LEGISLATIVE COMMITTEE MINUTES

SB121

Bill as Introduced

SB 121 - AS INTRODUCED

2021 SESSION

21-0960
10/08

SENATE BILL ***121***

AN ACT relative to a state-based health exchange.

SPONSORS: Sen. Rosenwald, Dist 13; Sen. Bradley, Dist 3; Sen. Sherman, Dist 24; Rep. Marsh, Carr. 8; Rep. Bartlett, Merr. 19; Rep. Weber, Ches. 1; Rep. Hunt, Ches. 11

COMMITTEE: Health and Human Services

ANALYSIS

This bill requires the insurance department to examine the implementation of a state health exchange and implement such an exchange upon approval of the joint health care reform oversight committee.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

SB 121 - AS INTRODUCED

21-0960
10/08

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to a state-based health exchange.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Federal Health Care Reform; Health Exchange. Amend RSA 420-N by inserting after section 10 the following new section:

420-N:11 Implementation of State-Based Exchange. Notwithstanding the provisions of RSA 420-N:7, the insurance department is authorized to examine the potential benefits of implementing a state-based exchange, including potential strengthening of state control over health insurance reform, potential health policy benefits, and potential economic benefits to the individual and group health insurance markets. If, in the department's opinion, implementation of a state-based exchange would strengthen state control and provide significant health policy benefits and economic benefits, the department may implement a state-based exchange upon approval of the joint health care reform oversight committee established in RSA 420-N:3.

2 Effective Date. This act shall take effect 60 days after its passage.

SB 121 - AS AMENDED BY THE SENATE

01/05/2022 2217s

2021 SESSION

21-0960
10/08

SENATE BILL ***121***

AN ACT relative to a state-based health exchange.

SPONSORS: Sen. Rosenwald, Dist 13; Sen. Bradley, Dist 3; Sen. Sherman, Dist 24; Rep. Marsh, Carr. 8; Rep. Bartlett, Merr. 19; Rep. Weber, Ches. 1; Rep. Hunt, Ches. 11

COMMITTEE: Health and Human Services

AMENDED ANALYSIS

This bill requires the insurance department to examine the implementation of a state-based health exchange and implement such an exchange upon approval of the governor, the oversight committee on health and human services, and the fiscal committee.

Explanation: Matter added to current law appears in ***bold italics.***
Matter removed from current law appears [~~in brackets and struckthrough.~~]
Matter which is either (a) all new or (b) repealed and reenacted appears in regular type.

STATE OF NEW HAMPSHIRE

In the Year of Our Lord Two Thousand Twenty One

AN ACT relative to a state-based health exchange.

Be it Enacted by the Senate and House of Representatives in General Court convened:

1 New Section; Federal Health Care Reform; Health Exchange. Amend RSA 420-N by inserting after section 10 the following new section:

420-N:11 Implementation of State-Based Exchange.

I. Notwithstanding the provisions of RSA 420-N:7, the insurance department is authorized to examine the potential benefits of implementing a state-based exchange, including potential strengthening of state control over health insurance reform, potential health policy benefits, and potential economic benefits to the individual and group health insurance markets. If, in the department's opinion, implementation of a state-based exchange would strengthen state control and provide significant health policy benefits and economic benefits, the department may implement a state-based exchange upon approval of the governor, the oversight committee on health and human services established in RSA 126-A:13, and the fiscal committee of the general court. Any contract with a state-based health exchange shall be approved by the governor and council.

II. Any decision by the commissioner to recommend that the state participate in a state-based exchange or contract with a private entity to do so shall be based on the potential for:

(a) Strengthened state control over health insurance reform.

(b) Economic benefits to the individual and group health insurance markets.

(c) Improved access to data for health policy decisions, including data regarding demographics and enrollee benefit / plan design preferences.

(d) Ease of use by stakeholders.

(e) Reliability of the state-based exchange, including integration with any federal or state Medicaid systems.

(f) Potential health policy benefits.

(g) Cost savings and the potential for changes over time.

2 Effective Date. This act shall take effect upon passage.

Amendments

Sen. Rosenwald, Dist 13
Sen. Bradley, Dist 3
March 16, 2021
2021-0843s
10/08

Amendment to SB 121

Amend the bill by replacing all after the enacting clause with the following:

1 New Section; Federal Health Care Reform; Health Exchange. Amend RSA 420-N by inserting after section 10 the following new section:

420-N:11 Implementation of State-Based Exchange.

I. Notwithstanding the provisions of RSA 420-N:7, the insurance department is authorized to examine the potential benefits of implementing a state-based exchange, including potential strengthening of state control over health insurance reform, potential health policy benefits, and potential economic benefits to the individual and group health insurance markets. If, in the department's opinion, implementation of a state-based exchange would strengthen state control and provide significant health policy benefits and economic benefits, the department may implement a state-based exchange upon approval of the governor and council and the commission on the status of health coverage markets for individuals and small employers established in RSA 404-J:1.

II. Any decision by the commissioner to recommend that the state participate in a state-based exchange or contract with a private entity to do so shall be based on the potential for:

(a) Strengthened state control over health insurance reform.

(b) Economic benefits to the individual and group health insurance markets.

(c) Improved access to data for health policy decisions, including data regarding demographics and enrollee benefit / plan design preferences.

(d) Ease of use by stakeholders.

(e) Reliability of the state-based exchange, including integration with any federal or state Medicaid systems.

(f) Potential health policy benefits.

(g) Cost savings to the state, and the potential for changes over time.

2 Effective Date. This act shall take effect upon passage.

2021-0843s

AMENDED ANALYSIS

This bill requires the insurance department to examine the implementation of a state-based health exchange and implement such an exchange upon approval of the governor and council and the commission on the status of health coverage markets for individuals and small employer.

Sen. Bradley, Dist 3
September 23, 2021
2021-2153s
10/08

Amendment to SB 121

Amend the bill by replacing all after the enacting clause with the following:

1 New Section; Federal Health Care Reform; Health Exchange. Amend RSA 420-N by inserting after section 10 the following new section:

420-N:11 Implementation of State-Based Exchange.

I. Notwithstanding the provisions of RSA 420-N:7, the insurance department is authorized to examine the potential benefits of implementing a state-based exchange, including potential strengthening of state control over health insurance reform, potential health policy benefits, and potential economic benefits to the individual and group health insurance markets. If, in the department's opinion, implementation of a state-based exchange would strengthen state control and provide significant health policy benefits and economic benefits, the department may implement a state-based exchange upon approval of the governor, the oversight committee on health and human services established in RSA 126-A:13, and the fiscal committee of the general court. Any contract with a state-based health exchange shall be approved by the governor and council.

II. Any decision by the commissioner to recommend that the state participate in a state-based exchange or contract with a private entity to do so shall be based on the potential for:

(a) Strengthened state control over health insurance reform.

(b) Economic benefits to the individual and group health insurance markets.

(c) Improved access to data for health policy decisions, including data regarding demographics and enrollee benefit / plan design preferences.

(d) Ease of use by stakeholders.

(e) Reliability of the state-based exchange, including integration with any federal or state Medicaid systems.

(f) Potential health policy benefits.

(g) Cost savings and the potential for changes over time.

2 Effective Date. This act shall take effect upon passage.

2021-2153s

AMENDED ANALYSIS

This bill requires the insurance department to examine the implementation of a state-based health exchange and implement such an exchange upon approval of the governor, the oversight committee on health and human services, and the fiscal committee.

Health and Human Services
October 26, 2021
2021-2217s
10/08

Amendment to SB 121

Amend the bill by replacing all after the enacting clause with the following:

1 New Section; Federal Health Care Reform; Health Exchange. Amend RSA 420-N by inserting after section 10 the following new section:

420-N:11 Implementation of State-Based Exchange.

I. Notwithstanding the provisions of RSA 420-N:7, the insurance department is authorized to examine the potential benefits of implementing a state-based exchange, including potential strengthening of state control over health insurance reform, potential health policy benefits, and potential economic benefits to the individual and group health insurance markets. If, in the department's opinion, implementation of a state-based exchange would strengthen state control and provide significant health policy benefits and economic benefits, the department may implement a state-based exchange upon approval of the governor, the oversight committee on health and human services established in RSA 126-A:13, and the fiscal committee of the general court. Any contract with a state-based health exchange shall be approved by the governor and council.

II. Any decision by the commissioner to recommend that the state participate in a state-based exchange or contract with a private entity to do so shall be based on the potential for:

(a) Strengthened state control over health insurance reform.

(b) Economic benefits to the individual and group health insurance markets.

(c) Improved access to data for health policy decisions, including data regarding demographics and enrollee benefit / plan design preferences.

(d) Ease of use by stakeholders.

(e) Reliability of the state-based exchange, including integration with any federal or state Medicaid systems.

(f) Potential health policy benefits.

(g) Cost savings and the potential for changes over time.

2 Effective Date. This act shall take effect upon passage.

2021-2217s

AMENDED ANALYSIS

This bill requires the insurance department to examine the implementation of a state-based health exchange and implement such an exchange upon approval of the governor, the oversight committee on health and human services, and the fiscal committee.

Committee Minutes

SENATE CALENDAR NOTICE
Health and Human Services

Sen Jeb Bradley, Chair
Sen James Gray, Vice Chair
Sen Kevin Avard, Member
Sen Tom Sherman, Member
Sen Rebecca Whitley, Member

Date: February 10, 2021

HEARINGS

Wednesday	02/10/2021
(Day)	(Date)

Health and Human Services	REMOTE 000	8:30 a.m.
(Name of Committee)	(Place)	(Time)

8:30 a.m.	**SB 120**	relative to physician assistant medical services through the Manchester Veterans Administration Medical Center.
8:45 a.m.	**SB 121**	relative to a state-based health exchange.
9:00 a.m.	**SB 123**	relative to copayments for COVID-19 testing.
9:30 a.m.	**SB 132-FN**	adopting omnibus legislation relative to COVID-19.

Committee members will receive secure Zoom invitations via email.

Members of the public may attend using the following links:

1. Link to Zoom Webinar: https://www.zoom.us/j/99818019001
2. To listen via telephone: Dial(for higher quality, dial a number based on your current location): 1-301-715-8592, or 1-312-626-6799 or 1-929-205-6099, or 1-253-215-8782, or 1-346-248-7799, or 1-669-900-6833
3. Or iPhone one-tap: US: +16465588656,,99818019001# or +13017158592,,99818019001#
4. Webinar ID: 998 1801 9001
5. To view/listen to this hearing on YouTube, use this link: https://www.youtube.com/channel/UCjBZdtrjRnQdmg-2MPMiWrA
6. To sign in to speak, register your position on a bill and/or submit testimony, use this link: http://gencourt.state.nh.us/remotecommittee/senate.aspx

The following email will be monitored throughout the meeting by someone who can assist with and alert the committee to any technical issues: remotesenate@leg.state.nh.us or call (603-271-6931).

EXECUTIVE SESSION MAY FOLLOW

Sponsors:

SB 120			
Sen. Sherman	Sen. Bradley	Sen. D'Allesandro	Rep. Marsh
Sen. Gray	Sen. Soucy	Rep. Knirk	
SB 121			
Sen. Rosenwald	Sen. Bradley	Sen. Sherman	Rep. Marsh
Rep. Bartlett	Rep. Weber	Rep. Hunt	
SB 123			
Sen. Sherman	Sen. Cavanaugh	Sen. Perkins Kwoka	Sen. Rosenwald
Sen. Whitley	Sen. Hennessey	Rep. Marsh	Rep. Woods
SB 132-FN			
Sen. Prentiss			

Kirsten Koch 271-3266

Jeb Bradley
Chairman

Senate Health and Human Services Committee

Kirsten Koch 271-3266

SB 121, relative to a state-based health exchange.

Hearing Date: February 10, 2021

Time Opened: 8:45 a.m. **Time Closed:** 9:21 a.m.

Members of the Committee Present: Senators Bradley, Gray, Avard, Sherman and Whitley

Members of the Committee Absent : None

Bill Analysis: This bill requires the insurance department to examine the implementation of a state health exchange and implement such an exchange upon approval of the joint health care reform oversight committee.

Sponsors:

Sen. Rosenwald	Sen. Bradley	Sen. Sherman
Rep. Marsh	Rep. Bartlett	Rep. Weber
Rep. Hunt		

Who supports the bill: Senator Rosenwald, District 13; Senator Sherman, District 24; Rep. Frost, Strafford 16, Holly Stevens, New Futures; Peter Bragdon, GetInsured; Gale Taylor; Nicole Fordey; Mel Hinebauch; Louise Spencer; Rob Spencer; Betsy Neville; Gordon Blakeney; Sally Hatch; Maureen Ellermann; Sandra Blanchard; Claudia Damon; Ruth Larson; Jeanne Torpey; Dina Solomon; Marie Straiton; Linda Matlage: Barbara Reed; Keryn Anderson; Juli Hincks; Helmut Koch; Laurie Koch; Lilian Carter; Ruth Perencevich; Elizabeth Corell; Kent Hackmann; Annie Rettew; Kathy Spielman; James Spielman; Lisa DeMio; Judith Blachek; Shana Potvin; Julie Donovan; Richard Demark; Susan Richman; Elizabeth Fenner-Lukaitis; Kimberly Carole; Jim Bosman; Karen Mitchell; Maxine Petruccelli; Charles Petruccelli; Catherine Goldwater; Nancy Brennan; Cheri Falk; Randy Hayes; Cora Quisumbing-King; Laura Vincent; Laura Aronson; Denise Clark; Ben Stinson; Diane St. Germain; Ed Friedrich; Barbara D. Cook; Nancy Graham; Thomas Wendy; Kelly Piche; Kim Healey; Marc Nozell; Nicole Gugliucci; Susan Chase; John Russel; Bridget Mooney; Geri Davidson; Melinda Chen; Martha Clark.

Who opposes the bill: Andrew Manuse; Alexandra Mennella.

Who is neutral on the bill: Tyler Brannen, NH Insurance Department; DJ Bettencourt; NH Insurance Department.

Summary of testimony presented in support:

Senator Rosenwald, District 13

- Senator Rosenwald said, SB 121 is enabling legislation which could allow NH to exercise more local control and save the state significant money.
- Following the passage of the Affordable Care Act in 2010, NH passed a law prohibiting NH from creating a state-based health benefit exchanged system, and instead mandated use of the federal exchange.
- The state pays to use the federal exchange at the rate of 3% per enrollee. This current year that adds up to ten million dollars.
- In the eleven years since, private businesses have created private marketplace solutions for state-based exchanges. This could be an option too that would provide us more data.
- NH would have more control, and carriers could better serve the needs of Granite Staters while also saving three million dollars rather than paying to use federal health care.
- Senator Rosenwald wanted to make it clear that this is enabling legislation that would simply lift the prohibition in NH on the creation of a state-based exchange. This bill does not create a state-based exchange but would allow the legislature to go forward to create a state-based exchanged if they choose.
- Senator Bradley asked, the way this bill is written, it has to have the approval of the Health Care Reform Committee. What would you think of adding the approval of the Fiscal Committee--which you are on—so that it touches more bases?
    - Senator Rosenwald said, I would not have a problem with that.
- Senator Whitley said, with the federal program, do we seed any control to the feds? Will we get any more policy-based information that would help us make future policy-based decisions?
    - Senator Rosenwald said, I think we would get better demographic information. Right now, the Insurance Department can get who each carrier is serving, their age, and their previous insurance status. But this is carrier by carrier, with a commercial product, we would have easier access.

Amit Dhawan

- Mr. Dhawan explained the benefits state-based exchange systems provide for in-state consumers based on what GetInsured had experienced:
    - (1) A state-based exchange provides more local control and more data for the state. Full control on demographic data, service area data, where coverage is lacking, etc.
    - (2) Provides a better user experience for mixed households and those with Medicaid; generally more flexibility across the state.
    - (3) An increased user fee of 3%, additional burden and contributes to hirer premiums in FNN states. The average premiums using fed is 21% higher cost.
    - (4) Technology has matured a lot since 2013 and setting up state-based exchange is much easier. This is because the transition process is now standard. Vendors like GetInsured have invested in those standards.
    - (5) State-based exchanges provide savings of up to 50% depending on factors.

Peter Bragdon, GetInsured

- Mr. Bragdon said, the law prohibiting the state of NH from creating a state-based legislature was established right after the Afford Care Act. The legislature was concerned that the state would try to establish a state-based exchange right away and fail very

badly. The department and the state did not feel that the state have the resources to do it. GetInsured was first hired by California to implement a state-based exchange and then Idaho, Washington, Nevada, Pennsylvania, New Jersey.

- Mr. Bragdon said, the money saved by switching is money the premiums people are paying. If the government matches that, people can save even more money.
- The statute referenced in the bill is RSA 420-N:7 Prohibition of State-Based Health Exchange. It starts by saying no NH state agency, department, or political subdivision shall plan, create, or enable a state-based health exchange.
- Mr. Bragon said if the state were to pass this bill, there would likely be some backlash because of this RSA. Some may say this language is clear, but this bill says 'notwithstanding RSA-N:7 to clarify that.
- Mr. Bragdon said this bill should be passed but also agrees that it should go through the Fiscal Committee and the NHID should do their research on it too.
- Mr. Bragdon said, a state-based exchange provides a ton of data.
- Senator Sherman said, what currently happens to the data? I understand it goes to the federal government. Would we be able to keep data on NH residents, or does it still get send to the feds? Could we look at our gaps in utilization? Could this make us more efficient in our delivery of health care?
    - Mr. Bragdon said, yes. The data now goes to the feds. Under a state-based exchange this information would stay with us to look at all of that.
- Senator Bradley asked, if we were to pass this bill, but we substitute line 7 with "if in the department's opinion" with the following, "the department shall report its findings with the Governor, House Speaker, and Senate President by November 1, 2021." Does that satisfy your concern about the 'notwithstanding,' but also satisfy my concern about jumping out too far, too fast without adequate oversight without having the legislature come back to authorize a state-based exchange but get the research.
- Mr. Bragdon said, the key is getting this moving. I agree it needs to come back to a legislative body. I think this is a policy matter of whether you want it to go to committees with the authority or the full legislature.

Summary of testimony presented in opposition: None.

Neutral Information Presented:

Tyler Brannen, NH Insurance Department (NHID)

- Mr. Brannen had appeared alongside Mr. Bettencourt to answer any questions from the committee members.

DJ Bettencourt, Deputy Commissioner, NH Insurance Department (NHID)

- The state of NH currently operates under a partnership with the federal government.
- RSA 420-N:7 currently prohibits a state-based exchange in New Hampshire.
- This bill would allow for a state-based exchange to be created if the NHID recommended that a state-based exchange would benefit the state.
- Mr. Bettencourt said the NHID will carry out any directive the legislature gives.

- In terms of the research, the NHID would look at key areas:
    - (1) Understand the issues around state liability given that the federal government currently bears the burden of liability, issues, and costs.
    - (2) The steps necessary to ensure implementation, the ability to procure one or more vendors, transfer data from the federal system onto a state-based system, ensure the new marketplace can share insurance information with Medicaid and the kids' insurance program (known as CHIP), communicate with insurers, maintain enrollment of existing marketplace consumers--all without a hitch
    - (3) Look at ensuring a better customer experience than they are currently getting on the federal exchange. This would ensure that more people are able to purchase the product that works best for them individually.
    - (4) Getting more Granite Staters insured and identifying coverage holes and checking if the state-based exchange can fill those gaps.
- The 2022 federal-exchange rate is 2.25% premiums charged, down from 3.5% in the years 2014-2019, and down again 3% in 2020-2021.
- State-based exchanges on the federal platform would be 1.75% and a direct enrollment down to 1.5%.
- The bill asks for a recommendation from the department. Mr. Bettencourt said the NHID recommends that the plan should come from a joint oversight committee or another legislature established entity. The reason is the department does not traditionally provide policy opinions. NHID will do the research but the department believe the decision should lie in the hands of policymakers. The department would prefer to remain in their role of "neutral fact-finders."
- Senator Avard asked, you mentioned state liability, can you go into detail about what that would be?
    - Mr. Bettencourt said, that pertains to the customer service and technical expertise. We want to ensure that if the state were to go in this direction, that NH will avoid the challenges that states had when they went to state-based exchanges. The state needs a smooth transition if it goes to a state-based exchange. If the state owns it, then the state wants it to go well.
    - Senator Avard said, you mentioned the department's opinion, is that similar to putting this into a study before we vote?
    - Mr. Bettencourt said, this is asking the department to do the research, and we will do it. The NHID holds the opinion that the starting place should be legislative committee.
- Senator Whitley said, if this goes to the Health Reform Oversight Committee, that committee does not meet very often. I believe that there's action to repeal that committee.
- Mr. Bettencourt said, we are aware there is consideration of whether this committee should continue to meet. This was just a suggestion. The NHID believes that this opinion should come from a legislative body, and not a department. It could be done by another group.
- Senator Bradley said, Senator Rosenwald outlined a potential savings of about three million dollars, that is the difference between 2.25% and 1.5% of the premium charge on the two exchanges. Based on what you know now, is that an accurate amount of potential savings?

- Mr. Bettencourt said, yes that sounds accurate. The uncertainties around that amount that would impact it are dependent on what vendor the state secured, the cost of running the program, myriad of options, and available funding matches from the federal government.
- Senator Bradley said, based on the department's assessment of the current state of federal versus state exchange--on what other states are doing--have other states' experiences of running their own state-based exchange become more user-friendly and have better customer experience?
- Mr. Bettencourt—states had different experiences, some good, some bad. If we conduct this research, we will provide case studies on which states did it right and why, who struggled and why, so NH can do it right. State-based exchanges have come a long way since this first began. Most states are in better places today than when this first began.
- Senator Bradley asked, if the committee were to re-refer the bill, hold for study, would the department be able to come back and do that research without a more formalized study committee to make a report back to the Senate HHS committee? Is that a procedurally good way to handle this?
    - Mr. Bettencourt said, we will conduct whatever research you ask; this could be either under the bill or to provide information so you can decide how you want to vote on the bill.
- Senator Sherman asked, if we were to go ahead with the bill, or if we re-refer, which option would get us to the finish line? Which would be more timely, and therefore lead to more cost savings, for stakeholders and tax-payers?
    - Mr. Bettencourt said, the committee must make the decision if you want to delay or not. The NHID will turn around research, or a report, as quickly as we can.

At the end of the hearing on SB 121, Senator Gray asked a question of Mr. Bettencourt.

- Senator Gray asked, delaying the decision on this for six weeks, still getting us to cross-over, and getting research from the department—does the commissioner think that would be meaningful time to provide us information to make this decision?
- Mr. Bettencourt said, obviously the more time the department is provided, the more information we can turn around. However, whatever time frame is given the department will get it done and provide the information.

KNK
Date Hearing Report completed: February 16, 2021

Senate Health and Human Services Committee

Kirsten Koch 271-4151

SB 121, relative to a state-based health exchange.

Hearing Date: September 23, 2021

Time Opened: 10:01 a.m. **Time Closed:** 10:25 a.m.

Members of the Committee Present: Senators Bradley, Gray, Avard, Sherman and Whitley

Members of the Committee Absent : None

Bill Analysis: This bill requires the insurance department to examine the implementation of a state health exchange and implement such an exchange upon approval of the joint health care reform oversight committee.

Sponsors:

Sen. Rosenwald	Sen. Bradley	Sen. Sherman
Rep. Marsh	Rep. Bartlett	Rep. Weber
Rep. Hunt		

Who supports the bill: Peter Bragdon, Preti Strategies; Jason Sparks, Get-Insured.

Who opposes the bill: None

Who is neutral on the bill: None

Summary of testimony presented:

Hon. Peter Bragdon, Preti Strategies

- Mr. Bragdon said, Get-Insured provides off the shelf state exchange software and he was here to explain the overall benefits of having a state exchange specific to NH.
- The state now has in statute a prohibition on state exchanges. This bill is only enabling. It provides the Insurance Department authority to look into to establishing a state-based exchange.
- In 2012 we didn't think the state had the resources to make a state exchange.
- The funding mechanism is the fee charged to the state (CMS) rate 2.25% of premiums and would be increased to 2.75%. If you take the savings the state would get, a state exchange could be operated for 40% less than the federal exchange.

- Reduced premiums are eligible for matching from the federal government.
- We've established the 1332 waiver.
- Group and individual rates can be reduced by using a state exchange.
- Red and blue states want more state control over their exchange.
- This bill gives the Insurance Department the authority to examine this, despite the state law.
- The Health Reform Oversight Committee should give approval, and maybe another group with more legislators. The Executive Council has a very limited role here constitutionally.
- Senator Sherman said, we talked about a data benefit about this. Currently we send the data off to the feds. With this, we would own the data.
    - Mr. Bragdon said, that's correct. Under the federal exchange you don't have access to a lot of information.
- Senator Bradley said he wanted to discuss his Amendment # 2021-0843 with Senator Rosenwald from the first time SB 121 was in committee.

Jason Sparks, Get-Insured

- In 2021 47,000 Granite Staters were covered by the marketplace.
- With their own exchange, states take more control, they get lower premiums, and higher enrollments.
- The Federal government's marketplace is a one size fits all marketplace. We saw this play out during the COVID-19 pandemic.
- Three reasons why New Hampshire should switch to state based exchange:
    - (1) A state exchange will give New Hampshire greater control of the health insurance market. Assessments of the federal marketplace show increasing from 2.25 to 2.75%. New Hampshire could set its own.
    - (2) Better technology exists now and lower costs. User fees paid to federal government totals $10 million. New Hampshire can better leverage those dollars to drive down premiums.
    - (3) A well-designed state-based marketplace to build upon helps consumers and residents, provides access to data and dashboards, and offers states a financial savings.
- Senator Avard asked, so the federal system comes in and gives us a one size fits all?
    - Mr. Sparks said, yes.
- Senator Sherman asked, do you have any data on the percentage of savings for customers that have switched from the federal platform to yours?
    - Mr. Sparks said, yes. There was a 5-7% increase in enrollment for states that did and a decrease in premiums.
- Senator Sherman asked about a bill to consolidate health care policy data. Where does this data live? Is it with the Department of Insurance, with the Department of Health and Human Services, or with you?

- Mr. Sparks said, it stays with the health benefit exchange. It is in a data security warehouse and presented to stakeholders in a secure way. To be clear, it would be property of New Hampshire, not property of Get-Insured.

- Senator Bradley said, New Hampshire's estimated payment is $1 million and savings would be $3.1 million. If there were enhanced matchings, and it went back to lower premiums, this would be a 3:1 match?
  - Mr. Sparks said, correct.
- Senator Bradley said, and if that was the case, it would also be used for premiums?
  - Mr. Sparks, the savings could be leveraged for whatever New Hampshire decides is the best purpose. It could be premiums. There is policy flexibility. Pennsylvania was paying upwards of $90 million to the federal government in user fees. They were able to save money and bring in an insurance program.

Senator Cindy Rosenwald, District 13

- Senator Rosenwald said, the only thing I didn't hear mentioned is that the individual premium savings could also be extended to the group market and help out smaller businesses as well.
- Senator Whitley asked, could you describe your amendment?
  - Senator Rosenwald said, it gave more clarity to how we would ask the Insurance Department to look at the issue.
- Senator Sherman said, there was that study that Peter Bragdon--
  - Senator Rosenwald interjected and said, they looked at it. The potential savings are up to about $3 million. The Insurance Department thought it would be more like $1.5 million. I would also suggest changing line 24, cost savings for the state, because it is likely savings for the insured person. (LINE 24: "cost savings" ~~for the state)~~
- Senator Bradley asked, are you okay with the committee Peter Bragdon suggested?
  - Senator Rosenwald said, the other would be the Fiscal Committee, but stay with an insurance related group.
- Senator Bradley said, what if it were fiscal and joint health care?
  - Senator Rosenwald said, well fiscal meets regularly. I am not familiar with the other.
- Senator Bradley said, would you have any trouble if we clarify "upon approval of the governor" and instead "by contract upon approval of the governor and the council?"
  - Senator Rosenwald said, I am fine with specifying that.

KNK
Date Hearing Report completed: September 24, 2021

Speakers

Senate Health and Human Services Committee
SIGN-IN SHEET

Date: 09/23/2021 **Time:** 10:00 AM

SB 121 Relative to establishing a state-based health exchange.

Name & Representing ***(please print neatly)***

Name & Representing	Support	Oppose	Speaking?	Yes	No
Peter Braydon - Preti Strategies	☑	☐	Speaking?	☑	☐
Jason Sparks - Get Insured	☑	☐	Speaking?	☑	☐
	☐	☐	Speaking?	☐	☐
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Name	Title	Representing	Position	Testifing
Dhawan Amit	A Member of the Public	Myself	Support	Yes
Bettencourt DJ	State Agency Staff	Insurance Department	Neutral	Yes
Rosenwald Cindy	An Elected Official	SD 13	Support	Yes
Brannen Tyler	State Agency Staff	Insurance Department	Neutral	Yes
Bragdon Peter	A Lobbyist	GetInsured	Support	Yes
Taylor Gale	A Member of the Public	Myself	Support	No
Stevens Holly	A Lobbyist	New Futures	Support	No
Fordey Nicole	A Member of the Public	Myself	Support	No
Hinebauch Mel	A Member of the Public	Myself	Support	No
Spencer Louise	A Member of the Public	Myself	Support	No
Spencer Rob	A Member of the Public	Myself	Support	No
Manuse Andrew	A Member of the Public	Myself	Oppose	No
Neville Betsey	A Member of the Public	Myself	Support	No
blakeney gordon	A Member of the Public	Myself	Support	No
hatch sally	A Member of the Public	Myself	Support	No
Ellermann Maureen	A Member of the Public	Myself	Support	No
Blanchard Sandra	A Member of the Public	Myself	Support	No
Damon Claudia	A Member of the Public	Myself	Support	No
Larson Ruth	A Member of the Public	Myself	Support	No
Torpey Jeanne	A Member of the Public	Myself	Support	No
Garen June	A Member of the Public	Myself	Support	No
Solomon Dina	A Member of the Public	Myself	Support	No
Straiton Marie	A Member of the Public	Myself	Support	No
Frost Sherry	An Elected Official	Myself	Support	No
Sherman Senator	An Elected Official	SD24	Support	No
matlage Linda	A Member of the Public	Myself	Support	No
Reed Barbara	A Member of the Public	Myself	Support	No
Anderson Keryn	A Member of the Public	Myself	Support	No
Hincks Juli	A Member of the Public	Myself	Support	No
Koch Helmut	A Member of the Public	Myself	Support	No
Koch Laurie	A Member of the Public	Myself	Support	No
Carter Lilian	A Member of the Public	Myself	Support	No
Perencevich Ruth	A Member of the Public	Myself	Support	No
Corell Elizabeth	A Member of the Public	Myself	Support	No
Hackmann Kent	A Member of the Public	Myself	Support	No
Rettew Annie	A Member of the Public	Myself	Support	No
Spielman Kathy	A Member of the Public	Myself	Support	No
Spielman James	A Member of the Public	Myself	Support	No
DeMio Lisa	A Member of the Public	Myself	Support	No
Blachek Judith	A Member of the Public	Myself	Support	No
Potvin Shana	A Member of the Public	Myself	Support	No
Donovan Julie	A Member of the Public	Myself	Support	No
demark richard	A Member of the Public	Myself	Support	No
Richman Susan	A Member of the Public	Myself	Support	No
Fenner-Lukaitis Elizabeth	A Member of the Public	Myself	Support	No
Carole Kimberly	A Member of the Public	Myself	Support	No

Bosman Jim	A Member of the Public	Myself	Support	No
Mitchell Karen	A Member of the Public	Myself	Support	No
Petruccelli Maxine	A Member of the Public	Myself	Support	No
Petruccelli Charles	A Member of the Public	Myself	Support	No
Goldwater Catherine	A Member of the Public	Myself	Support	No
Brennan Nancy	A Member of the Public	Myself	Support	No
Falk Cheri	A Member of the Public	Myself	Support	No
Mennella Alexandra	A Member of the Public	Myself	Oppose	No
Hayes Randy	A Member of the Public	Myself	Support	No
QUISUMBING-KING Cora	A Member of the Public	Myself	Support	No
Vincent Laura	A Member of the Public	Myself	Support	No
Aronson Laura	A Member of the Public	Myself	Support	No
Clark Denise	A Member of the Public	Myself	Support	No
Stinson Ben	A Member of the Public	Myself	Support	No
St Germain Diane	A Member of the Public	Myself	Support	No
FRIEDRICH ED	A Member of the Public	Myself	Support	No
Cook Barbara D	A Member of the Public	Myself	Support	No
Graham Nancy	A Member of the Public	Myself	Support	No
Thomas Wendy	A Member of the Public	Myself	Support	No
Piche Kelly	A Member of the Public	Myself	Support	No
Healey Kim	A Member of the Public	Myself	Support	No
NOZELL MARC	A Member of the Public	Myself	Support	No
Gugliucci Nicole	A Member of the Public	Myself	Support	No
Chase Susan	A Member of the Public	Myself	Support	No
Russell John	A Member of the Public	Myself	Support	No
Glassman Barbara	A Member of the Public	Myself	Support	No
Mooney bridget	A Member of the Public	Myself	Support	No
Davidson Geri	A Member of the Public	Myself	Support	No
Chen Melinda	A Member of the Public	Myself	Support	No
Clark Martha	A Member of the Public	Myself	Support	No

Testimony

THE STATE OF NEW HAMPSHIRE
INSURANCE DEPARTMENT

21 South Fruit Street Suite 14
Concord, New Hampshire 03301

Christopher R. Nicolopoulos
Commissioner

David J. Bettencourt
Deputy Commissioner

Email sent to: jeb.bradley@leg.state.nh.us

The Honorable Jeb Bradley
State House, Room 302
107 North Main Street
Concord, NH 03301

Senator Bradley:

Please find the attached policy brief on state based health insurance exchanges (SBE). Following your request to research the SBEs in response to SB 121, we directed our contractor Freedman Healthcare to produce this brief.

The report provides a background and general analysis on the purpose and responsibilities associated with exchanges, also referred to as the Marketplace. Additionally, Freedman Healthcare researched the costs, risks, and considerations associated with SBEs and the experiences in other states.

Currently, New Hampshire is a partnership state, and while the NHID performs the functions associated with plan management and product approval, subsidized health insurance must be purchased through the federal healthcare.gov website. As described in the brief, a federal or SBE needs to have a range of services available, from the commercial insurance and Medicaid enrollment mechanism to consumer services support staff. This is no small undertaking and must be done with considerable thought and planning.

Other key points the brief addresses includes:

- Though initially the HealthCare.gov platform was plagued with technological problems, in recent years it performs several complex functions relatively well, including extensive email outreach to consumers, resolving income-related data matching issues, and leveraging new technologies to create a streamlined enrollment process for consumers who rely on direct enrollment partners
- Regardless of potential cost saving opportunities, transitioning to an SBM is a complex undertaking that is best pursued as part of a broader vision for what the state hopes to achieve (e.g., increased enrollment or improved consumer experience).
- Enrollment growth is one indicator of market health and is a consistent benefit observed in states that transitioned to SBMs.

- Although a well-integrated platform is a significant potential benefit of operating an SBM, it requires a strong interagency commitment to achieve. The process is also dependent of existing Medicaid technology and staff availability to coordinate the change.

If SB 121 passes, NHID will assist the legislature toward implementing an SBE, but please be sensitive to our limited resources. Developing a consensus on the model and passing legislation that creates the infrastructure will be an important part of this process. The NHID will provide our expertise on insurance markets, but we do not have the staff or authority to develop a SBE.

Many states will create an independent entity to perform exchange related functions, and this would be a key part of the model. You may wish to consider input from the New Hampshire Department of Health and Human Services, the NH Health Plan, advocacy groups, insurance carriers, brokers, and health care providers as part of the decision process. Hearing from potential vendors about what services they offer would be an important step as well.

In summary, the threshold consideration regards liability. Currently, the federal government bears the responsibility for the exchange. In transitioning to an SBE, the state will assume the liability to produce and maintain a system that is superior to the federal system. Transitioning to an SBE is no small task and involves significant considerations that impact both the state and consumers.

Thank you for the opportunity to provide the research and input on this significant policy decision.

Sincerely,

Christopher R. Nicolopoulos, Esq.
Commissioner

D.J. Bettencourt
Deputy Commissioner

State-Based Marketplace Policy Brief for New Hampshire

A New Hampshire Insurance Department analysis of recent trends and results for states moving from the Federally Facilitated Marketplace to a state-based operation.

March 19, 2021

Freedman HEALTHCARE

Contents

State-Based Marketplace Policy Brief - New Hampshire
March 2021

The New Hampshire Insurance Department, in response to legislative activity, asked Freedman HealthCare to describe recent trends and results for states considering moving from the federal health insurance exchange, HealthCare.gov, to a state operation. This report examines the major benefits and risks of such a change, describes case studies of individual states, examines financial and non-financial implications, identifies leading vendors, and provides links to sources of further information, for use by NH officials before the 2021 legislative session ends.

I. EXECUTIVE SUMMARY

1. Recent advances in technology operations may allow states to develop and implement a State-Based Marketplace (SBM) platform for less than the fees paid to use the Federally Facilitated Marketplace (FFM) platform (HealthCare.gov).
2. All-in costs for SBMs in states recently converting range from $100-200/enrollee/year, including required functions and state personnel. At 2020 enrollment, this would be $4.5-8.9M annually for NH. Whether the switch will lead to long-term cost savings depends on the vendor contract negotiated by the state, the projected FFM user fee schedule, potential ACA regulatory and policy changes, and state management.
3. Converting to an SBM gives states real-time access to enrollment data, plus the flexibility to pursue state-specific exchange goals (such as targeting certain populations for enrollment or performing integrated eligibility across benefit programs).
4. Regardless of potential cost saving opportunities, transitioning to an SBM is a complex undertaking that is best pursued as part of a broader vision for what the state hopes to achieve (e.g., increased enrollment or improved consumer experience).
5. States that are uncertain about transitioning to a full SBM—or that want to proceed incrementally to reduce risk—may pursue SBM-FP status (SBMs that utilize the federal platform).
6. New Hampshire officials should carefully weigh the advantages and disadvantages of an SBM in making their decision.

II. BACKGROUND

Under the Patient Protection and Affordable Care Act (ACA), there are three essential functions for a health insurance marketplace:

1. Eligibility and enrollment
    i. Provide a platform for consumers to receive an eligibility determination for income-based premium tax credits and cost-sharing subsidies
    ii. Allow consumers to enroll in a qualified health plan (QHP) or connect them to Medicaid or CHIP, if eligible
2. Consumer assistance
    i. Establish a web portal, call center, and Navigator program[1] to help consumers find and enroll in public or private coverage
    ii. Assist consumers with changes in circumstance (e.g., in income, employment status, or household composition), which are more frequent compared to populations covered by employer insurance[2]
3. Plan management (*Note: Some states, including NH, already perform this task*)
    i. Review insurers' justifications for premium rates
    ii. Certify that participating health plans meet all requirements, including licensure
    iii. Provide oversight of plans, including de-certifying non-compliant ones

States may elect to design and run their own State-Based Marketplace (SBM) as long as it meets minimum requirements—including performing the functions above—and it is financially self-sustaining. States that choose not to implement their own marketplace rely on the Federally-Facilitated Marketplace (FFM), including its

[1] "Data Note: Limited Navigator Funding for Federal Marketplace States." Kaiser Family Foundation. October 13, 2020.
[2] "Revisiting churn: An early understanding of state-level health coverage transitions under the ACA." August 2016.

HealthCare.gov technology platform. Initially, political opposition to the ACA, as well as early operational and technological hurdles, led to most states using the FFM.

Currently, some FFM states conduct limited aspects of marketplace functions, like plan management or consumer assistance, but have not codified SBM through legislation. Other states operate as a "hybrid" or State-Based Marketplace-Federal Platform (SBM-FP). These states have legislative authority to run a state-based marketplace, and are responsible for all functions, but use HealthCare.gov as their eligibility and enrollment platform.

Table 1. State Functions and Authority Under the Three Types of ACA Exchanges

Function and Authority[3]	FFM	SBM-FP	SBM
State runs eligibility & enrollment platform	N	N	Y
State conducts plan management	N*	Y	Y
State administers consumer assistance	N*	Y	Y
State has legal authority to run SBM	N	Y	Y

*FFM states, including NH, may choose to conduct plan management and/or consumer assistance functions, although the federal government retains primary responsibility. Some sources refer to these as State Partnership Marketplaces (SPM)[4]

III. COMPARISON OF FFM AND SBM

Table 2. Key Aspects of Exchanges Under Federal vs. State Marketplace

Category	FFM	SBM
Legislation & Buy-In	Not needed	Requires legislation and early/extensive stakeholder engagement (including payers and brokers)
Cost & Platform	*Cost* - Federal 3% user fees (paid by health plans) or $240 to $360 per enrollee. - Fees have decreased over the last three years and will drop to 2.25% in 2022. (*Note: See Table 4. History of CMS fees 2014-2022 for more information*). *Platform* - FFM platform (HealthCare.gov) running since 2014 and already integrates with payment site and data services hub - Current and future enhancements limited to features applicable to all FFM states	*Cost* - Savings from user fees may be used to fund SBM. (In 2018, NH paid $10.6M in fees[5]). - In 2018 analysis of six SBMs, annual budgets ranged from $32.5M to $340M, with median of $63.2M.[6] More recent states to transition estimate annual budgets of between $11M-$30M (or $100-$200 per enrollee)[7] - CMS provides $2M grant funding to assist states with transition work *Platform* - Commercially available, stable SBM platforms - State-specific customization is available - State must migrate enrollee data from HealthCare.gov, reroute insurance data, and connect data services hub (to verify identity and eligibility) to state platform. May happen within about 18 months after legislation is passed.
Data Access	FFM sends limited individual enrollment data, often a month or more after the enrollment is effectuated	Real-time access to enrollee and potential enrollee data allows for: - Timely analysis (e.g., Medicaid/QHP churn) - Monitoring (e.g., website and call center interaction) - Targeted outreach (see below) - Live connection to integrated eligibility platform for other services (e.g., SNAP, housing)

[3] "State Health Insurance Marketplace Types, 2021" Kaiser Family Foundation. 2021.
[4] "States seek greater control, cost-savings by converting to state-based marketplaces" Urban Institute. October 2019.
[5] "Should your state consider building a state-based exchange?" GetInsured. April 11, 2019.
[6] "The Your Health Idaho Marketplace: A model for state-based adoption." Leavitt Partners Study. July 2018.
[7] "Adopting a state-based health insurance marketplace poses risks and challenges." Center on Budget and Policy Priorities. February 6, 2020

Autonomy	*Enrollment* - Must adhere to FFM enrollment period (historically a fixed six-week open period, currently expanded), but determined at federal level with no flexibility - FFM has increasingly limited criteria for Special Enrollment Periods (SEPs) *State Oversight* - Allows short-term/non-ACA compliant plans	*Enrollment* - Flexible/expanded open enrollment period (SBMs have not experienced adverse selection issues)[8] - Special Enrollment Periods can have flexible, state-specific rules *State Oversight* - State control over plan quality, including rates, and plan design.
Consumer Support	*Targeted outreach* - Not available, due to delayed and limited nature of the data provided by the federal government. *Plan Compare* - Generic plan comparison tool for all states *Call centers* - 150 languages - Operators must adhere to general scripts[9] - No escalation path for complex issues; referred to state for resolution *Additional Support* - Federal funding for Navigators eliminated, though may change with COVID relief bill.	*Targeted outreach* - Since all data resides on the state platform, states may reach to: o Consumers with late payments o Eligible, but unenrolled, consumers o Specific groups by age, language, geography, etc. *Plan Compare* - Customized consumer decision support tools *Call centers* - Insourced or outsourced - State-based to address state-specific needs *Additional Support* - Can train and deploy Assisters/Navigators to target specific areas of need

IV. COMPARISON TO HYBRID MODEL (SBM-FP)

SBM-FPs are often used as a transition step between FFM and full SBM (as Nevada, New Jersey, and Pennsylvania did prior to converting to their SBMs; Virginia is currently using SBM-FP in planned transition to SBM). These states gain an increased level of local control over consumer outreach and plan management. In return, federal government remits 0.5% of the state's FFM user fees to help fund these efforts.

Table 3. Characteristics of State-Based Marketplaces on Federal Platform, AKA "Hybrid" Exchanges

Category	Similar To	Notes
Legislation & Buy-In	SBM	May be possible to establish by executive order, with eventual legislation and stakeholder support needed.
Cost & Platform	FFM	*Cost* - Same 3% user fee as FFM states, but 2.5% goes to the FFM and 0.5% remitted to the state to offset cost of exchange - For 2022, CMS plans to reduce fees to 2.25% for SBM-FB states,[10] of which 0.5% will be remitted to state *Development* - Uses FFM platform (HealthCare.gov) for eligibility and enrollment functionality
Data Access	FFM	Limited data, with lag of a month or more

[8] "State marketplaces outperform the federal marketplace: enrollment and premium comparisons across state and federal marketplaces." National Academy for State Health Policy. April 1, 2019.

[9] "How assisters can help consumers apply for coverage through the marketplace call center." CMS. November 8, 2017.

[10] "Notice of benefit and payment parameters for 2022 final rule fact sheet." Centers for Medicare & Medicaid Services. January 14, 2021

Autonomy	Both	*Enrollment* (Like FFM) - Must adhere to FFM enrollment period; determined at federal level with no flexibility *State Oversight* (Like SBM) - State control over plan quality, including rates, and plan design
Consumer Support	Both	*Targeted Outreach* (Like FFM) - State responsible for outreach and marketing, but only receives limited data *Plan Compare* (Like FFM) - Uses generic plan comparison tool for all states *Call Centers* (Like SBM) - State-based and can address state-specific issues *Additional Support* (Like SBM) - Can train and deploy Assisters and Navigators to target specific areas of need

Table 4. History of CMS Fees 2014-2022

Year	FFM	SBM-FP
2014	3.5%	0.0%
2015	3.5%	0.0%
2016	3.5%	1.5%
2017	3.5%	1.5%
2018	3.5%	2.0%
2019	3.5%	3.0%
2020	3.0%	2.5%
2021	3.0%	2.5%
2022	2.25%	1.75%

V. BENEFITS OF TRANSITIONING TO SBM

1. *Increased enrollment and retention*[11] - Enrollment growth is one indicator of market health and is a consistent benefit observed in states that transitioned to SBMs. In the 2019 open enrollment period, FFM states saw enrollment decline nearly 4%, continuing a trend that started in 2017. During the same time period, SBM enrollment remained steady and, for some states, increased. SBM states have also been more successful at containing premium growth and maintaining affordable prices. These factors are related to:
    i. Open enrollment flexibility – States operating their own platform have the option to extend or shift their annual enrollment period. Longer sign-up periods are associated with an increase in plan selections.[12] A state may also choose to allow individuals with low or moderate incomes to enroll in plans at any time, which can contribute to enrollment increases throughout the year.[13]
    ii. Special Enrollment Periods (SEP) – Outside of the federal open enrollment window, consumers in FFM states can only purchase marketplace coverage if they experience a qualifying life event (e.g., losing health insurance, moving, getting married, etc.). SBMs have the autonomy to implement additional SEPs in response to local needs, including natural disasters.[14] Several SBMs allow users to self-attest to qualifying SEP events, rather than requiring them submit documentation like the FFM does. The following are examples of state-specific SEPs:
        a. COVID-19 – In 2020, twelve of thirteen SBMs implemented a broad SEP the early stages of the pandemic, an option that FFM states did not have due to the federal government's concern that it would lead to adverse selection and, in turn, higher premiums. However,

[11] "State marketplaces outperform the federal marketplace: enrollment and premium comparisons across state and federal marketplaces." National Academy for State Health Policy. April 1, 2019.

[12] "ACA Marketplace Open Enrollment Numbers Reveal the Impact of State-Level Policy and Operational Choices on Performance." The Commonwealth Fund. April 16, 2019.

[13] "Proposed change to ACA enrollment policies would boost insured rate, improve continuity of coverage." Center on Budget and Policy

[14] "During the COVID-19 crisis, state health insurance marketplaces are working to enroll the uninsured." The Commonwealth Fund. May 19, 2020.

evidence suggests that the SEP had the opposite impact: SBMs saw a relative increase among younger, healthier enrollees compared to the year before.[15]

b. Reduced Income – For people enrolled in off-marketplace minimum essential coverage (MEC) plans who experience income reduction that makes them newly eligible for marketplace subsidies.
c. State Premium Subsidy Awareness – For enrollees not aware of state-level premium subsidies.
d. Easy Enrollment Program – Maryland allows residents to initiate an SEP for an uninsured person in their household while completing a state tax return. (Note: recognizing that NH does not have an income tax makes this specific intervention moot, though it illustrates the flexible outreach a state may use.)

2. *Real-time access to consumer data*[16] – Consumer-level data is immediately available, allowing the state to analyze new and renewing customers—as well as who is not enrolling in marketplace coverage—by gender, age, race, ethnicity, geography, etc. The platform can also collect data to monitor users' interaction with the website and call center. This gives state officials the ability to:
   iii. Conduct timely analyses – Access to individual enrollment data would allow the state to proactively address common issues, such as simultaneous enrollment in multiple QHPs. Individual enrollment data also facilitates a more accurate churn analysis between Medicaid and the SBM. When paired with improved integration with the state Medicaid agency, this could lead to fewer lapses in coverage.
   iv. Improve consumer experience – The state may monitor what pages a user spends significant time on or leaves from and use that data to identify and revise confusing language or site navigation. Call center staff can have access to where a user is in the application process and what previous SBM communication they have received, allowing for faster resolution of issues.
   v. Tailor marketing and outreach efforts – States can launch a data-driven approach to increase the effectiveness and efficiency of campaigns. For example, Rhode Island saw increased plan selections after providing enrollment assistance at local community centers, and Colorado increased enrollment with targeted advertising (e.g., on Spanish-language radio stations) to reach specific populations.[17] SBMs have also been more successful engaging younger enrollees.[18]
3. *Potential for integrated eligibility systems* – Medicaid and other state benefit programs; potential to develop "no wrong door" eligibility and enrollment system.

VI. RISKS OF TRANISTIONING TO SBM

1. *Platform development and data migration*[19,20] – Though initially the HealthCare.gov platform was plagued with technological problems, in recent years it performs several complex functions relatively well, including extensive email outreach to consumers, resolving income-related data matching issues, and leveraging new technologies to create a streamlined enrollment process for consumers who rely on direct enrollment partners. To successfully transition to an SBM platform, the state must migrate consumer data from HealthCare.gov; limit data-matching issues and simplify the process for addressing them; and ensure that identity-proofing systems protect consumer information without presenting undo challenges. Second-generation technology vendors have demonstrated the ability to migrate consumer data and provide a state-based platform at approximately half the cost of the FFM, but there is significant price variation depending on the desired level of customization and other details. States must also coordinate outreach with CMS during the transition, which can provide bureaucratic challenges. Finally, a high level of oversight

[15] "Many states with COVID-19 Special Enrollment Periods see increase in younger enrollees." The Commonwealth Fund. January 28, 2021.
[16] "States seek greater control, cost-savings by converting to state-based marketplaces." Urban Institute. October 2019.
[17] "ACA marketplace open enrollment numbers reveal the impact of state-level policy and operational choices on performance." The Commonwealth Fund. April 16, 2019.
[18] "State-based health insurance market performance." National Academy for State Health Policy. September 2019.
[19] "Adopting a state-based health insurance marketplace poses risks and challenges." Center on Budget and Policy Priorities. February 6, 2020
[20] "Technology opportunities for the ACA marketplace." Manatt Health. December 2020.

and clear accountability are necessary for the development and implantation process to remain on time and on budget.

2. *Call Center and Navigator/Assistant Programs* – States relying on the FFM use the federal call center. FFM operators must adhere to general scripts that require complex issues to be transferred to state officials. States considering the switch to SBM should ensure that their new call center has adequately trained and supervised employees who are well-equipped to address the state-specific needs of residents. Some platform development vendors (e.g., GetInsured) offer all core exchange functions, including call centers, which minimizes the risks associated with multivendor coordination. Other vendors (e.g., MAXIMUS) specialize in operating Consumer Assistance Centers (CACs). Vendor staffing and training time estimates vary widely.[21] However, at least one state (Idaho) found that running its own call center was the most cost-effective option.[22]
3. *Limitations of Medicaid integration* – Although a well-integrated platform is a significant potential benefit of operating an SBM, it requires a strong interagency commitment to achieve. The process is also dependent of existing Medicaid technology and staff availability to coordinate the change.[23]
4. *Accurate cost projection* – Changing federal rules can undermine business planning and make it difficult to ensure marketplace stability and enrollment.

VII. ESTIMATED COSTS FOR NH SBM[24,25]

1. *Technology platform and call center* – These are the largest items in an SBM budget.
2. *Advertising* - States vary in the amount they spend on SBM advertising and outreach, but a larger investment is related to increased enrollment and improved risk pools. A 2018 survey of SBMs found that the advertising spending per uninsured resident vary widely depending on the media market, from less than $3 (Colorado) to over $65 in an expensive media market (District of Columbia) with an average of $13.23 per uninsured person. In 2019, NH had an uninsured population of about 84,600, so estimated advertising costs may be approximately $1M/year.
3. *Outreach* – State funded Navigator spending per uninsured person ranged from $2.20 (California) to $27.40 (Maryland) with an average of $13.37 per uninsured person. NH's estimated Navigator costs may be about $1M/year.
4. *State personnel* – to oversee operations and in some cases perform certain operations
5. All-in costs for SBMs in states recently converting range from $100-200/enrollee/year, including required functions and state personnel. At 2020 enrollment, this would be $4.5-8.9M annually for NH.

VIII. FUNDING OPPORTUNITIES

1. *User Fees* - All exchanges charge user fees or assessments that are calculated as a percentage of the premiums, though states have made different decisions about which insurers pay the fees and at what percentage. In 2018, NH health plans paid $10.6M in FFM user fees, at a rate of 3.5% of premiums for its 49,600 marketplace enrollees. If NH adopts the same fee as the FFM (states may elect to charge higher fees, as does Rhode Island), for 2022 or after, 2.25% of premium would yield about $7.0-8.0M annually (~$150-160/enrollee/year).
2. *Federal Medicaid Match* – CMS will match the costs for Medicaid-related work to support those enrollees (Minnesota, Pennsylvania[26], and Washington). The match may be at enhanced rates.

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[21] "Summary analysis of Nevada and New Mexico marketplace technology platform RFIs." DCBS Consumer and Business Services. January 7, 2019.

[22] "The Your Health Idaho Marketplace: A model for state-based adoption." Leavitt Partners Study. July 2018.

[23] "Technology opportunities for the ACA marketplace." Manatt Health. December 2020.

[24] "Adopting a state-based health insurance marketplace poses risks and challenges." Center on Budget and Policy Priorities. February 6, 2020

[25] "States lean in as the federal government cuts back on navigator and advertising funding for the ACA's sixth open enrollment." The Commonwealth Fund. October 26, 2018.

[26] Pennie Board of Directors Meeting Slide deck. July 17, 2020.

3. *1332 waiver* – SBMs are eligible for federal funding to support a reinsurance program or premium subsidies.[27] NH's current 1332 waiver supports reinsurance and thereby reduces premiums. We did not examine whether NH could revise its waiver to secure additional support.
4. *CMS Transition Funding* – CMS makes one-time grants of $2M to states to assist in an SBM transition. For NH, this amounts to about $40/enrollee (non-recurring).

IX. CONCLUSIONS

The ACA permits states to operate and control their own SBM, following federal rules and supported by several funding streams. This paper has outlined financial and non-financial aspects of conversion from FFP to SBM, the possible risks and benefits, and lessons learned from around the country. Converting to a hybrid SBM-FP may allow NH some added flexibility (including the ability to target specific groups for enrollment), while leaving platform and customer service operations to HealthCare.gov. Recent state conversions to SBM have been generally successful operationally and financially. If converting to an SBM, NH could potentially derive benefits of increased enrollment, integration with other programs, and lower costs. However, these benefits will be dependent upon the level of enrollment, changing federal policy, successful vendor procurement, and skilled state oversight.

[27] "What is a 1332 waiver?" HealthInsurance.Org. n.d.

X. APPENDIX

A. STATE CASE STUDIES

Table 5. Features of Recent State Transitions to State-Based Marketplaces

Notable SBM States				
State (Year Implemented) *Vendor(s)*	**2020 Enrollees**[28]	**Stated Transition Goals**	**Timeline**	**Cost Considerations and Notes**
Idaho[29] (2014) *GetInsured* *Accenture LLP*	78,431	"Maintain maximum control of the insurance market at minimum cost to consumers"	2013 – Adopted legislation 2014 – Launched SBM	In 2014, state awarded 5-year contract with two vendors totaling $41M ($104/enrollee/year, includes DDI, Project Management, and M&O)[30] Low-cost, capable vendors offering commercial off-the-shelf (COTS) solutions rather than building from scratch. One of the first *successfully* launched SBMs with lessons learned from other states, like not attempting to upgrade Medicaid systems while developing SBM platform. Prioritized operation/minimal essential functionality of marketplace. Incorporated marketplace into existing state infrastructure. SBM reimburses the Dept. of Health & Welfare for eligibility determination and call center functions; DOI handles plan management/rate review. In-house model is major source of cost saving; the only contracted services are system M&O and marketing activities.
Nevada[31] (2019) *GetInsured*	77,410	Cost savings, improve consumer experience, autonomy, access to data	2014 – Launched SBM 2015 – Switched to SBM-FP after IT failures 3/19/2018 – RFP issued 11/1/2019 – SBM launch (19 months from RFP to SBM)	In 2018, state awarded five-year, $24.4M contract with GetInsured ($63/enrollee/year). Once the SBM reaches a steady state, platform operation is expected to cost $6M/year ($78/enrollee/year) vs. $12M/year FFM fee. NV anticipates over 42% cost savings each year through FY2024 compared to using HealthCare.gov.[32] NV's all-in cost to operate its SBM is estimated as $172/enrollee/year.[33] NV met budget/schedule targets; call center was effective. Some technical issues arose at launch but were resolved quickly by vendor.

[28] "Total Marketplace Enrollment." Kaiser Family Foundation.
[29] "The Your Health Idaho Marketplace: A model for state-based adoption." Leavitt Partners Study. July 2018.
[30] "Your Health Idaho Announces Selection of Technology Vendors." GetInsured. February 21, 2014.
[31] "Nevada State Based Exchange Transition Talking Points." Nevada Health Link. February 25, 2019.
[32] "Fiscal and Operational Report." Silver State Health Insurance Exchange. December 31, 2020.
[33] "Adopting a state-based health insurance marketplace poses risks and challenges." Center on Budget and Policy Priorities. February 6, 2020

New Jersey[34,35] (2020) *GetInsured (DDI, M&O)* *MAXIMUS (call center)*	246,426	Stabilize market against ACA roll-backs, improve access	6/28/2019 – Adopted legislation 8/1/2019 – Submitted application 8/15/2019 – RFP issued 11/1/2019 – SBM-FP launch 11/1/2020 – SBM launch (14 months from RFP to SBM)	In 2019, state awarded five-year contract to GetInsured for $39.8M, and a 3-year contract to MAXIMUS for $17.8M. After initial set up, combined vendor cost for FY2021 estimated at $14.7M ($60/enrollee/year). Starting in 2021, NJ expects to generate over $200M in revenue from new 2.5% assessment of insurance premiums (replacing federal assessment that ended with 2020; NJ elected to charge a different rate than the federal platform).[36] Approximately $77M of this was dedicated to reinsurance program to address high-cost claims and lower premium costs, which made, the net premium for 2021 the lowest since HealthCare.gov implementation.[37] During first year as SBM, NJ enrolled over 9.4% more consumers than in 2020 and 5.6% more than 2019. In 2021 state also invested $3.5M in trained Navigators, up from $1.1 million in 2020 and $400,000 under the federal government in 2019. This expanded outreach allowed 16 local New Jersey organizations in the state to help residents enroll.[38]
Pennsylvania[39,40] (2020) *GetInsured*	331,825	Cost savings, operational efficiency, comprehensive, user-friendly consumer tool, access to data	2019 – Adopted legislation 4/19/2019 – RFP Issued 11/1/2020 – SBM launch (18 months from RFP to SBM)	In 2019, state awarded seven-year contract to GetInsured. Once the SBM reaches a steady state, PA expects platform operation to cost $33.3M ($100/enrollee/year), and total costs of $49.9M ($150/enrollee/year) vs. a FFM user fee of $98M/year. PA expects federal enhanced Medicaid match funding of $17.7M for 2022 to help reduce state costs by about a third.[41] First SBM open enrollment – 9.7% year-over-year increase. - Retained 97% of customers from Healthcare.com[42] - Sent over 7.5M emails to targeted customers - No major system, eligibility or enrolment blocking issues identified. - "Other issues resolved in timely fashion by GetInsured and KPMG"

[34] "Governor Murphy Announces New Jersey to Transition to State-Based Exchange." March 22, 2019.
[35] "NJ Department of Banking and Insurance announces selection of GetInsured to develop, operate tech platform & MAXIMUS to operate CAC for state-based HIX." NJ Dept. of Banking and Insurance. January 6, 2020
[36] "Governor Murphy signs legislation to restore a key provision of the Affordable Care Act and lower the cost of health care in New Jersey." Office of the Governor. July 31, 2020
[37] "Governor Murphy announces health insurance signups in NJ surpass previous two years." Office of the Governor. February 8, 2021
[38] "Governor Murphy announces launch of new state-based-health insurance marketplace, Get Covered New Jersey." Office of the Governor. October 14, 2020
[39] Pennsylvania RFP (Word Doc). Issued April 19, 2019
[40] "Pennsylvania moves to take over health insurance exchange." Associated Press. June 4, 2019.
[41] Pennie Board of Directors slide deck. November 18, 2020.
[42] Pennie Board of Directors Strategic Planning Session Feb 25, 2021.

Table 6. Features of States Considering SBM Transition

States Transitioning to SBM				
State (Model)	**Enrollees**[43] (2020)	**Transition Goals**	**Timeline**	**Cost Considerations and Notes**
Virginia[44,45,46] (FFM)	269,474	Cost savings, flexibility and autonomy, increased enrollment and affordability	7/1/2020 – Adopted legislation 12/15/2020 – Launched SBM-FP 2/10/2021 – RFP issued (5/1/21 scheduled award date) 1/1/2023 – Expected launch of full SBM	Estimated cost of SBM is $45M/year ($167/enrollee/year) vs. FFM user fee of $86M/year In August 2020, state awarded two Navigator programs $1.5M in grant funds. Reinsurance program currently under consideration
New Mexico[47,48] (SBM-FP)	42,714	Cost savings, greater flexibility, access to data	2013 – Adopted SBM legislation 2015 – Switched to SBM-FP 11/2021 – Expected launch full of SBM (originally planned for 11/2020)	Using the savings from switching to the hybrid model (SBM-FP), NM conducts outreach and education, operates a call center, contracts for plan management, and runs the SHOP program. Awarded contract to Optum and NFP Health to build, deploy, and operate SBM for policy year 2022. According to board meeting minutes from 11/2020, project is on track overall.

Table 7. Features of States Using State-Based Marketplace on Federal Platform

Notable SBM-FP States		
State	**Enrollees**	**Notes**
Maine[49]	62,031	Initially planned to become full SBM due to wanting greater flexibility to improve user experience and to invest current FFM user fees into state efforts to increase enrollment. Final decision to adopt, pending determination that SBM is cost-effective and aligned with state goals. 2019 – Gov. notified CMS of intention to implement SBM-FP for plan year 2021, SBM for plan year 2022 2020 – Adopted legislation and submitted SBM application 8/4/2020 – RFP for Navigator Services issued 11/1/2020 – Launched SBM-FP 1/1/2022 – SBM launch date (pending final decision to adopt)

[43] "Total Marketplace Enrollment." Kaiser Family Foundation.
[44] HB 1428 Virginia Health Benefit Exchange Summary
[45] "Virginia receives approval to expand access to health care through state-based exchange." Office of the Governor. August 21, 2020.
[46] "Virginia working to transition from federal insurance exchange to state-based marketplace." The Roanoke Times. February 8, 2020
[47] New Mexico Request for Proposals (Word Doc)
[48] beWellnm Board Meeting slide deck. November 20, 2020.
[49] "Maine progresses toward a state-based health insurance marketplace." Department of Health and Human Services. August 6, 2020.

		- During SBM-FP phase, Maine DHHS will assume more responsibility for outreach, marketing, and consumer assistance - Received $2M from federal government to pay for outreach efforts.[50] However, as an SBM-FP, Maine is no longer eligible to receive Navigator grants from the federal government.[51]
Oregon[52]	145,264	2011 – Adopted SBM legislation 2015 – Due to IT issues, switched to SBM-FP 2016 – Considered transitioning back to SBM, tabled for 3-5 years (was slightly more expensive to run their own exchange platform, but would have enabled the state to have a more finely-tuned enrollment platform, specific to Oregon's needs). 2018 – Reinsurance program began 2019 – RFI issued for vendors interested in developing SBM platform and customer service center. OR state's Marketplace Advisory Committee reports • Dissatisfaction with Healthcare.gov call center, lack of OR-specific regulations/plans • Desire for greater flexibility for enrollment dates o Looking to establish lower-cost, more efficient platform

[50] "Maine plans state-based marketplace for Affordable Care Act insurance." Consumers for Affordable Health Care. September 3, 2019.
[51] "2020 CMS Navigator Cooperative Agreement Recipients." CMS. N.D.
[52] Oregon Request for Information (PDF).

B. BUDGET DATA FROM OTHER STATES

Table 8. BUDGET DATA FROM SBMs

State	Total Expenditures & Per Enrollee Cost (2020 enrollment)	State Personnel Costs	Selected Operational/Contracted Costs	
Idaho[53] (FY2020) Enrollees: 78,431	$9,342,066 $119/enrollee/year	$3,437,367	*Professional Services*	$1,754,631
			Marketing/Advertising	$792,032
			Call Center Services	$2,143,701
Nevada[54] (FY2021 approved) Enrollees: 77,410	$21,076,085 (includes $6.6M cash reserve) $186/enrollee/year (excluding cash reserve)	$2,304,145 (22 FTEs)	*Exchange platform*	$5,669,055
			Marketing/Outreach	$3,249,004
			Navigators	$1,480,622
New Jersey[55] (FY2021 projected) Enrollees: 246,426	$43,774,355 $178/enrollee/year	$2,700,000	*Development*	$19,573,503
			Marketing/Outreach	$10,000,000
			Navigator/Enrollment Assistance Grants	$4,000,000
			Exchange Improvements	$7,500,00
Pennsylvania[56] (CY2021 proposed) Enrollees: 331,825	$49,958,630 $151/enrollee/year	$6,231,524 (30 FTEs)	Total:	$43,727,106
			External Affairs	$8,583,356
			IT/Customer Service	$33,274,350
			General Operations	$1,869,400
Rhode Island[57] (FY2020) Enrollees: 34,634	$10,821,172 $312/enrollee/year (RI is a 1st generation SBM)	$1,815,022 (12 State FTEs)	Total:	$7,749,311
			IT	$3,684,243
			Legal Services	$4,433
			Management/Consultant	$3,834,748
			Other Contracts	$225,887

C. VENDORS

Table 9. Prominent DDI Vendors in the SBM Landscape

Vendor (Founded)	**Experience**	**Growth/Stability**
CSG[58] (1997)	- In IA: Project management Office (PMO) and Independent Verification & Validation (IV&V) services - In RI – IV&V on Unified Health Infrastructure Project (UHIP), risk mitigation, and User Acceptance Testing (UAT) - In MA, IV&V oversight, risk management, validation testing and attestation for federal compliance	Less prominent in platform development
Deloitte[59] (1890)	- Responsible for RI's UHIP, which experienced major failures after 9/2016 launch and several years after. ACLU filed federal class action lawsuit over how platform's poor performance impacted	Losing customers. Uneven performance

[53] "Financial Statement." Idaho Health Insurance Exchange. June 30,2020
[54] "Fiscal and Operational Report." Silver State Health Insurance Exchange. December 31, 2020.
[55] "Fiscal Year 2021 Revised Budget Proposal." New Jersey Department of Banking and Insurance. November 1, 2020.
[56] "Pennie Board of Directors Slide Deck." December 17, 2020.
[57] Rhode Island Health Insurance Exchange Budget (page 74)
[58] CSG Delivers website: https://csgdelivers.com/program-expertise/healthcare/health-insurance-marketplace/
[59] Deloitte's website: https://www2.deloitte.com/us/en/pages/public-sector/solutions/health-insurance-exchange-life-sciences-and-health-care-services.html

	low-income, elderly, and disabled residents. In 2019, Deloitte paid RI/federal government settlement, agreed to discount rates.[60] - In 2020, was sued over security vulnerabilities found in OH pandemic unemployment website data.[61] - In 2021, FL Chief Inspector General released findings that the unemployment system Deloitte built had several fatal defects prior to 2013 launch that caused system failure during pandemic.[62]	
GetInsured[63] (2005)	- CA, ID using platform for six years. - Recently transitioned NV, NJ, and PA from FFM platform. - Can manage and operate call center; tightly integrated into platform[64] - For PA, lowest cost proposal among Qualified Offerors	Growing exponentially; consistently used since 2014. Provides full individual SBMS (end-end)
Optum[65] (formally hCentive; 2009)	- Served as a general contractor to HealthCare.gov in 2013 - Used by CO, NY, and NM. - Brought in by MD after they terminated original vendor (Noridian Healthcare Solutions).[66]	Provides full individual SBMS (end-end)

[60] "R.I. still unsure how much it will get from $50-million Deloitte settlement." Providence Journal. May 21, 2019.
[61] "Deloitte sued over pandemic unemployment website data breaches." Bloomberg Law. May 22, 2020.
[62] "Review of the Department of Economic Opportunity Florida Connect System." Office of the Chief Inspector General. March 4, 2021.
[63] GetInsured's website: https://company.getinsured.com/
[64] PA Health Insurance Exchange Authority Board of Directors Special Session Slide Deck. PHIEA. November 13, 2019
[65] Optum's Website: https://www.optum.com/business/solutions/government/state/health-insurance-exchange.html
[66] "Maryland fires contractor that built troubled health insurance exchange." Washington Post. February 24, 2014.

D. KEY CONSIDERATIONS AND LESSONS LEARNED

Certifi - Transitioning to a State-Based Exchange: A Complete Guide (10/20/2020)	NASHP – Advice from Marketplace leaders (5/20/2019) [slide deck]	Urban Institute Health Policy Center – States Seek Greater Control, Cost-Savings by Converting to SBM	Center on Budget & Policy Priorities - Adopting a SBM Poses Risks and Challenges (2/6/2020)
Steps to Transitioning: 1. Get buy-in a. Legislative stakeholders b. Payers 2. Select Vendors a. Technology b. Call center c. Security d. Marketing/ Communications 3. Migrate data 4. Create marketing plan 5. Maintain enrollment 6. Ongoing innovation	1. Focus on the basics 2. Prioritize consumer experiences 3. Set clear expectations and timelines 4. Build Stakeholder relationships a. State policy makers b. State agencies c. Governor's office d. Federal officials e. Insurance carriers f. Navigators/Brokers g. Consumers 5. Establish clear leadership that can take action 6. Use SBM as health reform "hub" across agencies 7. Adapt over time	1. Know and articulate state goals 2. Set realistic expectations 3. Allow for sufficient lead time 4. Engage stakeholders early and often **Primary driving factors transition** - Prospect of cost savings - Improved consumer experience - Autonomy over insurance markets	1. Set targets for increased enrollment across programs. 2. Determine immediate, concrete ways that SBM can match/exceed FFM user experience 3. Prioritize significant investments in marketing, outreach, and enrollment assistance. 4. Commit to—and make immediate strides towards--a "no wrong door" eligibility and enrollment system 5. Ensure that SBM spending will be sufficient to provide high-quality services to residents and achieve the state's other goals for the transition. 6. Protect consumers from subpar health plans and problematic web-broker/insurer marketing practices. 7. Leverage the establishment of SBM to advance broader policy changes.

Stakeholder engagement tips - See Implementation of ACA in Kentucky: Lessons Learned to Date and the Potential Effects of Future Changes

New Hampshire Legislature
Health and Human Services Committee
Testimony of Jason Sparks, GetInsured
9/23/21

Introduction

Senator Bradley and Committee Members,

Thank you for the opportunity to testify on the topic of establishing a State-Based Health Insurance Marketplace (SBM) in New Hampshire. On behalf of GetInsured, I'm grateful for Senator Bradley's leadership, and for holding this discussion on New Hampshire's need to exert greater control over its own healthcare future.

Prior to joining GetInsured, I held the Chief Information Officer position at DC HealthLink, the State-Based Marketplace in Washington, D.C. In my 4 years in that capacity I had the opportunity to work on the marketplace's successful implementation and operations. Prior to DC HealthLink, I led operations for Enroll America, a nationwide non-profit focused on health insurance education and outreach. Based on these experiences, and the more than ten years I've spent in the public and private sectors on healthcare policy, I can tell you firsthand of the importance for states to regulate their own health insurance markets.

States, rather than the federal government, are in the best position to be responsive to and address the unique needs of their markets, citizens, and communities. States are also at the forefront of finding creative and innovative ways to address the crises facing America's healthcare system today — high costs, poor outcomes, coverage and care inequities, to name a few. Establishing a State-Based Marketplace is an important step for New Hampshire to begin to chart its own course in healthcare.

What is a State-Based Health Insurance Marketplace?
Under federal law, a public health insurance marketplace serves as a gateway to access federal premium tax credits. These marketplaces also play an important role in how consumers shop for and enroll in health insurance coverage, providing not only the front-end shopping experience through the marketplace website and application process, but also deciding which plans will be certified as Qualified Health Plans (QHPs). By law, if a state does not establish and operate its own marketplace, the federal government must step in and run one on its behalf. New Hampshire's marketplace has been run by the federal government since 2013. In 2021 nearly 47,000 Granite Staters are enrolled in health insurance through the federal marketplace.

State Flexibility
New Hampshire's 1332 waiver and resulting reinsurance program demonstrate that when a state begins to take more control over its health insurance market, lower premiums and higher enrollments follow. New Hampshire saw **a modest increase in enrollments and an average of 16 percent decrease in**

premiums year one after establishing its reinsurance program. This is an example of the benefits of policy flexibility. Following are some additional examples of flexibilities an SBM would afford New Hampshire.

The pandemic provided a real-life example of how operating a state-based marketplace provides a state with the flexibility it needs to best serve its constituents and balance the needs of all stakeholders in an insurance market. The Special Enrollment Periods (SEPs) that SBMs offered are a very clear illustration of how a state can set forth policies that best fit their needs. **Regardless of whether the federal government is running a special enrollment period or not, a state-based exchange can determine its own SEP policies.**

State-based marketplaces can also determine how long, or short, their open enrollment periods will operate. As confirmed in Friday's final CMS rule, State-Based Marketplaces "with their own eligibility and enrollment platforms will be able to set their own annual Open Enrollment Period end dates, so long as these dates are on or after December 15, 2021." Each state knows its health insurance markets — insurance carriers, assisters and brokers, commercial group, and individual plans, as well as the uninsured populations, and can **put forth policies that best serve consumers regardless of how the federal government is running its OEP.**

Now is the time for New Hampshire to take action to reassert a traditional role in overseeing its health insurance markets by establishing their own State-Based Marketplace, building on the momentum the reinsurance program began. It's also a wise defensive measure against potential federal encroachment on state authority and can also serve as a platform for future market- and consumer-oriented reforms – all based on real time data the SBM provides.

Why Should New Hampshire Establish a State-Based Marketplace (SBM)?
There are three overarching reasons New Hampshire should establish its own SBM:

1. **Establishing an SBM will give New Hampshire more control over the direction of its health insurance market and will protect the state from restrictive, and potentially harmful, federal regulations.** Under federal law, states operating their own SBMs are given significant latitude to design and implement exchanges within federal standards. In addition, SBMs have the authority to set and collect user fees as well as determine rules around special and annual enrollment periods.

2. **Better technology and lower costs make it easier than ever for states to establish and operate their own SBMs, saving taxpayers and enrollees money.** Like with most other technologies, the cost of building a marketplace has gone down significantly while technology and performance have drastically improved since 2013 and the early days of state marketplaces. Recently, GetInsured successfully migrated three states from the Federal platform: Nevada, Pennsylvania, and New Jersey. GetInsured created these marketplaces at a fraction of the cost of earlier marketplaces.

These states, along with Idaho (the first state that chose to migrate from FFM to SBM), are also able to operate their marketplaces at lower costs than other states — and the federal government. Today, federal platform fees (2.75% of premiums in 2022) are passed along to consumers in the form of higher health insurance premiums. In 2020, New Hampshire enrollees sent nearly $10 million in hidden taxes to Washington to cover the cost of the federal marketplace. By establishing its own SBM, New Hampshire would have the opportunity to reduce this burden on consumers by charging a lower user fee, or seeking an alternative means to fund marketplace operations, such as using CMS funds, both of which would help to lower premiums.

3. **A well-designed SBM can serve as the foundation for future, creative and market-based reforms.** Because of the additional regulatory and design flexibility afforded them, SBMs can also be effective platforms for implementing new market-oriented health reforms, such as:

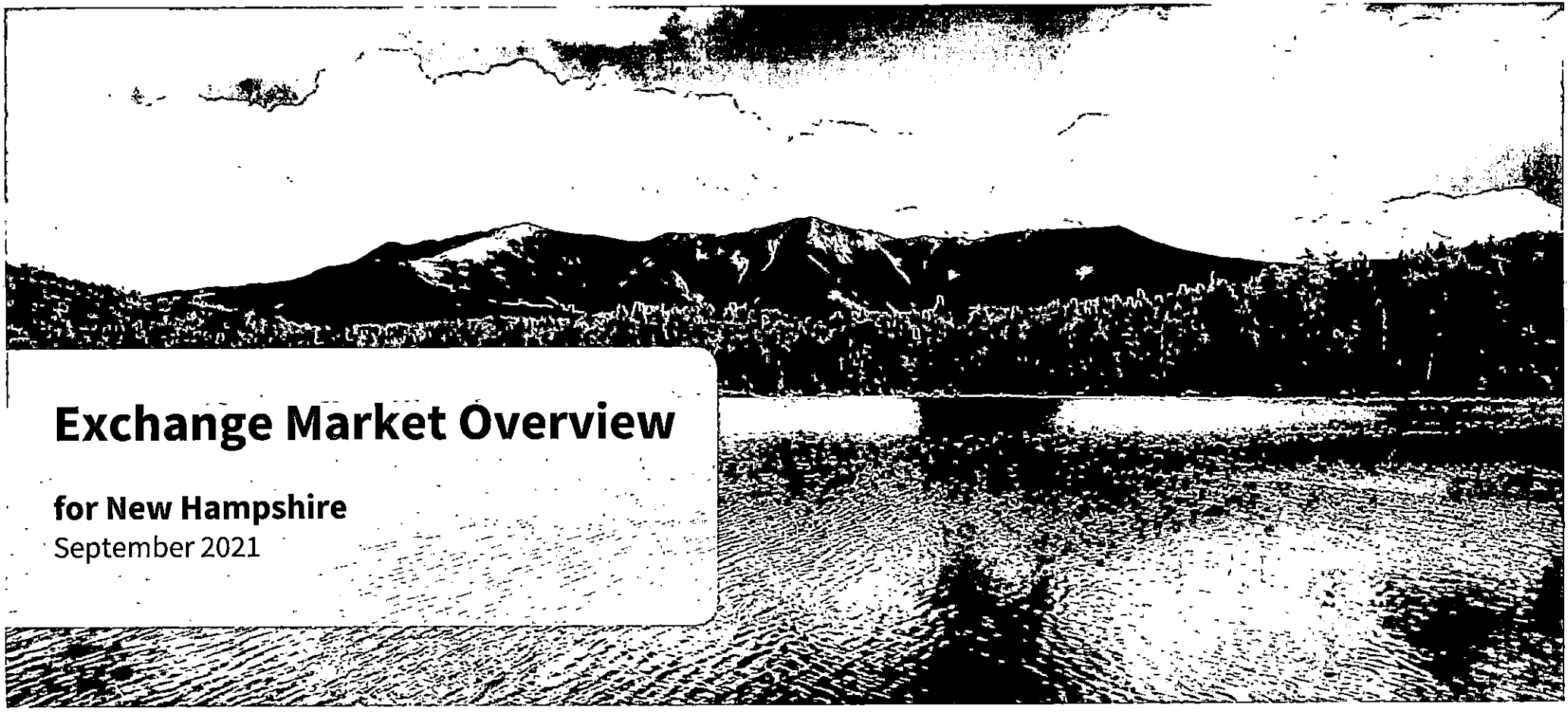
    - **Additional Plan Options:** Expand the availability of catastrophic plans, potentially increasing consumer choice and making coverage more affordable.
    - **Account-Based Subsidies:** Direct public subsidies into a defined-contribution, consumer-directed account that an individual uses to pay health insurance premiums or other health care expenses.
    - **Support for Churn Population:** The QHP and Medicaid populations tend to move between the programs frequently and only a locally run SBM can work closely with the Medicaid department to optimize the consumer experience and prevent gaps in coverage.

Conclusion

We at GetInsured have seen firsthand the benefit of state autonomy and flexibility in addressing the unique needs of health insurance markets and consumers around the country, but specifically at our clients: Idaho, Nevada, Minnesota, Pennsylvania, California and New Jersey. In the current political environment, it is more important than ever that states take back authority over their health insurance markets to the maximum extent possible. Establishing an SBM is an important step states like New Hampshire can take to not only shelter themselves against federal regulations, but also to plan for future, market-based reforms that give consumers greater choice and improve affordability.

Thank you for the opportunity to testify today, and I look forward to taking any questions.

GetInsured



Exchange Market Overview

for New Hampshire

September 2021

GetInsured

About GetInsured

Founding Mission: Leverage Modern Technology to Bring Transparency and Efficiency to Healthcare

Broad Healthcare Experience

More than 15 years' experience with consumers, brokers, carriers, and state exchanges

Market Leader

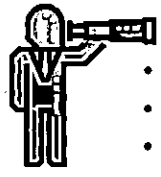
- Only vendor with proven FFM to SBM transition experience
- GetInsured technology powers 70% of all SBM enrollments
- 7 SBMs leverage the GetInsured platform

National Footprint

- Offices across the US
- 500+ employees
- Exceptional engineering and healthcare talent

Proven "Exchange SaaS" Solution

- Award-winning cloud-based SaaS technology platform
- Integrated consumer assistance center



Seasoned Organization

- Venture backed – Bessemer Venture Partners
- Financially stable
- Visionary leadership team

GetInsured

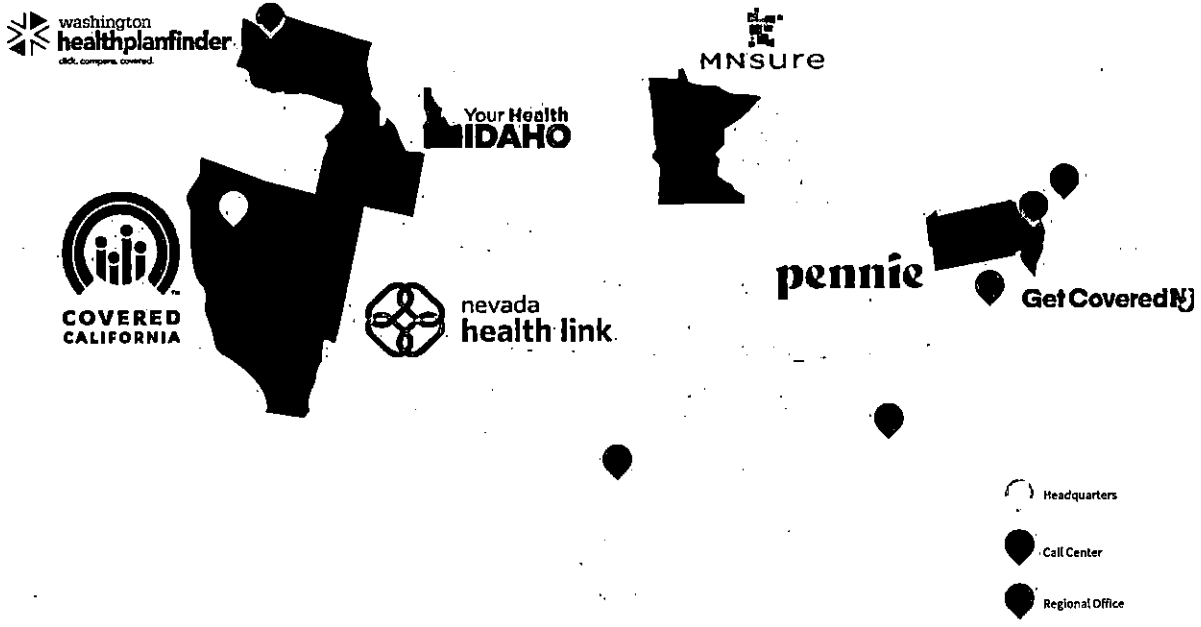
We are a Market Leader in State Exchanges

70%
of Exchange enrollments supported by GetInsured technology

99%
Household Renewal Rate year-over-year

STATES

We lead the market with seven State-Based Exchanges clients including California, Idaho, Washington, Minnesota, Pennsylvania, New Jersey, and Nevada.



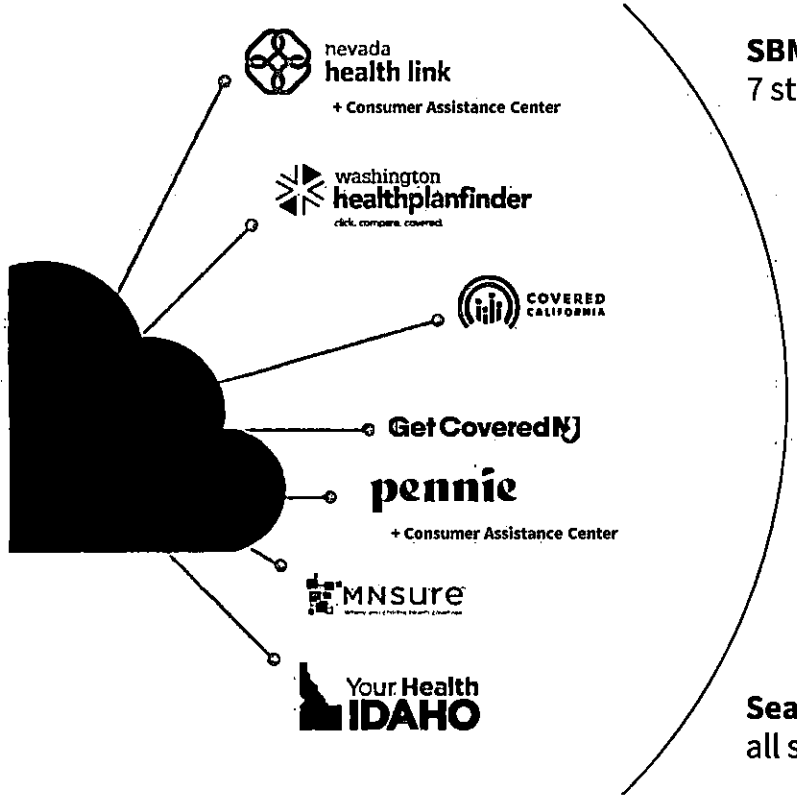
29
Successful open enrollments across 7 Exchanges

25M
transactions to date

2.6M
Americans using the GetInsured platform

State-Based Marketplace Implementations

Integrated Solution, Seasoned Team, Low-Risk Project Approach



SBM Market Leadership and Scale: More than 2 million enrollments annually; 7 states, 8,000 brokers, and 1,000 plans

Proven Cloud-based SaaS Technology Platform: Configurable, scalable, and cost-efficient platform; award-winning user experience

Seamless FFM to SBM Transition Track Record: Comprehensive data migration blueprints; expertise in pre-built complex integrations

Integrated Consumer Assistance Center: SBM-ready, holistic consumer experience via efficient sharing of tools, workflows, and knowledge base

Low Risk Implementations: Flawless launch on-budget, on-time, every time; pass all CMS gate reviews

Seasoned Team: Strong expertise with regulatory requirements; deep engagement with all stakeholders

GetInsured

Highlights from Our Implementations

2014 — COVERED CALIFORNIA

- **1st and largest ACA Exchange**
- Pioneered "Single Door" eligibility model
- Passed all CMS gate reviews
- Lowest incidence of CMS disputes
- Supported Medicaid expansion
- Implemented CA state subsidy for PY2020

2015 — Your Health IDAHO

- **Nation's first FFM to SBE transition**
- Flawless launch in 10 months from award
- Recognized as most efficiently run SBM
- Pioneered FFE data migration blueprint in close collaboration with CMS, DHW, & the Exchange
- 60% of consumers select plans using provider search

2017 — washington healthplanfinder (click. compare. covered.)

- **Powerful decision support tools increase percentage of consumers who select recommended plans from 45% in 2018 to 56% in 2019.**
- 54% of consumers used provider or prescription search.
- Plan management allowed for close collaboration between the Exchange & carriers.

2018 — MNsure

- Decision support launched for 2019 OEP
- **Smooth transition from the legacy system of record (home-grown) and marketplace (Connecture) to GetInsured platform**
- Integrated eligibility determination model using METS (Minnesota Eligibility Technology System) re-configured to integrate using Account Transfer

GetInsured

Highlights from Our Implementations (cont'd)

2019	nevada health link	• On-time data migration from FFE to SBE • **Flexible eligibility determination model: consumers may apply on the Exchange portal or through DWSS** • **Single vendor for exchange platform and consumer assistance center**	• New BrokerConnect™ to increase carrier engagement • Projected cost savings to exceed $6 million for 2020 alone • Exceptional Circumstances SEP due to COVID-19
2020	pennie	• **Single vendor for exchange platform and consumer assistance center** • Exchange in the box and migration services • "No Wrong Front Door" eligibility determination	• **Remote call center operation due to COVID-19 impact** • **Integration with the Exchange's marketing platform** • **98.6% 2021 household renewal rate**
2020	Get CoveredNJ	• Exchange in the box and migration services • **One door/integrated eligibility and MitC** • **Subsidy integrated into eligibility and enrollment experience for go-live**	• **99.97% 2021 household renewal rate**

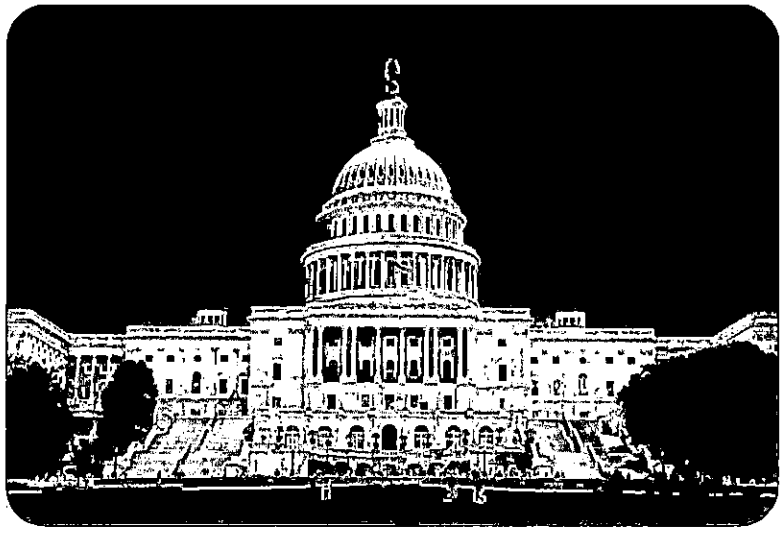
State Exchange

September 2021

GetInsured

Biden Administration has increased Federal Subsidies for health insurance purchased through Exchanges

New, more generous subsidies from the Biden Administration are expected to add as much as 12.3 million more people to this market nationally over the next five years, effectively doubling the enrollments.



The American Rescue Plan Act (ARPA) includes the following provisions at a cost of $34B:

- Removes the 400% FPL cap through 2022
- Anyone can access subsidies, even if employed
- Net cost of insurance now capped at 8.5% of income
- Funds $0 cost premiums for uninsured

New Hampshire added 9k enrollees during the Special Enrollment Period February 15 – August 15, 2021.

New Hampshire can choose to craft its own healthcare policies once a New Hampshire state exchange is in place.

GetInsured

Introduction: Why Build a State-Based Marketplace

The move from the FFM to a State-Based Marketplace is risk-free because end-to-end (call center, technology, and operations) solutions are readily available from private vendors with a proven track record. The exchange operates as a public-private partnership or quasi-government entity.

Operating costs for States on the FFM are uncertain and will likely increase to support Biden Administration policies. Worse, HealthCare.gov is built to support many states with an inflexible infrastructure that will not easily support policy flexibility. High-level benefits of building an SBM include:

- Independence from Federal Government - Local control, transparency
- Cost savings, which can be repurposed for reinsurance
- Lower premium growth rates, ability to innovate with state policy
- Better consumer experience
- Better control and access to the state data for planning purposes
- Better collaboration with carriers, easier reconciliation
- Increased enrollments
- Better churn management between Medicaid and commercial insurers
- Local call-center jobs

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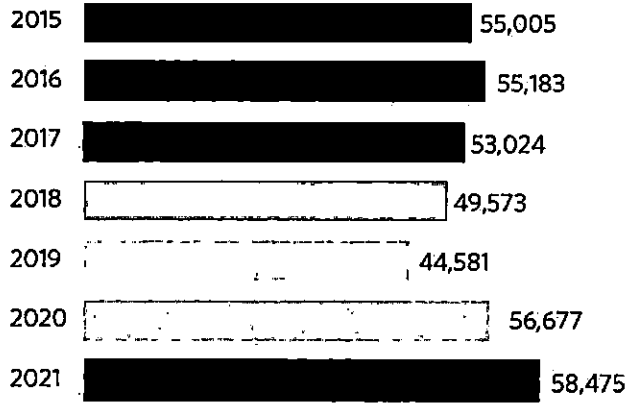
JM156

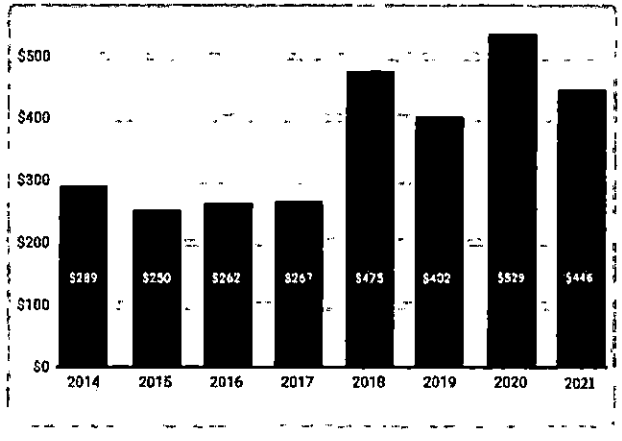
Impact of Premiums: Lower Premiums Lead to Higher Enrollment

- Since 2014, New Hampshire has seen premium increases as high as 77.9% year-over-year. Due to reinsurance, the premium in 2021 is to drop up to 20 percent.
- By operating state exchange, New Hampshire will realize cost savings in comparison to the FFM assessment fees which carriers pay and pass on to the consumer in the form of higher premiums. This could allow for premium reductions resulting in higher enrollments. Some states with state exchanges have seen premiums up to 20% lower than the FFM, according to the Commonwealth Fund.

New Hampshire's Enrollment Trend (2014 - 2021)



New Hampshire's Premium Trend (2016 - 2021)



Slide 10

PN319 [@Jennifer Milner] - can you please update w/NH numbers?
Paul Neutz, 9/18/2021

PN321 The 2020 enrllment numbers are off. and the 2021 premiums dropped significantly due to the resinsurance program
Paul Neutz, 9/18/2021

JM153 Pls review
Jennifer Milner, 9/18/2021

PN325 Is the source of the data KFF?
Paul Neutz, 9/19/2021

JM156 CMS PUF files for 2020/2021, don't remember where we got the older numbers

Jennifer Milner, 9/19/2021

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Projected New Hampshire FFM User Fees in 2022

Based on assessment fees of **2.75%**

Estimated average monthly premiums of **$476**

Estimated PY2022 effectuated enrollments **46k**

NH's estimated payment to Healthcare.gov in 2022 **$8.1 million**

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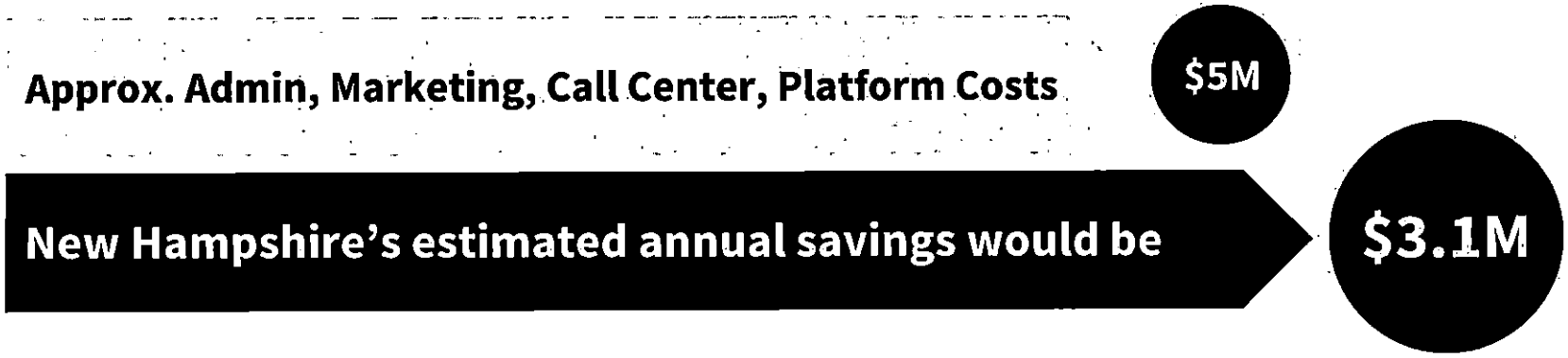
Projected Cost Savings of a New Hampshire State-Based Marketplace in 2022

- When the ACA first launched and states were building exchanges, the technology was new, oftentimes cumbersome, and certainly very costly.
- Today, with several years of experience under their belts, private vendors can build modular systems for a fraction of the original cost of setting up an exchange. These savings go back to the state.
- Nevada (with 77k enrollees) estimates that user fee would translate into costs of $12 million for the state; but with their own platform, operational costs will be closer to $6 million — a savings of 50 percent
- Idaho (with 75k enrollees) has been operating an exchange since 2014 at an annual budget of around $9.5M



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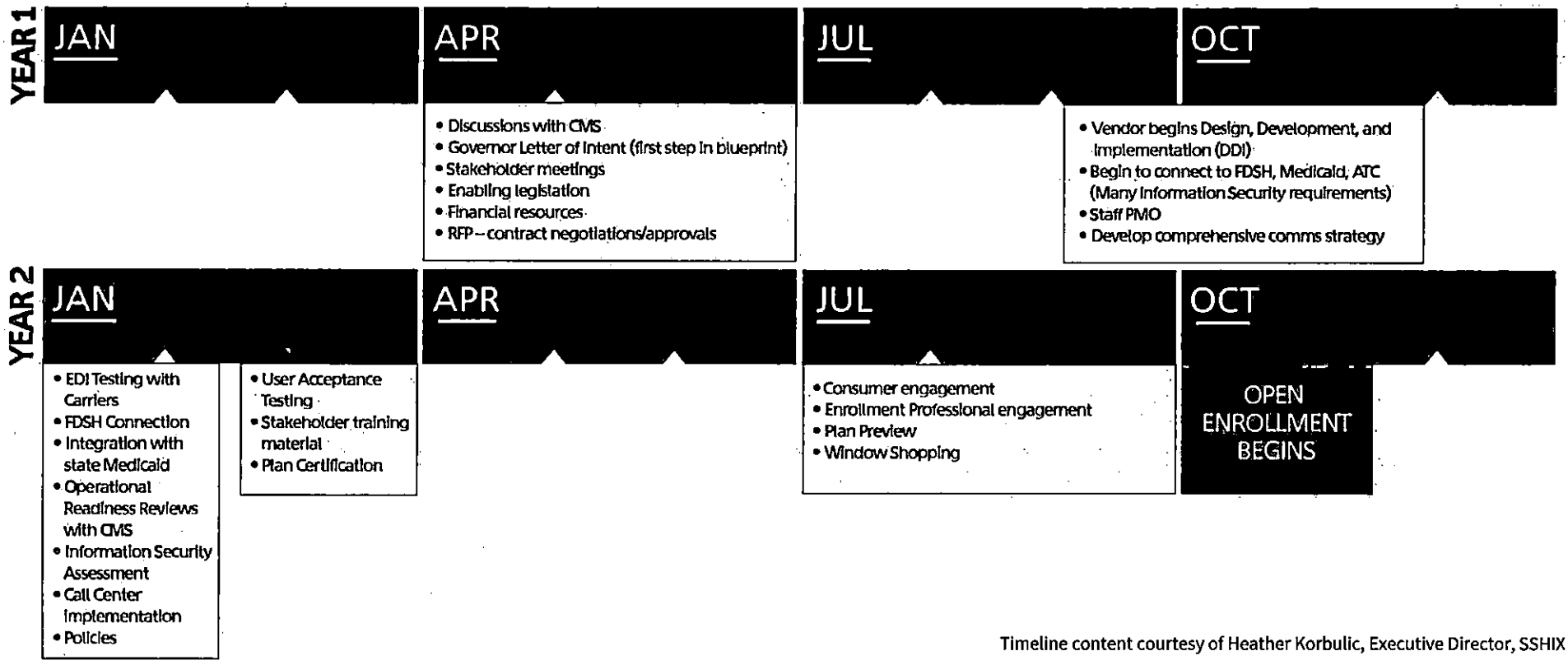
Example Implementation Timeline: SSHIX Nevada



Timeline content courtesy of Heather Korbulic, Executive Director, SSHIX

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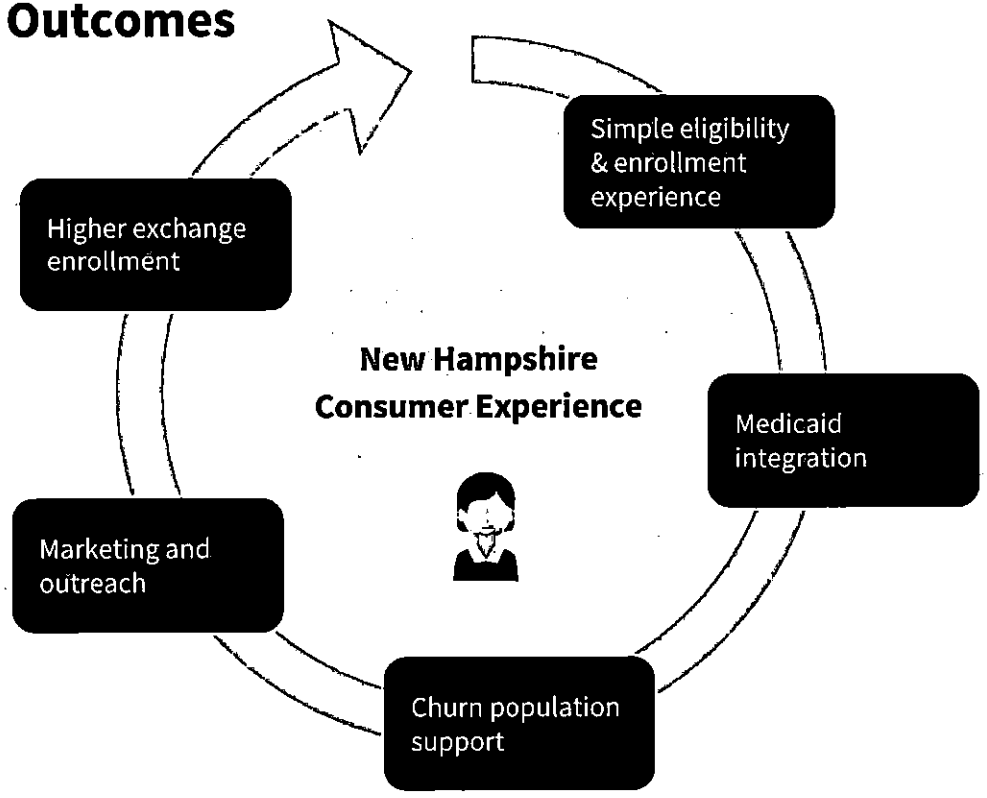
In Summary: Key Outcomes



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Thank You for Your Time

Voting Sheets

Senate Health and Human Services Committee
EXECUTIVE SESSION RECORD
2021-2022 Session

Bill # SB 121

Hearing Date: 2/10/21

Executive Session Date: 3/24/21

Motion: Re-refer to committee **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X	X		X	
Sen. Avard	X		X	X	
Sen. Sherman	X			X	
Sen. Whitley	X			X	

Motion: Consent Calendar **Vote:** 5-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X			X	
Sen. Gray, Vice Chair	X	X		X	
Sen. Avard	X		X	X	
Sen. Sherman	X			X	
Sen. Whitley	X			X	

Motion: _____ **Vote:** _____

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Motion: _____ **Vote:** _____

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Reported out by: Sen. Avard

Notes: _____

Senate Health and Human Services Committee
EXECUTIVE SESSION RECORD
2021-2022 Session

Bill # SB 121

Hearing Date: 9/23/21 (2nd hearing)

Executive Session Date: 10/26/21

Motion: Amendment #2021-2153s OTP **Vote:** 4-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X	X		X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard					
Sen. Sherman	X		X	X	
Sen. Whitley	X			X	

Motion: OTPA **Vote:** 4-0

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair	X	X		X	
Sen. Gray, Vice Chair	X			X	
Sen. Avard					
Sen. Sherman	X		X	X	
Sen. Whitley	X			X	

Motion: _____ **Vote:** _____

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Motion: _____ **Vote:** _____

Committee Member	Present	Made by	Second	Yes	No
Sen. Bradley, Chair					
Sen. Gray, Vice Chair					
Sen. Avard					
Sen. Sherman					
Sen. Whitley					

Reported out by: Sen. Bradley

Notes: _____

Committee Report

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE
FOR THE CONSENT CALENDAR

Wednesday, March 24, 2021

THE COMMITTEE ON Health and Human Services

to which was referred **SB 121**

AN ACT relative to a state-based health exchange.

Having considered the same, the committee recommends that the Bill

BE RE-REFERRED TO COMMITTEE

BY A VOTE OF: 5-0

Senator Kevin Avard
For the Committee

This bill requires the insurance department to examine the implementation of a state health exchange and implement such an exchange upon approval of the joint health care reform oversight committee. The Senate Health and Human Services Committee unanimously voted for this bill to be re-referred to committee. The New Hampshire Insurance Department completed an initial report. The committee decided it would be best to re-refer the bill to further analyze the costs, benefits, liabilities, and federal changes relating to the bill.

Kirsten Koch 271-3266

FOR THE CONSENT CALENDAR

HEALTH AND HUMAN SERVICES

SB 121, relative to a state-based health exchange.
Re-refer to Committee, Vote 5-0.
Senator Kevin Avard for the committee.

This bill requires the insurance department to examine the implementation of a state health exchange and implement such an exchange upon approval of the joint health care reform oversight committee. The Senate Health and Human Services Committee unanimously voted for this bill to be re-referred to committee. The New Hampshire Insurance Department completed an initial report. The committee decided it would be best to re-refer the bill to further analyze the costs, benefits, liabilities, and federal changes relating to the bill.

STATE OF NEW HAMPSHIRE

SENATE

REPORT OF THE COMMITTEE

Thursday, October 28, 2021

THE COMMITTEE ON Health and Human Services

to which was referred **SB 121**

AN ACT relative to a state-based health exchange.

Having considered the same, the committee recommends that the Bill

OUGHT TO PASS WITH AMENDMENT

BY A VOTE OF: 4-0

AMENDMENT # 2021-2217s

Senator Jeb Bradley
For the Committee

Kirsten Koch 271-4151

HEALTH AND HUMAN SERVICES

SB 121, relative to a state-based health exchange.
Ought to Pass with Amendment, Vote 4-0.
Senator Jeb Bradley for the committee.

General Court of New Hampshire - Bill Status System

Docket of SB121

Docket Abbreviations

Bill Title: relative to a state-based health exchange.

Official Docket of **SB121.**:

Date	Body	Description
1/29/2021	S	**Introduced** 01/06/2021 and Referred to Health and Human Services; **SJ 3**
2/5/2021	S	Remote **Hearing:** 02/10/2021, 08:45 am; Links to join the hearing can be found in the Senate Calendar; **SC 10**
3/24/2021	S	Committee Report: Rereferred to Committee, 04/01/2021; Vote 5-0; CC; **SC 17**
4/1/2021	S	Rereferred to Committee, **RC** 23Y-1N, MA; 04/01/2021; **SJ 10**
9/8/2021	S	**Hearing:** 09/23/2021, Room 100, SH, 10:00 am; **SC 36**
12/16/2021	S	Committee Report: Ought to Pass with Amendment **#2021-2217s**, 01/05/2022; **SC 49**
1/5/2022	S	Committee Amendment **#2021-2217s**, AA, VV; 01/05/2022; **SJ 1**
1/5/2022	S	**Ought to Pass with Amendment** 2021-2217s, MA, VV; OT3rdg; 01/05/2022; **SJ 1**
3/23/2022	H	Introduced 03/17/2022 and referred to Commerce and Consumer Affairs
3/30/2022	H	Public Hearing: 04/06/2022 01:30 pm LOB 302-304
3/30/2022	H	Subcommittee Work Session: 04/07/2022 10:00 am LOB 302-304
4/13/2022	H	Executive Session: 04/20/2022 01:00 pm LOB 302-304
4/22/2022	H	Committee Report: Refer for Interim Study (Vote 18-0; CC)
5/4/2022	H	Refer for Interim Study: MA VV 05/04/2022 **HJ 11**

NH House | NH Senate

Other Referrals

Senate Inventory Checklist for Archives

Bill Number: SB 121 **Senate Committee:** HHS

Please include all documents in the order listed below and indicate the documents which have been included with an "X" beside

X Final docket found on Bill Status

Bill Hearing Documents: {Legislative Aides}

X Bill version as it came to the committee

X All Calendar Notices

X Hearing Sign-up sheet(s)

X Prepared testimony, presentations, & other submissions handed in at the public hearing

X Hearing Report

___ Revised/Amended Fiscal Notes provided by the Senate Clerk's Office

Committee Action Documents: {Legislative Aides}

All amendments considered in committee (including those not adopted):

___ - amendment # _____ X - amendment # 2021-0843s Rosenwald

___ - amendment # _____ ___ - amendment # _____

X Executive Session Sheet

X Committee Report

Floor Action Documents: {Clerk's Office}

All floor amendments considered by the body during session (only if they are offered to the senate):

___ - amendment # _____ ___ - amendment # _____

___ - amendment # _____ ___ - amendment # _____

Post Floor Action: (if applicable) {Clerk's Office}

___ Committee of Conference Report (if signed off by all members. Include any new language proposed by the committee of conference):

___ Enrolled Bill Amendment(s)

___ Governor's Veto Message

All available versions of the bill: {Clerk's Office}

X as amended by the senate ___ as amended by the house

___ final version

Completed Committee Report File Delivered to the Senate Clerk's Office By:

Kirsten Koch 11/4/2021

Committee Aide **Date**

Senate Clerk's Office AK