SOFTHEON

# HIX 3.0

## Sustainable Information Technology and Operations Solutions for State-Based Marketplaces

# Introduction

In the early days of the Patient Protection and Affordable Care Act (ACA), there was an expectation that most (if not all) states would establish a State-Based Marketplace(SBM). However, for several well-documented reasons,most states deferred to or relied on the Federally Facilitated Marketplace (FFM) for most – or all – of their Marketplace operations and information technology (IT). These decisions led to the formation of a "spectrum of relationships" between states and the federal government related to Marketplace operations and IT:

**State-Based Marketplace on the Federal Platform (SBM-FP):** Several states that declared they would establish their own marketplaces decided to rely on – and pay for usage of – FFM functionality while retaining select SBM functions.

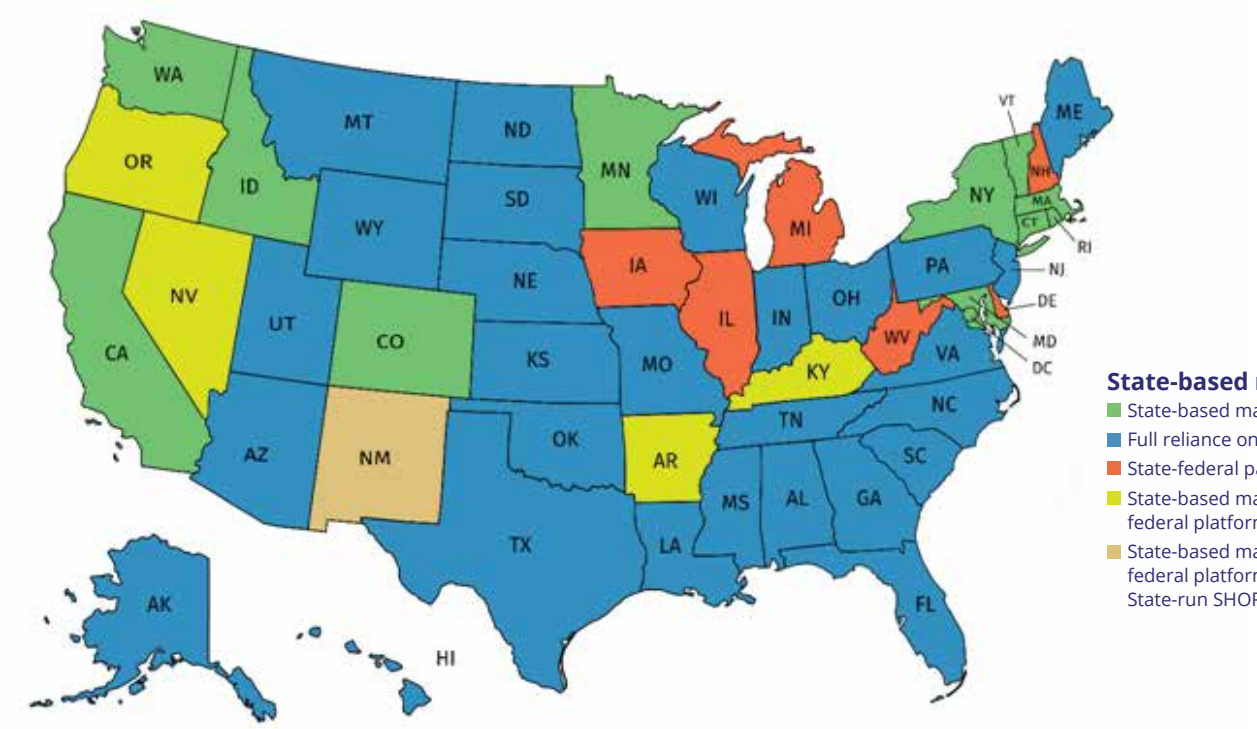
**State- Federal Partnership:** In this scenario astate retains primary responsibility for certain activities related to plan management and/or consumer assistance and outreach, while using the FFM IT platform and relyingon the FFM for all other Marketplace operations.

**SHOP/Individual Marketplace Split:** New Mexico uses the FFM IT platform for its individual marketplace while running its own SHOP marketplace.

**Full Reliance on the FFM:** Except for the retention of certain plan management functions, which state insurance departments were already performing, in this scenario a state relies on the FFM for most Marketplace operations – including eligibility and enrollment, financial management and customer service – and related IT supports.

Exhibit 1 (below) provides more information on the use of various marketplace models across the nation.

## Exhibit1. ACA Marketplace Types




**Note:** SHOP exchange models vary

Despite spending billions of dollars on IT, most Marketplaces – including the FFM – experienced a raft of well-documented technical problems when first launched in 2013.Since then, several states have taken or are taking action to shore up their operations and IT infrastructures and reduce operating costs by transitioning to a new class of vendors - **Exchange Operators** - that offer robust marketplace IT solutions on a software-as-a-service (SaaS)basis. This is the same technology used by millions of individual and group health plan enrollees in the private sector, and business services such as contact center management.

This paper builds on the HIX 2.0: Exchange Operator - A New Model for Marketplace Operations and Information Technology paper written by Day Health Strategies (DHS), Health Management Associates (HMA), and Wakely Consulting Group. That paper outlined the rationale for states that operate SBMs to consider using Exchange Operators to take advantage of more efficient ways to organize and divide responsibilities for operating their public marketplaces and – potentially – to achieve significant cost savings. Five years after the launch of the first SBMs, Exchange Operators now have a track record andcan demonstrate reliable performance, positive user experience, and low total cost of ownership. In this paper, in addition to revisiting the Exchange Operator model,we will outline the advantages to states of establishing their own SBMs and discuss how Exchange Operators can help states implement a sustainable Marketplace solution.

This paper is structured as follows:

We **revisit** key aspects of our HIX 2.0 white paper that states considering establishing their own SBM should find useful;

We **highlight** recent federal and state activities driving the SBM movement and the need for more effective and efficient IT solutions and operational supports;

We **describe** and offer some examples of how states are navigating the changing landscape; and

We **explain** how states can benefit by establishing an SBM while leveraging Exchange Operator solutions.

Additionally, in Appendix A we share an example of how an Exchange Operator such as **Softheon** can help SBMs build sustainable Marketplace operations and IT solutions.

# I. The Exchange Operator Model

SBMs need to continually look for ways to reduce operating costs, gain additional operational flexibility and enhance functionality. In our previous paper, we argued that SBMs should delegate major components of their marketplace operations and IT to Exchange Operators. Prior to the emergence of public marketplaces, the leading Exchange Operators already had multiple years of experience offeringsolutions for private commercial exchanges or providing a broad suite of exchange-like functions to multiple brokerage and/or insurance company clients.

Since releasing HIX 2.0, the Exchange Operator market has matured and become highly competitive. While much has changed over the last couple of years, much of what we said still holds true, including:

- States that run their own marketplaces (i.e. SBMs) need to reduce costs given budget pressures without compromising performance or user experience.

- Given traditional state government agency strengths, states should seriously consider focusing on determining applicant eligibility for insurance affordability programs, governing the Marketplace, and controlling associated "policy levers" while delegating major components of marketplace operations and IT to Exchange Operators much like they have done with Medicaid and CHIP programs.

- Exchange Operators may provide a more efficient, effective operating model than the traditional approach of contracting with multiple vendors, including a systems integrator, to maintain and operate a costlier "one-off" IT platform.

Typical Exchange Operator functionality, illustrated in Exhibit 2 (next page), includes:

- Integration with issuers to ensure timely and accurate plan data transfer and validation;

- A website for shoppingand enrolling in health plans including robust decision-support tools;

- Interoperability with the Federal Data Services Hub and Medicaid and CHIP eligibility systems;

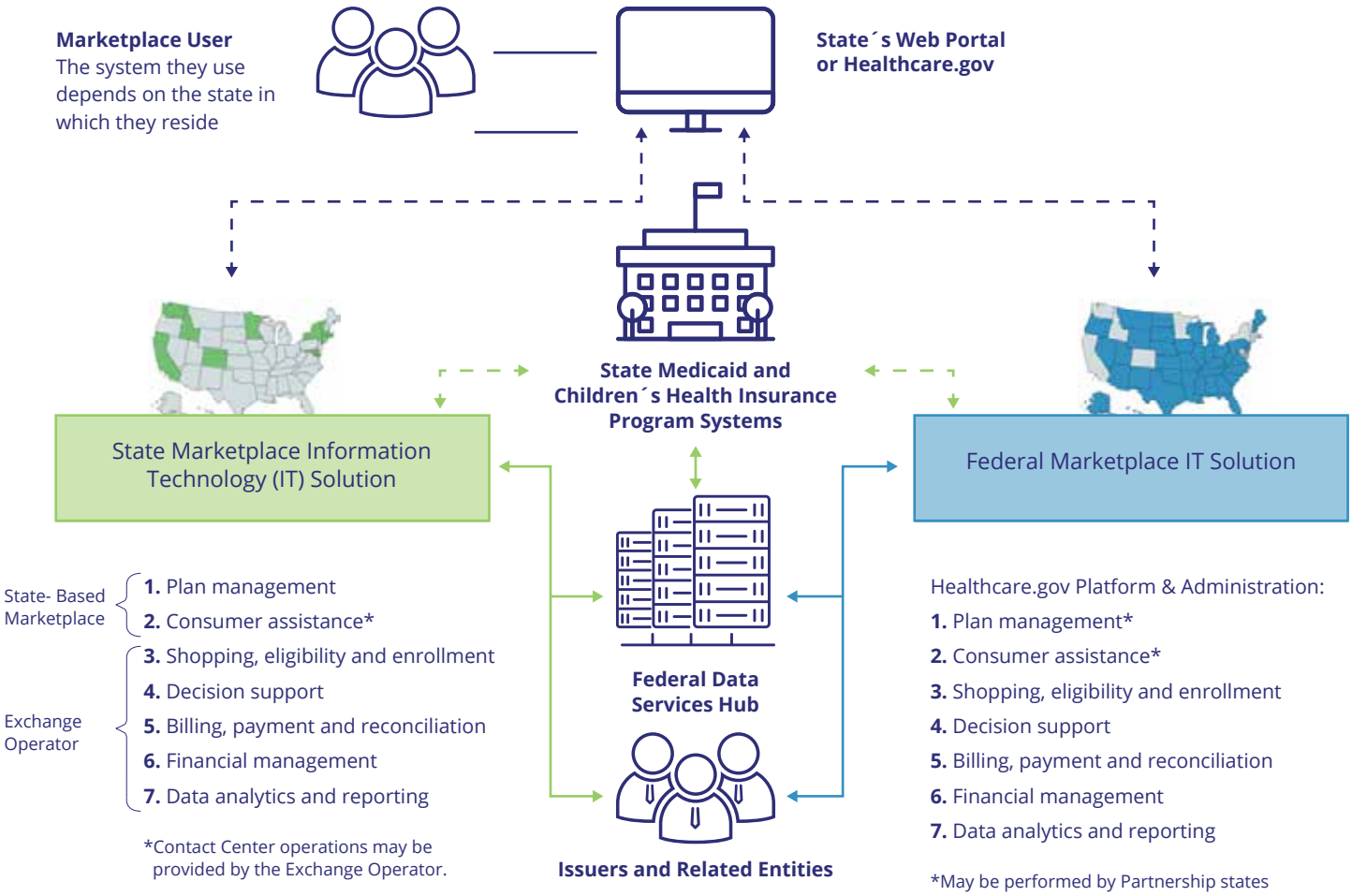
- Streamlined enrollment and payment transfers to issuers;

- A portal for brokers, navigators, and in-person assisters to help customers shop and enroll; and

- Robust data analytics and reporting.

As noted previously, some Exchange Operators also provide an array of contact management services including fully outsourced contact center operations services.

## Exhibit 2. Potential Exchange Operator Functionality




In exploring the potential advantages and drawbacks of transitioning certain Marketplace functions to an Exchange Operator, we strongly advised states to employ a structured approach.To that end, we discussed a methodology for assessing the total cost of ownership (TCO) of a Marketplace's as-is IT environment vis-à-vis a Marketplace that leverages solutions from Exchange Operators.By definition, the TCO includes all costs associated with the use and maintenance of an IT investment over time.Besides being a useful comparison tool, using this method of cost assessment can help an organization identify technology-related costs that are harder to ascertain or quantify and – in the process – lay the groundwork for reducing inefficiencies and improving the allocation of constrained resources and funds.

For the purpose of developing this methodology, we adopted a definition of TCO that includes both direct and indirect costs associated with a Marketplace IT environment.Direct costs are more easily quantified and include hardware and software expenses (licensing, system integration, maintenance, and upgrades), costs associated with operating and maintaining the IT system (labor costs, facilities, network costs, and internet connectivity), and administrative expenses (finance, HR, and costs to manage & train internal IT staff or outsourced providers).Appendix B includes a non-exhaustive list of cost-related factors that should be used to compare TCO across Marketplace IT solution options.

# II.Federal and State Activities Driving the SBM Movement

Several changes have taken place recently, or are anticipated for the 2019 benefit year, that are causing states to rethink the value the FFM offers and whether they can continue to afford to use it. These changes include user fee increases, the introduction of Enhanced Direct Enrollment (EDE), and new flexibility in determining Essential Health Benefits. At the same time, several states are actively pursuing ACA Section 1332 waivers. These waivers, if approved, could require more operational flexibility at the state level than the FFM provides.

For these and other reasons, several states are seriously considering establishing their own SBM, and others are expected to follow.

Perhaps the most significant change driving decisions about SBM establishment is the FFM user rate increase. For the 2019 benefit year, the Centers for Medicare & Medicaid Services (CMS) is maintaining the user fee rate at 3.5 percent of premium for FFM states and setting the user fee for SBMs on the Federal Platform (SBM-FP) and partnership states at 3.0 percent of premium. The SBM-FP user fee rate is up from 2.0 percent of premiums as established for the 2018 benefit year [1].

Another significant change is the adoption of Enhanced Direct Enrollment (EDE). Beginning during the Open Enrollment Period for plan year 2019, CMS implemented an optional program to allow Qualified Health Plan (QHP) issuers and web-brokers in FFM and SBM-FP states to operate as Direct Enrollment (DE) entities by leveraging a suite of application program interfaces (APIs) that allow partners to host application and enrollment services on their own website and to create, update, submit, and ultimately retrieve eligibility results for an application. The EDEprogram provides a DE entity with the data and tools necessary to fully manage customer relationships, including the ability to update applications when necessary, verify that consumers have effectuated policies, and resolve data inconsistencies and payment issues. To participate in EDE, entities must select an auditor and undergo an operational readiness review [2].

To provide states with additional choices with respect to benefits and affordable coverage, CMS has given states additional flexibility in how they select their Essential Health Benefit (EHB)-benchmark plan for plan years 2020 and beyond. States will be able to:

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[1] HHS Notice of Benefit and Payment Parameters for 2019 Fact Sheet

(https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-09.html)

[2] Third-party Auditor Operational Readiness Reviews for the Enhanced Direct Enrollment Pathway and Related Oversight Requirements

(https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-for-the-Proxy-Direct-Enrollment-Pathway-for-2018-Individual-Market-Open-Enrollment-Period.pdf)

Choose from one of the 50 EHB-benchmark plans that other states used for the 2017 plan year;

Replace one or more of the ten required EHB categories of benefits under its EHB-benchmark plan used for the 2017 plan year with the same categories of benefits from another state's EHB-benchmark plan used for the 2017 plan year (for example, a state may select the prescription drug coverage EHB category from another state's EHB-benchmark plan used for the 2017 plan year and the hospitalization EHB category from a third state's EHB-benchmark plan used for the 2017 plan year); or

Otherwise select a set of benefits to become its EHB-benchmark plan, provided the EHB-benchmark meets the scope of benefits and other specified requirements.

These three options are subject to additional requirements, including two scope of benefits conditions [3]. States will also have the flexibility to choose whether to allow issuers in the state to substitute benefits across EHB categories starting in 2020.

Finally, states are availing themselves of the State Innovation (Section 1332) Waiver option in the ACA to pursue initiatives that impact marketplace operations; many of these changes involve establishing reinsurance programs while others seek to make more fundamental changes to health insurance markets. Refer to Appendix C for more information on Section 1332 waiver activity.

[3] First, consistent with the ACA, the EHB-benchmark plan must provide a scope of benefits that is equal to or greater than the scope of benefits provided under a typical employer plan (to the extent any supplementation is required to provide coverage within each EHB category). Second, the state's EHB-benchmark plan must not exceed the generosity of the most generous among a set of comparison plans. Refer to HHS Notice of Benefit and Payment Parameters for 2019 Fact Sheet (https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2018-Fact-sheets-items/2018-04-09.html)

## III. How States Can Benefit by Establishing an SBM While Leveraging Exchange Operator Solutions

Several states are actively exploringtransitioning to an SBM, including Oregon and New Mexico , , and based on its current timetable,Nevada is set to become the first state in the nation to transition from an SBM-FP to an SBM. According to press releases and interviews, the state expects that Nevada Health Link's move from SBM-FP to SBM will result in greater flexibility to operate an exchange tailored to the needs of Nevadans while saving the state millions of dollars in operating costs.  Like several other states that intended to establish SBMs, Nevada experienced serious operational and IT problems during the launch of its marketplace. As a result, state authorities decided to transition to the SBM-FP model. With the planned increases in SBM-FP user fees, Nevada Health Link leadership determined that it would be unable to adequately perform functions such as plan certification and operating local consumer assistance centers. Moreover, the state expects that a shift to full SBM status will enable it to exert control over all aspects of its marketplace and build on past success such as 2018's 2.2 percent enrollment increase. In contrast, most FFM states saw a decline in enrollment.

States are considering establishing SBMs and looking to Exchange Operators for Marketplace operations and IT solutions for multiple reasons, including:

**Cost Savings** – With the increase in user fee rates charged by CMS for use of the FFM, SBM-FP states will have to decide whether the FFM's "one size fits all" functionality is still a value. For most SBM-FP states, the rate increase will squeeze their operating budgets and lead to a re-evaluation of whether other options, such as transitioning to SBM status and using solutions such as SaaS to provide exchange functions previously offered by the federal platform. As mentioned earlier, Nevada has estimated that using its own exchange platform could result in 50 percent savings over the cost of using the FFM in 2019 and beyond. If states find that operating their own exchange IT platform results in significant savings, freed-up funds could be rolled into other aspects of value-adding exchange operations such as consumer engagement.

**Greater Flexibility and Functionality–** which should lead to stronger enrollment and might lead to lower premiums: Although overall enrollment in QHPs dipped 3.7 percent in 2018, SBMs saw a combined enrollment increase of 0.2 percent.States utilizing the FFM (including SBM-FP states), saw an overall enrollment decline of 5.3 percent. A cited driver for the disparity was the flexibility SBM states had to lengthen open enrollment periods and the more robust marketing budgets many SBMs have to draw consumers to their exchanges. Overwhelmingly, states reported that having the flexibility to extend the deadline was critical to fulfilling outreach strategies and giving consumers sufficient time to enroll. Also, most marketplaces are expanding or modifying their advertising to counter misinformation and remind consumers they are open for business.

While avoiding a decline in enrollment is an achievement for those states that have chosen the SBM model, bigger achievements could result from the fusion of operational flexibility, the new policy related to EHB benchmarks (already announced by CMS in the 2019 Notice of Payment Parameters) and options such as reinsurance and other innovations allowed by states undertaking 1332 waivers.In short, to get the best enrollment and consumer value outcomes from increased loosening of federal regulations, states should seek ways to increase the flexibility of their IT platforms so they can tailor services to local needs and enable the redirection of funds to improve enrollment and the health of the overall state risk pool.

A commonly cited complaint with the FFM is a lack of flexibility for state-specific requirements.For instance, the FFM platform could not integrate with Minnesota's public programs or calculate subsidies based on its custom affordability scale. Additionally, the FFM could not exchange data or transfer accounts with New Mexico's Medicaid agency.Exchange Operatorscan configure their IT platforms to accommodate a state's unique needs and circumstances.

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[4] Oregon Could Relaunch State Insurance Exchange; The Bend Bulletin; May 13, 2018
(https://www.bendbulletin.com/localstate/6232435-151/oregon-could-relaunch-state-insurance-exchange)

[5] Health Insurance Exchange platform RFI No. 2018-001; New Mexico Health Insurance Exchange; June 2018
(https://www.bewellnm.com/getmedia/c9d281b2-6b68-4590-87a8-de4d57e0adcd/NMHIX_INDIVIDUAL-EXCHANGE-RFI_No_2018-001.pdf;.aspx)

[6] Request for Proposal 96SSHIX-S68; Silver State Health Insurance Exchange; March 2018
(https://nevadaepro.com/bso/external/bidDetail.sdo?bidId=96SSHIX-S68&parentUrl=activeBids)

[7] Ibid.

Through Exchange Operators, SBMs also have an opportunity to provide a better user experience, more decision-support tools, improved capacity to accommodate spikes in traffic, and real-time customer data access to inform outreach and marketing efforts.

**Leverage, Leverage, Leverage** - States using SaaS platforms to perform exchange functions could re-purpose that functionality in support of other public programs, in keeping with modularity and reuse principles and in alignment with the Medicaid Information Technology Architecture (MITA).

**Premium Assistance** - Some states, such as Arkansas and New Hampshire, utilize premium assistance for private insurance in their Medicaid programs. If that state also uses an Exchange Operator to fulfill the functions of an SBM, the SBM SaaS platform could be modified to also operate the premium assistance functions for the state Medicaid program. The similarity of providing QHP enrollees with the benefit of advanced payment of the premium tax credit (APTC) and premium assistance for Medicaid enrollees should allow significant opportunities to re-use the SaaS platform for multiple state programs, which could save states money and prevent them from having to contract with multiple vendors and use multiple products to achieve a similar goal.

Public programs that include enrollee payments for insurance deductibles, such as Healthy Indiana Plan (HIP) Plus: HIP Plus members are required to pay affordable monthly contributions into a Personal Wellness and Responsibility (POWER) Account and receive a full commercial benefit package that includes coverage for vision, dental, and chiropractic services.States adopting a similar model as well as employing a SaaS solution for the SBM could utilize the same platform functions, tailored to the needs of each program.

## IV.Next Steps for States

Even though SBM establishment grant funding is no longer available to states, thanks to the evolution of the Exchange Operator, marketplace states seeking to establish SBMs are able to explore that option and – as in the case of Nevada – execute that strategy.States considering transitioning to an SBM should be very deliberate and follow an approach anchored on best practices for major IT and business process outsourcing initiatives:

- Formulate and reach agreement on goals and objectives for SBM establishment.

- Assess IT assets, IT management capabilities, and administrative capabilities with the goal of identifying capabilities for which the state would engage an Exchange Operator.

- Based on the results of the assessment, develop a work and resource plan for potentially engaging an Exchange Operator to provision SBM IT solutions and business process supports; the plan would incorporate a procurement process as well as advisory and implementation management services as deemed necessary.

- In exploring the potential advantages and drawbacks of transitioning certain Marketplace IT functions to an Exchange Operator, employ a structured approach for assessing the total cost of ownership (TCO) of a Marketplace's as-is IT environment vis-à-vis a Marketplace that leverages solutions from Exchange Operators.

- To ensure that the resulting comparison, analysis, and recommendations carry the most weight with decision makers at both the state and federal levels, we strongly recommend the use of experienced advisory resources that have cost-benefit analysis, IT management, and Marketplace establishment and operations expertise. Marketplaces may only have one shot to "get this right"; as such, ensuring reliance on the best possible data and advice becomes a critical success factor.

## Appendix A:How an Exchange Operator can Help SBMs Build Sustainable Marketplace Operations and IT Solutions

As the Exchange Operator market has evolved, several companies have emerged as providers of a comprehensive set of Marketplace operations and IT solutions. One of these providers, **Softheon (www.softheon.com)**, played an important role in building the nation's first state health benefit exchange in 2008 with the Massachusetts Health Connector, is the current SHOP platform provider for Access Health CT, and is trusted by more than a third of healthcare payers to manage almost 40 percent of ACA Marketplace membership information and related transactions. Softheon has been recognized as a leading Software-as-a-Service (SaaS) and Business-Process-as-a-Service (BPaaS) solution provider by Gartner, IDC, AHIP, ACAP, and HCEG.

**Softheon** strives to develop and implement cost-effective solutions to complex challenges faced by Marketplaces, issuers, and other health care stakeholders. The suite of solutions designed by Softheon to support SBM operations, illustrated in Exhibit 3 (next page), has been purposely architected to achieve the following:

**Lower/reduced switching costs and time.** The barriers to switching vendors are not what they were several years ago. Softheon technology powers the SHOP exchange platform for Access Health CT and is directly responsible for a 30 percent increase in SHOP volume in its first year of operations. Moreover, from contract signature to go-live, the Softheon team deployed a full end-to-end platform in only 41 days.

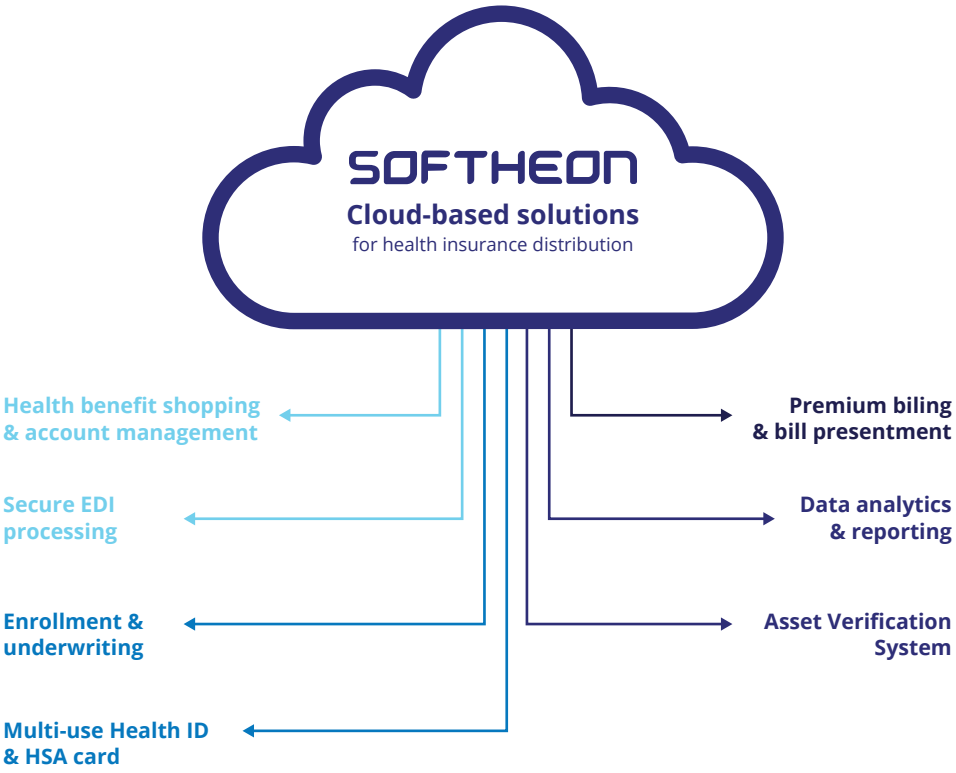
**Reduced operating costs.** Softheon solutions have resulted in organizational efficiencies which has enabled clientsto re-task employees and invest in functions such as outreach.

**Greater configurability to facilitate adherence to state and federal requirements**, including but not limited to legal and regulatory requirements. Softheon solutions have been architected to support modular implementations, avoiding the risks and uncertainty of "rip and replace" projects, as well as the worrisome issues of governance and functional ownership of shared tenant arrangements. Softheon is built on a highly flexible, cloud-ready, n-tier architecture platform that provides an adaptable but secure environment for the system, its users, and data. Furthermore, Softheon'smulti-tenancy model provides for policy-driven enforcement, segmentation, isolation, governance, service levels, and chargeback/billing models for different consumer constituencies.

**Enhanced user interface/experience** by providing greater control over the user interface and experience for consumers, brokers, and issuers along with decision-support tools. Softheon's Claritysolution enables users to interact with the system through simple yet pervasive human user interfaces accessible via web browsers and mobile devices.Softheon functionality includes but is not limited to plan sorting, scoring, and display along with robust decision support capabilities such as real-time subsidy calculators and plan comparison tools.

**Improved access to data and more robust analytics and reporting capabilities**. Softheon's Foundry solution offers reporting tools, including Executive Dashboards which focus on Key Performance Indicators and overall trends. Additionally, Foundry has distinct pre-built operations and performance reports as wellas required CMS reports such as a payment processing report, 820 discrepancy report, and baseline submission.Foundry can "push" reports to users via secure file transfer, electronic mail, and web. Softheon works with its clients to address reporting needs not addressed in the "out-of-the-box" product including new state or CMS requirements. Examples of reports are shown in Exhibit 4 (next page).

## Exhibit 3.Softheon Solutions Suite



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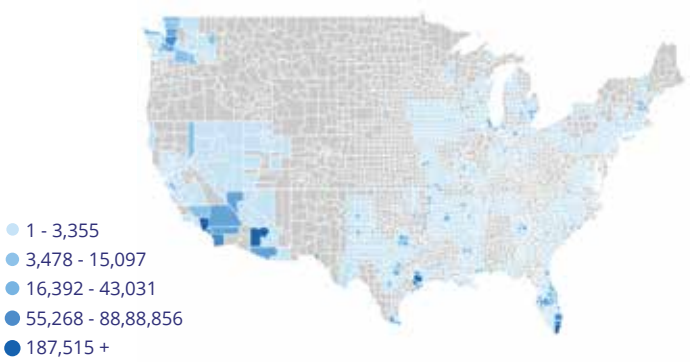
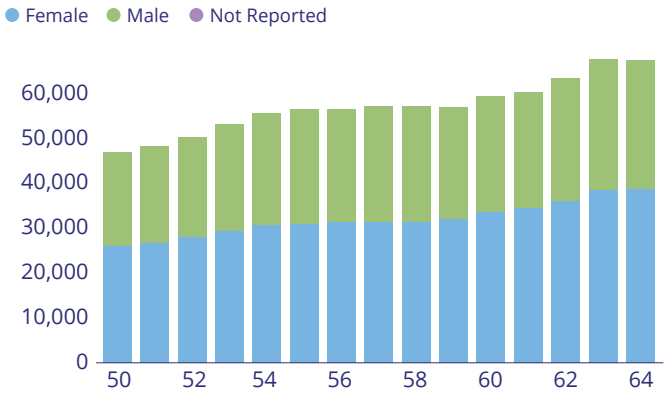
## Exhibit 4. Softheon Foundry Analytics Dashboard

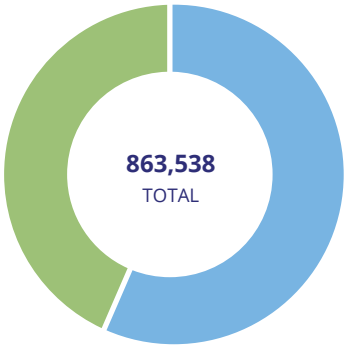
Enrollees by Country - National




QHP Enrollees Data- Membership, Grouped by Age and Gender

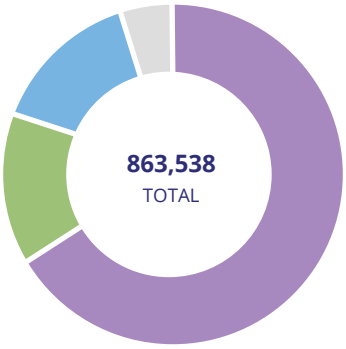



QHP Enrollees Data
**Gender Distribution**



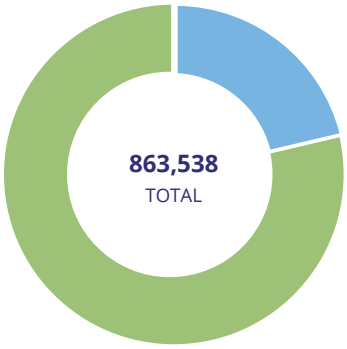

| | |
|---|---|
| Female | 56,38% |
| Male | 43,62% |
| Not reported | 0,00% |

QHP Enrollees Data
**Language Distribution**




| | |
|---|---|
| Not Reported | 66,72% |
| Spanish | 14,61% |
| English | 14,13% |
| Other | 4,55% |

QHP Enrollees Data
**Subsidized/ Non-Subsidized**




| | |
|---|---|
| Non-Subsidized | 21,06% |
| Subsidized | 78,94% |

# Appendix B:Cost-Related Factors for Total Cost of Ownership (TCO) Assessment

The following is a non-exhaustive list of cost-related factors that should be used to compare TCO across Marketplace IT solution options:

**1.** Actual costs incurred related to software licensing, operating hardware, system integration, application maintenance, and support, etc.

**2.** Costs for operating, maintaining, and performing regular upgrades of infrastructure, including servers, storage, security devices, and their related software.

**3.** Ongoing operation and maintenance of 3rd party products and software applications.

**4.** Facility costs including space, HVAC, and power.

**5.** Personnel costs associated with:

a. Operation and management of the infrastructure.
b. On-going maintenance and operation of the applications.
c. Providing changes and release management of applications.
d. Business analysts to work with the Marketplace management
team to define and guide technical implementation.

**6.** Indirect costs including but not limited to management, administrative, and oversight costs as well as state-level costs that are allocated to the Marketplace organizational unit/cost center.

**7.** Non-recurring implementation and transition costs, including staff training, which can be amortized/ spread over the projected life of the IT solutions to be acquired or retained.

Additionally, an assessment of IT sourcing options must account for the following factors which, despite being more difficult to quantify, are essential for assessing the true value of an IT solution:

**1.** The extent to which existing IT solutions are actually delivering the functionality for which they were built/acquired.

**2.** The solution's usability as measured by user satisfaction with the solution's capabilities and user experience.

**3.** The solution's ability to interoperate with other information systems.

**4.** The solution's "manageability" – the extent to which changes to the solution can be made easily and rapidly.

**5.** The solution's "supportability" – the quality and responsiveness of the team responsible for supporting the solution.

**6.** The ability for the SBM to attract and retain essential technology staff to support application and infrastructure operations and maintenance.

**7.** End-user satisfaction.

# Appendix C:ACA Section 1332 Waivers – A Snapshot of State Activity

**The Alaska** Reinsurance Program (ARP) is a state-operated reinsurance program which covers claims in the individual market for individuals with one or more of 33 identified high-cost conditions. The ARP is administered by the state of Alaska and the Alaska Comprehensive Health Insurance Association (ACHIA). Alaska will fund the ARP with assessments levied on all types of Alaska health insurers, including individual, small group, large group, and stop-loss entities. Additionally, because the ARP will lower premiums, the second lowest cost silver plan premium will be reduced, resulting in the Federal government spending less in premium tax credits. As such, the state will receive pass-through funding based on the amount of premium tax credits (PTC) that would have been provided to individuals in the State of Alaska absent the waiver (but will not be provided under the waiver). As required by Federal law, Alaska's 1332 waiver will not increase the Federal deficit.

Alaska insurers in the individual market who have identified an enrollee as having one of the 33 identified high-cost conditions sends that enrollee's premiums to the ACHIA and the ACHIA reimburses the insurer for that enrollee's future claims. The enrollee, who is charged the same premium as other similarly-rated enrollees, remains enrolled in the health plan that he or she selected and does not experience any changes in care or claims payment.

**Maine** seeks to allow federal pass-through funding to partially finance reinstatement of the Maine Guaranteed Access Reinsurance Association (MGARA), the state's reinsurance program that operated in 2012 and 2013. The MGARA will reimburse insurers 90% of claims paid between $47,000 and $77,000 and 100% of claims in excess of $77,000 for high-risk enrollees diagnosed with certain health conditions or who are referred by the insurer's underwriting judgment.

**Maryland** seeks to allow federal pass-through funding to partially finance the Maryland Reinsurance Program. The plan will reimburse insurers 80% of claims between an attachment point that is to be determined and a cap of $250,000.

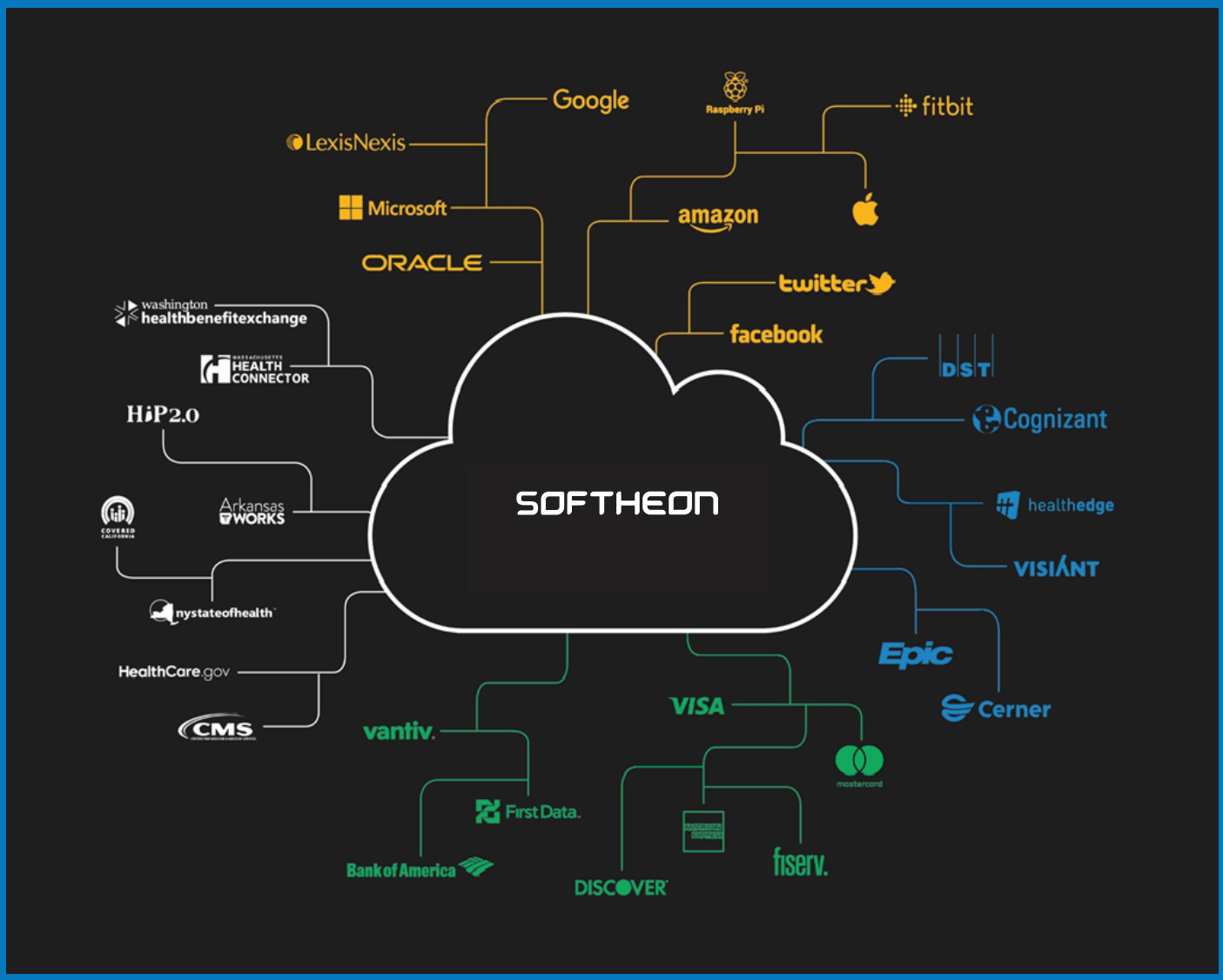
**Minnesota's** waiver allows federal pass-through funding to partially finance the Minnesota Premium Security Plan (MPSP), a reinsurance program that reimburses insurers 80% of claims above $50,000 and up to a cap of $250,000. It also sought federal pass-through funding equal to the amount the federal government would have spent on tax credits and cost sharing subsidies for residents eligible for the state's Basic Health Program, MInnesotaCare if the reinsurance program were not in place. The waiver was submitted on May 5, 2017 and was approved on September 22, 2017. Although the federal government approved pass-through funding for the reinsurance program, it did not approve pass-through funding for BHP, thus providing the state with less federal funding than it had sought.

**New Jersey** seeks to allow federal pass-through funding to partially finance the Health Insurance Premium Security Plan. The plan will reimburse insurers 60% of claims between $40,000 and $215,000.

**Ohio** is seeking to waive the individual mandate requirement. Although Congress "zeroed out" the penalty associated with the individual mandate beginning in 2019, it did not eliminate the requirement. **Waiver application deemed incomplete in May 2018**.

**Oregon's** waiver allows federal pass-through funding to partially finance the Oregon Reinsurance Program (ORP). The ORP reimburses insurers 50% of claims between an attachment point (to be determined) and an estimated $1 million cap. It was submitted on August 31, 2017 and was approved on October 18, 2017.

**Wisconsin** is seeking to allow federal pass-through funding to partially finance the Wisconsin Healthcare Stability Plan (WIHSP). The WIHSP would reimburse insurers 50%-80% (exact percentage to be determined) of claims between $50,000 and $250,000.




## About SOFTHEON

Our mission at Softheon is to create simple, innovative solutions that make health insurance affordable, accesible, and plentiful. We create software that is trusted by over **60 healthcare payers** participating on public exchanges, managing **37% of the overall ACA membership**. From enrollment and premium billing to reporting and reconciliation, we are revolutionizing how health plans and states serve their members.

We have a rich history of providing turnkey Software-as-a-Service (Saas) and Business Process as a Service (BPaas) solutions that address state and health plan needs. For over 15 years, our solutions have provided the **end-to-end tracking, monitoring, and reporting** of business activities for individual and small group enrollment, financial management, and customer service processes.