Brent R. Scott, President
Kelly C. Atkinson, Executive Director

Health Insurance Exchange Unanswered Questions

Presented to the Business & Labor Interim Meeting in September of 2007
Presented to the Health & Human Service Committee in September of 2007

by
THE UTAH HEALTH INSURANCE ASSOCIATION

September 18, 2007

The concept of an Insurance Exchange was first presented to the membership of the Utah Health Insurance Association (UHIA) by Norm Thurston of the Board of Health approximately two years ago. The idea of the exchange was to extend insurance coverage to the uninsured by making insurance more affordable. At the time of original presentation members of UHIA raised concerns and questions about how the exchange would work and if it would accomplish the stated objective to reduce the number of uninsured. To date these questions have not been addressed.

In May of 2007 similar questions were presented in written form for consideration to John T. Nielsen. In August of 2007 UHIA met with Mr. Nielsen and did not receive answers to our questions or concerns about the potential obstacles faced by the exchange concept.

Today UHIA is providing a list of the questions, potential obstacles, and challenges faced by the exchange concept along with a statement of the current state of health insurance in Utah. These questions are provided to the members of the above committees in the hopes that Utah legislators will have better success in getting answers to these questions than UHIA has over the last two years.

OVERVIEW

The exchange concept has been billed as a way to reduce health care cost. UHIA sees little in the concept to reduce the number one problem that keeps individuals from being insured – affordability. The concept does little to reduce the compensation to health care providers, little to cut the cost of hospital care, little to reduce the cost of drugs, and nothing to reduce the increase costs associated with the development of new technology. According to a January 2006 report by PricewaterhouseCooper these are the factors that have caused health insurance premiums to increase ("The Factors Fueling Rising Healthcare Costs 2006", PricewaterhouseCooper). The expense of premiums is a direct reflection on the ***cost of medical care.*** Will the exchange reduce the cost of health care? In 2006 domestic carriers paid an average of 91 cents of every dollar on health care claims leaving only nine cents per dollar for administration.

In addition the exchange concept creates a massive government program to deal with a problem that only affects about 5.6% of Utah's population. This figure is derived by analyzing the data provided by the Utah Department of Health's uninsured survey of 2006. According to the survey 67,800 individuals between

the ages of 0 to 18 years of age are uninsured. Of the 67,800 only 21,700 are at or exceed 200% of the federal poverty level. According to the survey there are 104,000 people uninsured between the ages of 19 to 64 years of age exceed 150% of federal poverty level. In the same age group 116,000 are under 150% of federal poverty level. The same survey records that 107,600 are employed full-time and are uninsured. There are 39,300 individuals employed part-time who are uninsured, 36,200 are self employed and uninsured, and another 37,000 are unemployed and uninsured. According to the data contained in the survey 171,900 individuals currently qualify for either an existing State or federal program to assist them in the purchase of insurance. The exchange concept being proposed by the advocates will restructure the health insurance industry to address a problem that affects only 5.6% of Utah's total population and would dismantle a system that is serving 94.4% of Utah's population (including privately and self-insured, CHIP, HIP Pool, and Medicaid.)

The exchange concept seeks to solve a problem that does not exist. Proponents argue that some individuals cannot get health insurance in Utah due to pre-existing conditions. However, health insurance coverage in the state of Utah is guaranteed! If an individual applies for coverage they can get an individual policy, group policy, or qualify for the HIP Pool.

The problem of portability which the exchange concept seeks to solve is also addressed in the current system with federal COBRA and State conversion laws and regulations.

UHIA believes the quasi-socialization of the system proposed by the exchange concept is not the answer to address the needs of the uninsured. Attacking the factors that are contributing to medical inflation is the key to making insurance more affordable.

QUESTIONS
Federal Issues:

Will Utah be required to gain exemption from federal laws in order to implement the Exchange?

Public Health Service Act (PHSA) is the federal law that addresses HIPAA guaranteed availability and guaranteed renewability when coverage is offered through a bona fide association health plan (*see*, 45 CFR §§146.152(b)(6) and (g)). It requires that associations offer/renew coverage to/of all members of a bona fide association that makes health insurance coverage available to its members. If something like the United Way's "straw man" proposal were to pass (which would eliminate all private-market insurance for individuals and small employers and require that it be purchased through an exchange), Western Mutual Insurance (WMI) and other mutual insurance carriers would have to refuse to issue/renew legitimate Utah members of their associations. This would be in violation of the federal law. Such an exchange law would be preempted under ERISA and the PHSA. Of course, this also raises the issue of whether any small employer carrier in Utah (not just association plans like WMI) would be allowed to terminate existing insured groups without running afoul of HIPAA's guaranteed renewability requirements. HIPAA requires that carriers renew coverage at the option of the plan sponsor (Public Health Service Act §2712). HIPAA also provides that health insurance issuers that actively market coverage in the small group market must: (1) accept every small employer that applies for coverage and make all products that they actively market in the small group market available to all small employers; and (2) accept for enrollment every eligible individual who applies for coverage when first eligible (Public Health Service Act §2711(a)). It is the position of the Centers for Medicare and Medicaid Services that an issuer is not relieved from the requirement to offer all products to all small employers, even if a state requires or permits issuers to offer products to some (but not all) small employers in the small group market. *See*,

HCFA Insurance Standards Bulletin 00-03 (June 2000).

Defining the Essential Benefit Package:

Will all individuals in the state of Utah be required to have some form of health care coverage with the Essential Benefit Package serving as the minimum?

If the Essential Benefit Package becomes the minimum standard of coverage, should it also become the benefit package for Medicaid enrollees?

As drafted in the Straw Man proposal the Essential Benefit Package becomes a "floor" for benefits meaning that no benefit policies can be sold in the State that have lesser or fewer benefits. What impact will this have on products such as Health Savings Accounts (HSA) partnered with high-deductible health plans? Can an individual have a high-deductible health plan under the Straw Man proposal?

What governs the work that the independent commission (Commission) will perform in determining what is classified as preventive services, primary services, life services, or "comfort care" services? For example, is shoulder surgery always "comfort care?" What is the cost of the structure that will be required to support the work of the Commission (synthesizing the clinical data and information)?

Will the Commission provide an appeal mechanism?

Will all insurers be required to administer benefits in accordance with the categories of services that the Commission defines?

The Essential Benefit Package described in the Straw Man proposal does not reflect that a category of services will always be excluded, such as cosmetic services.

How are vision and dental services treated in the Essential Benefit Package?

Physician compensation is not addressed in the current proposal. Is there a common set of medical policies needed through the Commission or the Exchange Mechanism to determine how and when to pay physicians and other health care professionals for services?

Exchange Mechanism Operations:

Do the proponents of the Exchange expect a reduction in the number of carriers participating in the market due to the structure of the Exchange? For instance, Educators Mutual Insurance Association can only insure school districts, Western Mutual Insurance can only insure members of the Western Petroleum Marketers Association, Public Employees Health Plan can only insure members of the Utah Retirement System, and Deseret Mutual Benefit Association can only insure employees of the LDS Church.

Is the Exchange the <u>only</u> source of coverage for small employers and individuals? If so, can no benefit policy be offered for sale outside of the Exchange?

Would small employers still be allowed to purchase group coverage, or would they transition to just providing financial contributions through Section 125 plans to their employees? This is important to understand because it radically changes the current market – basically doing away with small group

coverage and implementing an individual-only market for everyone not covered under an ERISA-governed plan (i.e., those who work for large employers).

Is coverage sold through the Exchange guarantee issue? If so, what happens to the State's high risk pool (HIP Utah)?

What is the role of quasi-governmental entities such as PEHP in the Exchange mechanism?

We have stated that, "Brokers will continue to provide advice and counseling, enroll individuals and groups, and receive a commission for services rendered." In the Exchange, who will provide compensation to brokers? What services are expected for that compensation?

In a guarantee issue environment how is the Exchange constructed to protect against individuals "shopping" for benefits, e.g., enrolling on a higher-benefit plan when needed, and then enrolling on a less-expensive Essential Benefit Package when not?

Financing Issues:

Will small employers and individuals save money under this proposal? If so, how and what is the estimated savings?

Should administrative costs be part of the estimate for this proposal?

Should estimates also reflect additional subsidy costs for those who are insured under the current system but who would qualify for a subsidy under the proposal?

Have the financial consequences of other events been taken into account? If the high risk pool's enrollees are incorporated into the overall individual market, what is the impact?

Is an employer permitted to establish two different Section 125 plans?

If an employer is required to establish a Section 125 plan in the Exchange, what do they do with the monies in their already established Section 125 plan? How do they distinguish between the two?

What is the level of employer contribution toward premium that will be required by setting up Section 125 plans for employees?

Eligibility Issues:

Will the Exchange handle eligibility requirements?

Who is eligible? Adults only? Adults and children? All government employees? Are school districts included because teachers are "technically" government employees? Who covers foster children? What about non-documented workers?

Is there a requirement to have coverage for dependents? What is the penalty if you do not cover a dependent?

How will the Exchange handle families with spouses that work in different companies, one a large

employer and the other a small employer?

What if one of the spouses is over 65? Is Medicare primary? Does the Exchange coverage assume Medicare is primary meaning everyone is now individual?

Will carriers be required to maintain eligibility, claims payment, collection of premiums?

What penalties will apply to individuals that do not purchase insurance?

What are the requirements of dependency, i.e., age, disability, etc?

COB Issues:

How will the Exchange mechanism coordinate benefits between a large employer and the Exchange?

In divorce who has the responsibility for the dependent's coverage? Must it be outlined in all divorce decrees?

What about children for whom there is an order of coverage that do not live in Utah?

Will CHIP, HIP Pool, and Medicaid all be rolled into the Exchange?

How will claims for government programs be paid?

Does the carrier distinguish between State and federal subsidy programs?

Rating:

What does community rating mean?

Will coverage sold through the Exchange mechanism be community-rated? If so, what "community" is the basis for rating? Is it the entire Exchange mechanism or an individual insurer's book of business through the Exchange or some other basis?

Will the rate be exactly the same for everyone? Will single coverage be rated the same as family coverage?

Are there rate variations based on age or gender? How will a carrier know someone's age?

If the community sets the rate and it is inadequate, who covers the shortfall?

Compliance Issues:

What money will pay claims if collection of premium takes six to eight months?

Since the Exchange is considered "group" coverage how will information about individuals get collected to permit carriers to comply with federal laws?

Who will track compliance issues?

What happens when an employer drops below 50 employees? What happens when an employer goes above 50 employees?

How will different employees be interpreted? What is full time? What is part time? How do you deal with temporary employees? What about employees who are taking unofficial leaves of absence?

How will non-Utah domiciled companies be required to comply?

Portability Issues:

How does a large employer treat a new employee that brings his/her "portable" coverage to the large employer environment when federal law requires the large employer to make same coverage available to all similarly situated employees?

Can portable Exchange policies be taken out of state? Do State subsidies go with the portable policy?

What if one parent lives in Utah and the responsible parent lives in another state? What if the dependent lives in another state? Are missionaries considered dependents?

Risk Issues:

Will there be a risk-adjuster model in the Exchange mechanism? If so, what will it look like and how will it operate?

Is the State going to be the re-insurer of last resort? (It may be difficult under these circumstances for an insurer to get reinsurance since they cannot underwrite or manage risk or differentiate policy language. Carriers that cannot get reinsurance cannot be in the market.)

How will risk adjusting be handled? (Massachusetts permits underwriting, no community rating and their program is still employer based. In Utah, individual premium rates are currently limited to the maximum small employer rate so small employers are subsidizing individual coverage to the extent necessary. The Exchange would require premium rates to increase for comparable coverage.)

Coverage Issues:

Who determines what is "comfort care" or "medically necessary" care?

How do you split "comfort care" for coding purposes, such as back surgery?

Can small employers with 15 and under employees eliminate maternity coverage because they are not required to provide it under federal law?

What are the coverage maximums?

Does the Exchange eliminate State mandated benefits, such as adoption indemnity, mental health coverage, etc?

Will the Exchange eliminate federal COBRA and State conversion requirements? How will that

coordinate with COBRA and State conversion that is required for large employers?

How will the Exchange handle people coming from other states? Are there residency requirements?

How often will individuals be permitted to change their coverage?

How does the Exchange handle life events, such as, death, divorce, etc.? Will it give more or less than HIPAA?

How will the Exchange impact the HIPAA-permitted practice of employers who currently offer their employees monetary incentives to take care of themselves?

Are immunizations for foreign travel going to be required coverage?

Will supplemental coverage be allowed? Must supplemental coverage be purchased through the Exchange?

If there are issues related to coverage, will those issues be appealed through the Commission?

Will carriers no longer need their appeals departments?

Are appeals consistent with policy provisions or based on perceived need?

Will Medicare Supplement plans be available through the Exchange? How will compliance issues and underwriting be handled?

If a carrier only sells Medicare Supplement plans are they permitted to sell through the Exchange since they do not offer other products?

Will supplemental programs and other coverage, such as dental, be community rated?

How will worker's compensation and disability be handled?

How will coverage for sexual dysfunction be handled?

How will coverage for domestic partners be handled?

Are there requirements as to the type of policy in the Basic Benefit Plan? HMO, PPO, open?

If an individual chooses an open plan and their dependent moves out of state, how will benefits be paid?

What happens when a carrier drops out of the Exchange? Under what circumstances can a carrier withdraw? What is the penalty? How long is the penalty? What if they withdraw because of loss? Is individual coverage guaranteed renewable?

What if the population does not come to the Exchange because it is more expensive?

Employer Tax Issues:

Are employer contributions a flat dollar amount or a percentage amount of premium?

What about employers losing their tax incentives? (Contributions to premium would be disallowed as a tax deduction. Highly compensated individuals could find their entire premium is now taxable income. Self employers currently pay premiums with pre-tax dollars, so the Exchange would not save them money. Low income individuals do not make enough money to pay taxes, so they would not save money in the Exchange and it could actually result in higher costs for those individuals.)

Collection of Premiums:

Who will collect premiums?

Will carriers be required to subsidize claims payment until an individual pays the premium?

Can carriers go back to providers for claims reimbursement if an individual never pays their premium?

Is there a grace period for premium payment?

To what extent are non-payers subsidized by payers if the carriers are required to continue paying claims?

Website:

What will the website do?

Will there still be producers?

Exchange Commission:

Will the only auditing function reside at the Exchange?

Will there be financial audits of the Exchange if the Exchange is the risk adjuster?

Who will review the Exchange in terms of administration of Section 125 plans?

If the Commission has rulemaking authority, how will three to five people handle rulemaking along with appeals, benefits structure, etc.?

Will the Commission be required to take into consideration the actuarial cost of benefits? Will that be done before creating a benefit package?

Will the Commission set rates?