Inside
HEALTH INSURANCE EXCHANGES

Volume 3, Number 11 • July 4, 2013

Timely News and Strategies for Developing and Operating Federal, State and Private Exchanges

Contents

Get instant health reform news! Follow **HEX** *on Twitter at http://twitter.com/AISReform or "Like" AISHealth on Facebook.*

Managing Editor
Steve Davis
sdavis@aishealth.com

Executive Editor
Jill Brown

ACA Mandate Delay Gives Employers Breathing Room, but Few Details on Rule

The Obama administration will delay for one year the employer-mandate provision of the health reform law, according to a July 2 blog post by Mark Mazur, assistant secretary for tax policy at the Treasury Dept.

While the delay gives employers some breathing room, it will mean less revenue from anticipated penalties for the administration. And for critics, it's another indication that the law is flawed. While some industry observers interviewed by *HEX* say the decision is a prudent move by the administration, others question the method the administration chose to announce the delay. And details about what exactly employers and carriers need to do to comply with the provision are still needed.

The law requires employers with 50 or more employees to offer affordable health coverage or pay a $2,000 per-employee penalty (the first 30 employees are exempt.)If the coverage offered is deemed unaffordable, the penalty increases to $3,000 for each employee who accesses a federal premium subsidy through an insurance exchange. Employers also must implement systems to track and report information about the coverage they offer to employees. In response, some employers have indicated that they would reduce their full-time labor forces to avoid the penalties and reporting requirements.

Chip Kerby, an employee benefits attorney at the Washington, D.C.-based law firm Liberté Group, says it was expected that the administration would offer some leniency in the first year of the requirement. He says he was most surprised that the administration announced the delay via blog post from "a second-level" Treasury official.

continued on p. 6

Federal Premium Subsidies Could Mean Big Enrollment Gains for Medicaid Companies

Commercial coverage is unchartered territory for most Medicaid managed care firms, but those carriers could have some huge advantages over their more mainstream competitors on state insurance exchanges.

Case in point: Massachusetts-based Neighborhood Health Plan (NHP) saw its enrollment nearly double to about 230,000 — due in part to the state's 2006 reform law (*HEX 10/11, p. 3*). The company offers Medicaid and subsidized and individual products through the Connector as well as commercial group and individual products outside of it.

However, launching a commercial product could be challenging for pure-play Medicaid managed care plans, which typically lack experience in managing risk the way they would need to do with a commercial population. Moreover, their contracted provider networks might not align with those of the commercial carriers, which could make them less attractive to higher-income consumers. FamilyCare Health Plans, a Medicaid managed care firm that applied to offer coverage through Oregon's exchange, recently withdrew its filing, says spokesperson Vicki Guinn. In May, FamilyCare's proposed rates for individual coverage landed on the high end of

the price spectrum among carriers that submitted rates (*HEX 5/16/13, p. 1*).

Medicaid companies contacted by *HEX* say they intend to focus on the low-income uninsured and the low-income parents of children they already cover. "They're already tapped into those family units, so this is a way to bring the whole family together. [Medicaid carriers] really do see exchanges as an opportunity," says Jeremy Palmer, a principal and consulting actuary in Milliman's Indianapolis office. They'll also be able to capture some of the "churn" as income fluctuations push and pull low-income enrollees between Medicaid and subsidized commercial coverage, he adds.

Molina Eyes Nine Exchanges

Molina Healthcare, Inc. is targeting low-income people who transition in and out of Medicaid as income changes, parents of children who receive coverage through state Children's Health Insurance Programs (CHIP) and low-income uninsured who earn too much to qualify for Medicaid. The company intends to offer individual coverage through exchanges in nine of the 10 states where it has existing Medicaid operations.

People with annual incomes of between 134% and 250% of the Federal Poverty Level (FPL) "are the ones who will be eligible for the largest subsidies and are the most in sync with the [Medicaid] population we have today," says Lisa Rubino, president of Molina Healthcare of California. "There has never been a better time to be a Medicaid health plan with the opportunities in front of us,…the exchanges and the expansion of Medicaid."

Although Molina will offer coverage statewide on some exchanges, coverage in other states will be limited to targeted counties where most of its Medicaid lives are concentrated. Seven of the state exchanges where Molina participates will be operated by the federal government, so carriers won't know if they'll be participating until final certification after Labor Day.

Molina, along with several national and regional Medicaid managed firms, expects to participate in Texas' federally facilitated insurance exchange. About 2.8 million uninsured Texans have annual incomes between 100% and 400% of the FPL and will be eligible for federal premium subsidies.

CHC to Offer Bronze, Silver, Gold

Community Health Choice (CHC), a Medicaid managed care firm that serves the Houston market, proposed bronze, silver and gold plans for the exchange. Different cost-sharing plan designs could mean four variations of the silver plan. While the premiums will be the same, the copayments and annual deductibles will be lower for applicants with the lowest incomes, says CHC President and CEO Ken Janda. CHC will target the uninsured on the lower end of the income scale and people who already have some connection to the company, such as through a child enrolled in the CHIP program, he tells *HEX*.

In Texas, Medicaid covers pregnant women with incomes up to 185% of the FPL and children from families with incomes up to 200%, but there is no Medicaid coverage for childless adults. And because Texas opted not to expand Medicaid eligibility, as called for by the reform law, childless adults who earn less than 100% of the FPL won't qualify for either Medicaid or federal premium subsidies.

The company has about 245,000 enrollees, and Janda projects the exchange could bring in anywhere from 2,500 to 30,000 new members. "We just don't know how fast the take-up rate will be in the first year. And we don't know if we will have one or four or six or 12 QHPs plans…and we don't know how our premiums will compare, but we hope it will be competitive," he tells *HEX*. "If we have the lowest-cost silver plan, we may get more members than we anticipate, but if we are $100 more than others, it will be very difficult to get people to choose us."

Some states required or urged their Medicaid carriers to submit bids to participate on their exchanges.

Inside Health Insurance Exchanges (ISSN: 2161-1521) is published 24 times a year by Atlantic Information Services, Inc., 1100 17th Street, NW, Suite 300, Washington, D.C. 20036, 800-521-4323, www.AISHealth.com.

Managing Editor, Steve Davis; Executive Editor, Jill Brown; Publisher, Richard Biehl; Marketing Director, Donna Lawton; Fulfillment Manager, Tracey Filar Atwood; Production Director, Andrea Gudeon.

Subscriptions to *HEX* include free electronic delivery in addition to the print copy, e-Alerts when timely news breaks, and extensive subscriber-only services at www.AISHealth.com that include a searchable database of *HEX* content and archives of past issues.

To order an annual subscription to **Inside Health Insurance Exchanges** ($482 bill me; $452 prepaid), call 800-521-4323 (major credit cards accepted) or order online at www.AISHealth.com.

Nevada, for example, required its Medicaid managed care firms to offer at least one silver and one gold qualified health plan (QHP) in its exchange. One silver QHP from each Medicaid company will be designated as a "Transition QHP," explains Jon Hager, executive director of the Silver State Health Insurance Exchange. "If you are enrolled in a [Medicaid managed care plan] and become ineligible for Medicaid, you will [have] the opportunity to enroll in the appropriate Transition QHP." An online information release form, which enrollees can choose to sign, will allow information — such as preauthorizations and transition of care information — to be transmitted from the Medicaid managed care carrier to the commercial Transition QHP. The commercial carrier can then manage the enrollee's care, potentially without needing to ask for additional information from the enrollee's providers, he explains.

Medicaid managed care plans that do participate in state insurance exchanges must offer the same commercial products as other carriers. Washington state, for example, requires carriers to offer only silver and bronze options, while California's exchange requires products from all four metal tiers.

Five Advantages for Medicaid Firms

Small Medicaid managed care firms could find it tough to compete with well-financed commercial carriers that have brand recognition, deep pockets and big advertising budgets. And some people will be reluctant to enroll in a health plan offered by a Medicaid company. But Medicaid firms will have some important advantages. Here's a look at five of them:

(1) A sicker population: It's expected that many people who apply for federally subsidized coverage through exchanges will have been uninsured for several years, and could have multiple chronic conditions. From an actuarial standpoint, those enrollees will be more similar to dual-eligibles (i.e., people who qualify for both Medicare and Medicaid) than to members of the commercially insured individual market, said John Gorman during a June 13 panel discussion at the Gorman Health Group's annual forum outside of Washington, D.C. "Between 80% and 90% of people coming into the exchange are going to be people who will be bouncing on and off of Medicaid rolls and other sources of insurance at some point during the year," he told attendees. "So if you're participating in the exchange, but don't have a Medicaid product on the other side of the poverty limit, then you are looking at losing one-third to one-half of your membership in churn every year."

(2) Lower-cost provider networks: For the subsidized population, Medicaid managed care companies are in the enviable position of being able to offer network providers higher rates than they receive for Medicaid patients. Commercial carriers, however, will be asking providers to accept lower rates to help keep premiums competitive. Rubino agrees that negotiating higher rates with providers will be an important advantage when enhancing Molina's existing provider networks. Janda admits that hospitals typically want commercial rates, but with such a high uninsured population, CHC is trying to convince hospitals that joining its network will help them reduce uncompensated care. "We're not shifting people out of existing insurance,"

Free Health Coverage…Probably Isn't

Federal subsidies available through state and federal insurance exchanges will be based on the second-lowest-cost silver plan. For people with annual incomes between 100% and 150% of the federal poverty level (FPL), the subsidy could mean no premiums for bronze-level plans. However, those enrollees would face higher copayments and deductibles than people enrolled in a silver plan that has a higher actuarial value.

Consider this: Premiums for a silver plan for a 30-year-old non-smoker earning $12,000 a year might cost $300 per month, and a $280 subsidy would drop that down to $20 per month. That same subsidy would cover the entire premium for a bronze plan. However, carriers need to warn applicants that the actuarial value of a bronze plan is just 60%, which will mean significantly higher deductibles and copays when compared to a silver plan that has a 94% actuarial value.

Emphasizing the bare-bones plans "could cause problems with providers if people choose the so-called free option, but can't afford to cover the out-of-pocket costs. Providers could wind up with a lot of bad debt because they can't afford the high deductible," warns Ken Janda, president and CEO of Community Health Choice (CHC), a Medicaid managed care firm that serves the Houston market. "You're not doing your providers or your enrollees any favors by trying to steer them to the free plan. We would be better off getting them to pay a bit more for much better coverage."

Contact Janda at ken.janda@chchealth.org.

he explains. "Some hospitals agree with us and some don't."

(3) Brand recognition among low-income: While large commercial carriers tend to have better brand recognition overall, that isn't necessarily the case when it comes to the lower-income population. Neighborhood Health Plan of Rhode Island (NHPRI), for example, submitted a bid to participate in the individual and small-group markets in Rhode Island's exchange. "They feel like their brand among the lower-income population is very strong," says Palmer. NHPRI and Blue Cross & Blue Shield of Rhode Island are the only carriers in that state to have submitted bids for the individual market.

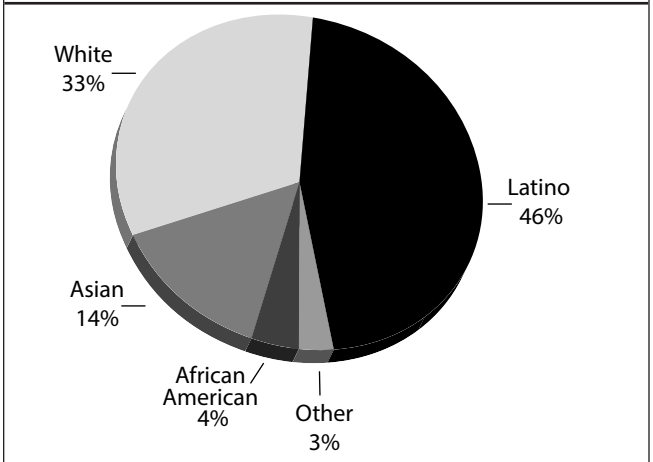
(4) Lean administrative margins: Medicaid health plans also are accustomed to operating with lean administrative margins. Nationally, Medicaid managed care firms had a profit margin of less than 1% in 2012, according to Palmer's recent research. And these firms have been using risk adjustment for many years, which could give them a leg up when dealing with the risk-adjustment provision of the reform law. Rubino agrees, adding, "we are very frugal in how we spend the government's money."

(5) Existing relationships with essential community providers: Health plans that offer QHPs on an exchange are required to include in their network "a sufficient number and geographic distribution of providers that serve predominately low-income, medically underserved individuals," CMS explained May 13 in a list of frequently asked questions. As a Medicaid company, Molina also already has relationships with essential community health providers, as required by the reform law. "We didn't have to go out and forge new relationships like many commercial carriers," Rubino adds. She says her company also employs a culturally sensitive staff, and offers services such as free transportation and onsite child care to help remove barriers that keep people from seeking care.

Contact Sunny Yu for Rubino at sunny.yu@molinahealthcare.com, Hager at jhager@exchange.nv.gov, Palmer at jeremy.palmer@milliman.com, Janda at ken.janda@chchealth.org and Guinn at vickig@familycareinc.org. ✧

California's Subsidy-Eligible Population by Ethnicity

In California, Latinos account for nearly half of all uninsured. Here's how it breaks down.



SOURCE: Covered California, July 2013

HHS, AARP Launch Efforts to Reach, Educate Uninsured Latinos

Latinos make up about 17% of the U.S. population, yet account for one-third of the nation's uninsured (see chart, this page). And nearly half of the nation's uninsured Latinos are under the age of 26, according to *Kaiser Health News*.

Enrolling that young and healthy population could improve the overall risk pool. To reach them, HHS recently re-launched CuidadoDeSalud.gov, the Spanish version of HealthCare.gov, which also was revamped and re-launched in June. And HHS is pushing its top officials — including Sec. Kathleen Sebelius — to make themselves available to Spanish-speaking media outlets to discuss exchanges and other provisions of the reform law.

On June 24, AARP launched its outreach effort, which is aimed at older uninsured Latinos and their families. It's a difficult population to reach. Many uninsured Latinos have low incomes, don't understand how health insurance works and are unfamiliar with the basic terminology. But they do understand that insurance is important to the health and security of their families, explains Andres Castillo, AARP's senior advisor for Hispanic education and outreach. "We felt like this is a community where we could make a positive social impact by explaining the law, and the benefits and protections of having insurance," he tells *HEX*.

'Promotoras' Could Help Extend Reach

To reach this population, AARP is partnering with a variety of prominent national and local Latino organizations that have a strong community presence. Some of the groups work with "promotoras," volunteers from Latino communities who receive specialized training to disseminate basic health information to residents.

CASA de Maryland is tapping its 20 promotoras to help explain exchanges, federal subsidies and coverage requirements. CASA de Maryland is one of 10 organizations in the state's two most populous counties that will

receive a portion of the $7.8 million the state has dedicated to its navigator program. AARP isn't specifically working with that organization.

Castillo says that Latinos tend to have higher rates of diabetes and obesity than non-Hispanic populations. The promotoras "took it upon themselves to educate their communities" about the risks of obesity and how to manage diabetes. AARP will educate those volunteers so that they can educate people in their communities about health insurance and the reform law, and will tap into this network of promotoras affiliated with the Hispanic Federation in the New York tri-state area.

AARP also is collaborating with the National Council of La Raza, Esperanza and the League of United Latin American Citizens. And on Aug. 1, AARP will launch a Spanish-language consumer tool, which will be available then at www.mileydesalud.org.

Contact Allyson Funk for Castillo at afunk@aarp.org. ✧

CMS's Final Rule Outlines Exceptions to Individual Mandate

Low-income people who live in states that opted not to expand Medicaid eligibility won't be subject to the financial penalties called for by the health reform law, according to a final rule CMS released on June 26.

The 139-page final rule outlined nine narrowly defined exemptions to the law's individual mandate. The rule exempts, among others, low-income individuals who can't afford coverage, undocumented immigrants, Indian tribal members and their dependents, and members of certain religious sects.

The rule isn't expected to have much of an impact on carriers or on the penalties collected by the federal government. A majority of individuals who qualify for the exemption would have qualified for Medicaid under Section 2001(a) of the Affordable Care Act "and thus would not have been commercially insured or subject to the penalty to begin with," explains Dan Schuyler, a director at the consulting firm Leavitt Partners who helps guide the firm's health insurance exchange practice.

The categories included in the rule cover individuals who: (1) cannot afford coverage, (2) have a household income below the tax filing threshold, (3) are members of federally recognized Indian tribes, (4) have experienced a "hardship," (5) have experienced a coverage gap of less than three months, (6) are members of certain religious sects, (7) are members of a health care sharing ministry, (8) are incarcerated, and (9) are not lawfully present. The IRS also issued two related notices.

In an accompanying guidance, CMS spells out the circumstances that may constitute a hardship, including homelessness; domestic violence; death of a close family member; natural or human-caused disaster; substantial medical debt; and caring for an ill, disabled or aging family member.

continued

The June 26 final rule also addresses a requirement that HHS, in coordination with the IRS, designate certain types of coverage as "minimum essential coverage." These includes Medicare and Medicaid programs, the Children's Health Insurance Program, a health plan for Peace Corps volunteers and coverage under grandfathered health plans. Individuals who are covered by one of these programs do not have to pay the penalty.

To see the rule, visit http://tinyurl.com/na9uhwn. ✧

Employers Get Mandate Delay

continued from p. 1

This administration has "the most well-oiled communication machinery we've ever seen," he quips. "It just struck me as a strange, somewhat defensive, way to communicate."

More importantly, Kerby notes that no one knows anything about how the reporting provisions will work and what employers and carriers will need to do to comply. "I'm shocked these details are still up in the air — we don't know what employers are going to have to report; we don't know what carriers are going to have to report." He says that despite the one-year delay in enforcement, IRS guidance is needed sooner rather than later. "Employers and carriers need time to prepare, test and implement."

According to Mazur's post, rules related to the reporting requirements will be issued this summer.

Delay Is in Response to Employers

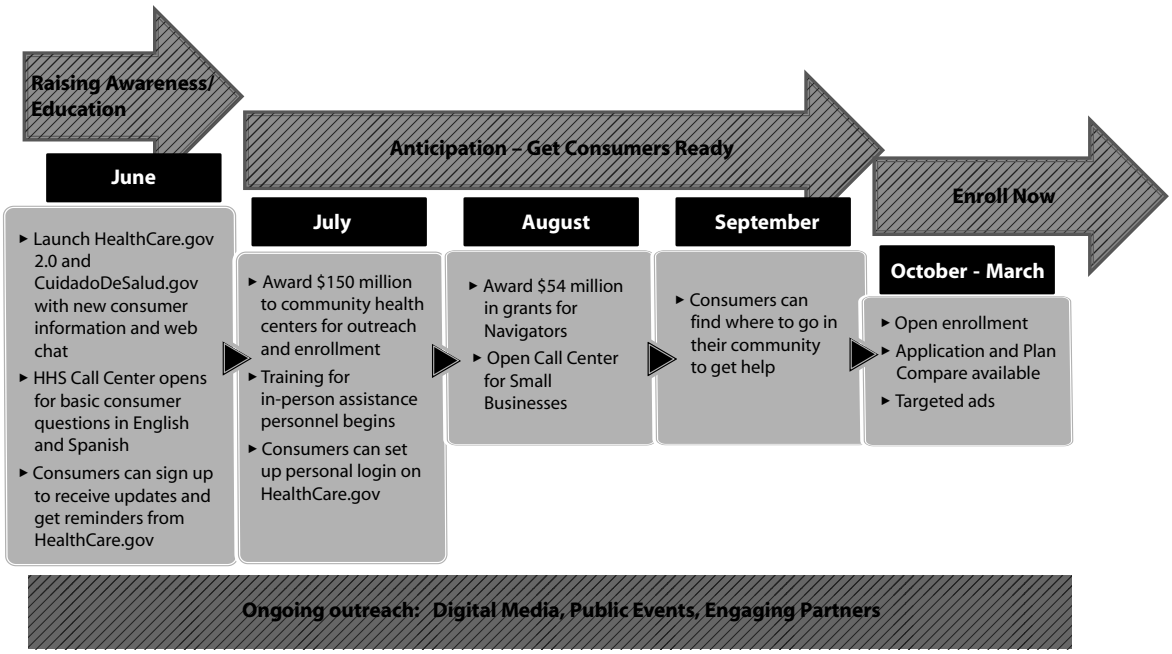
According to Mazur, the decision was made in response to employers' concerns about the complexity of the requirements, and the limited time available to comply.

"The administration no doubt felt it had to move to avoid the Affordable Care Act being tarred as a job-killer with employers laying off employees or reducing them to part time to avoid the penalty," says Tim Jost, a Washington and Lee University law professor who serves as a consumer representative for the National Association of Insurance Commissioners.

"I view this as a sensible move that helps to ensure the longer-term success of the ACA," adds Rosemarie Day, president of Day Health Strategies in Somerville, Mass. "We took this sort of flexible approach to implementing key provisions of health reform in Massachusetts, and it paid off in the long run." Day helped launch and operate Massachusetts' insurance exchange, the Commonwealth Connector, in 2006.

CMS Says Exchanges Are 'On Target'

Under the banner "On Target for Opening the Health Insurance Marketplace," CMS on June 24 issued a timeline offering a very basic overview of what will happen between now and Oct. 1 in the development of insurance exchanges and the outreach to potential enrollees.



SOURCE: CMS, June 24, 2013. Visit www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/marketplace-outreach-timeline.pdf.

Jost says the administration's reasons for the delay are "serious." The technical problems of preserving a health insurance system overwhelmingly based on employer-sponsored coverage while creating a parallel government-financed private individual insurance system are immense, and the administration wanted time to make sure the interface worked, he explains.

And Joel Ario, who headed CMS's Office of Health Insurance Exchanges, says the decision to delay the requirement "was a good move, giving all parties time to find a flexible approach to employer reporting without impeding the coverage goals of the ACA. Employers have legitimate concerns about efficiency that can be worked out with extra time." Ario now is managing director at Manatt Health Solutions.

What Will Be Delayed Next?

The delay of the employer mandate could be seen as an acknowledgement that the federal data services hub won't be ready to verify employer health plan offerings by Oct. 1, according to a July 3 note to investors from Brian Wright, an equities analyst at Monness, Crespi, Hardt & Co., Inc. He points to Mazur's comment that "Real-world testing of reporting systems" in 2014 will contribute to a smoother transition to full implementation in 2015. But if employer-sponsored coverage isn't verifiable because of voluntary reporting in 2014, "then more people could say they aren't offered employer coverage and garner subsidies," he wrote.

Kerby suggests that the delay also makes it impossible for the Treasury to enforce the individual mandate and to correctly determine eligibility for premium tax credits. Mark Lutes, an attorney at Epstein Becker & Green, agrees and says the same complexity issues exist in exchange implementation. "If later they are acknowledged and accommodated, then there would need to be a concomitant delay in the individual mandate," he says. In March, HHS indicated it would delay a feature of the Small Business Health Options Program in federally facilitated and state-partnership exchanges that would allow employees to choose from a menu of health plan options in each metal tier (*HEX 4/3/13, p. 6*). HHS also made premium aggregation optional for state-based exchanges in 2014 and mandatory in 2015.

To read Mazur's blog post, visit http://tinyurl.com/potye8b.

Contact Jost at jostt@wlu.edu, Ario at jario@manatt.com, Kerby at chip@libertegroup.com, Lutes at mlutes@ebglaw.com and Day at rosemarie@dayhealthstrategies.com. ✧

EXCHANGE BRIEFS

◆ **While six health insurers have applied to participate in Iowa's insurance exchange, Wellmark Blue Cross Blue Shield, the state's largest carrier, will not participate in that state's insurance exchange until 2015**, *The Waterloo Cedar Falls Courier* reported July 1. Wellmark has 2 million members in Iowa and South Dakota. The newspaper quotes Wellmark CEO John Forsyth saying he was concerned about the government's ability to roll out the new marketplace. The carriers that have applied to participate are Coventry Health Care of Iowa, CoOportunity Health, Avera Health Plans, Gunderson Health Plan, Sanford Health and Health Alliance Midwest. Coventry and CoOportunity Health intend to offer coverage statewide, while the others will be available regionally, the newspaper reported. Iowa is one of six states that opted for a state-federal partnership exchange model.

◆ **In a June 28 letter, 16 Republican members of the House Ways and Means Committee asked HHS Sec. Sebelius to explain how the federal data services hub will protect sensitive patient information.** The letter was prompted by the Government Accountability Office's recent reports on the status of federally facilitated and state exchanges. Maryland's insurance exchange last month became the first state-based exchange to send and receive information via the hub *(HEX 6/19/13, p. 1)*. See the letter at http://waysandmeans.house.gov/uploadedfiles/hhs_data_hub.pdf.

◆ **The National Football League has indicated it will not lend its star power to promote the health reform law or insurance exchanges after two high-ranking Republican senators warned that doing so would indicate the league supports a controversial law**, which could taint the NFL's brand. Late last month, Senate Minority Leader Mitch McConnell (R-Ky.) and Minority Whip John Cornyn (R-Texas) wrote letters to the commissioners of the NFL, Major League Baseball, National Basketball Association, National Hockey League, Professional Golf Association and the chairman and chief executive officer of NASCAR, and urged them not to help the Obama administration "promote new health insurance plans under Obamacare." The senators referred to the law as "one

EXCHANGE BRIEFS (continued)

of the most divisive and polarizing political issues of our day." See the letters at www.mcconnell.senate.gov.

◆ **The American Library Association announced that 17,000 libraries will be part of its effort to make information and computer time available to the nation's uninsured.** The initiative will provide public libraries with information about the reform law and will connect librarians with CMS Navigators and certified application counselors to help their patrons understand the options for enrollment in health insurance through the exchanges, according to a July 1 statement from CMS. Visit www.cms.gov.

◆ **California's health insurance exchange, Covered California, on June 25 revealed the pediatric dental health plans that will be sold on the marketplace.** The six selected companies are WellPoint, Inc. unit Anthem Dental, Blue Shield of California, Delta Dental of California, Health Net Dental, LIBERTY Dental Plan and Premier Access Dental. Coverage includes stand-alone plans, and all offerings can be bundled with health insurance for a single premium. Nine stand-alone plans are being offered by five issuers, while Health Net Dental is available only in a bundled option, Covered California said. Visit http://tinyurl.com/osxyzpx.

◆ **On June 28 — his last day on the job — Rhode Island Health Insurance Commissioner Christopher Koller released final 2014 rates for individual, small-group and large employers.** The two carriers that will participate in the state's exchange — Blue Cross & Blue Shield of Rhode Island and Neighborhood Health Plan of Rhode Island — saw their final rates decrease 5% and 10%, respectively. With final forms and rates approved, the next step for the state's exchange is to enter into final discussions around which plans will be offered on the exchange. Upon conclusion of this process, qualifying plans will be approved for inclusion on the exchange, according to Koller's office. Koller left the office to take over a foundation in New York City. Visit www.ohic.ri.gov.

◆ **Insurance carriers that intend to participate in Mississippi's federally facilitated exchange are avoiding some of the poorest rural parts of the state, which could leave more than 50,000 residents without any coverage options**, despite qualifying for federal subsidies, according to *Kaiser Health News*. Private insurers have applied to offer coverage in just 46 of Mississippi's 82 counties. Insurance Commissioner Mike Chaney has indicated that uncertainty about the law has kept BlueCross BlueShield of Mississippi, which now offers coverage statewide, from applying to sell coverage through the exchange. HHS has extended a deadline and is allowing Mississippi to give carriers several more weeks to file applications to sell coverage, according to the article. Visit the Mississippi Insurance Dept. at www.mid.ms.gov.

◆ **Montana's state Auditor Monica Lindeen (D) said that an actuarial study indicates that coverage offered through the state's insurance exchange this fall will cover more services and be less expensive than individual policies available now**, according to a June 25 article in the *Billings Gazette*. Three carriers — Blue Cross Blue Shield of Montana, PacificSource Health Plans, and the Montana Health CO-OP — filed paperwork with Lindeen's office to sell products on the marketplace. Blue Cross Blue Shield of Montana also submitted forms for a multi-state plan, a product developed under a contract with the federal government. Visit Lindeen's office at www.csi.mt.gov.

◆ **Prime Therapeutics LLC — a pharmacy benefit manager collectively owned by 13 Blue Cross and Blue Shield plans — has launched an educational Web site, PrimeHelps.com, aimed at people who will be shopping for coverage through an insurance exchange.** The site features an introductory video, a questions-and-answers section to help people understand pharmacy benefits, and a dictionary explaining terms and phrases in simple-to-understand language. If a person is ready to explore plan options, the site directs them to the appropriate Blue Cross and Blue Shield plan. Prime will launch a "pre-enrollment site on Sept. 1 that will offer plan comparison and drug comparison tools. People use their pharmacy benefits up to 11 times a year, but they use their medical benefits just 1.5 times a year, on average," Prime's Chief Marketing Officer Michael Showalter tells *HEX*. "So people are going to care a lot about their pharmacy benefits" when shopping for health coverage on the exchanges. Prime is the nation's second largest PBM in the individual market, serving more than 21 million members. Provisions of the reform law that go into effect in 2014 could add another 1 million members, the company estimates. Visit www.primetherapeutics.com.

If You Don't Already Subscribe to the Newsletter, Here Are Three Easy Ways to Sign Up:

1. Return to any Web page that linked you to this issue

2. Go to the MarketPlace at **www.AISHealth.com** and click on "Newsletters."

3. Call Customer Service at 800-521-4323

If you are a subscriber and want to provide regular access to the newsletter — and other subscriber-only resources at AISHealth.com — to others in your organization:

Call Customer Service at **800-521-4323** to discuss AIS's very reasonable rates for your on-site distribution of each issue. (Please don't forward these PDF editions without prior authorization from AIS, since strict copyright restrictions apply.)