students cost about $600 a year, but prices could rise up to $2,000. The Affordable Care Act allows people to stay on their parents' plans until age 26, but many parents also lack insurance in the current economy.

"In this one small situation, I have students that really are going to be hit so hard financially," she said. "I think that really some of them will decide not to go to school."

Colo. treasurer warns of pension funds

Jared Polis withdraws fracking suit in effort to gather more evidence

Denver Parks and Rec puts 14 cameras in Civic Center, hopes to reduce crime

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Preston Tucker, CEO – Colorado Health Council

Biography:

Since 2007 Preston Tucker has served as Chief Executive Officer of Colorado Health Council, directing the firm's internal and external business priorities and forming strategic partnerships within the healthcare sector of Colorado.

Prior to taking charge as CEO, Tucker was Vice President of Employer Accounts and oversaw an increase of department revenue of over 150%, helping establish Colorado Health Council as the dominant force in employer-based healthcare in the state.

Previously, Tucker administered accounts and billing at Colorado's largest network of hospitals and primary care providers.

Tucker sits on the board of CO Kids Trust, Colorado's consortium of private-sector leaders focused on improving outcomes for early-childhood development. Tucker also co-owns the PT Charities, a development and growth consulting firm for health and education charities.

Tucker earned a bachelor's degree from Georgetown University and a master's in business administration from University of Colorado Boulder.