Utah's Response to the Federal Request for Comments on Implementing Health Insurance Exchanges (File Code OCIIO-9989-NC)

Federal Exchange Regulations Should Support Innovation and State–Designed Solutions

The Utah Model is one of the leading models of state-designed health system reform. The State of Utah has put into place the necessary foundations to support a functional exchange and has a plan for implementing other reforms highlighting the effectiveness of a market-driven approach to reforming the health system. Utah urges the Secretary of Health and Human Services to allow the states to determine the exchange model that best meets the needs of the citizens of the state.

Our single most important message in this response is that the U.S. Department of Health and Human Services (HHS) needs to consider granting states broad flexibility moving forward. HHS needs to resist the temptation to expand federal authority over state exchanges so long as the functions described in federal statute are met. It is the role of the states to define their goals and objectives and the role of HHS is to help states get there.

Not only are states laboratories of innovation (which should apply here with especial force), but they are also the sovereign units of government within our system of federalism. We are concerned that HHS will require states to demonstrate upfront that their models will be successful or they will be replaced with a federal solution. In reality, neither states nor federal agencies know what will be successful until it has been tried. This point suggests that each state should be allowed to put forth their best effort and in the process we will have 50 points of learning to help us move forward.

We firmly believe that Utah is on the right track to meeting Utah's needs with its array of health reform initiatives. However, this does not necessarily mean that other states should reform their health systems the exact same way.

Utah developed its health system reform only after finding the state's unique areas of need. While the Utah Model can serve as a starting point for states who find themselves in similar situations vis-à-vis the insurance market structure, the legislative environment, or the overall economy, each state needs to be able to adapt and mold their plan to their specific needs.

HHS should allow each state to customize health reforms, including the formation of a

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State Health Insurance Exchange. We recommend that HHS encourage customization and not force states to adopt measures that would not focus on their unique problems or would otherwise hinder current efforts that are made in good faith.

Aspects of the Affordable Care Act and Exchange Regulations that will be Troublesome for All States

There are several aspects of potential exchange requirements that will interfere with all states' ability to implement state-designed health reform. We acknowledge that the statute itself is the source of some of these problems, but they can be mitigated with flexibility. It cannot be stated strongly enough that because of inconsistencies and ambiguities in the statute, states need to have final definitions on a number of key provisions, including:

- The eligibility of U.S. citizens under 100% of the Federal Poverty Level (FPL) for subsidies
- "Maintenance of effort" requirements
- Definitions of income
- Required interactions between Medicaid and the exchange

These definitions are critical to the development of successful state-designed exchanges. In addition to these definitional questions, there are other aspects that will be troublesome for every state that is contemplating a state-designed exchange.

Qualified Health Plans

There is some suggestion that states should define the types of benefits packages that will be offered through the exchange, certify those plans and put those out to bid. While this may work for some states, this approach is not consistent with a market-based approach to an exchange. States should not be required to get involved in decisions related to the benefit design and procurement on behalf of employers, employees, or individuals.

Certifying Health Plans for the Exchange

To the extent that the state will have to certify, decertify or regulate Qualified Health Plans offered through the state exchange, the most appropriate place for that to happen would be in the state's department of insurance. The overarching principle is to promote variety, choice, and flexibility. The state of Utah has no interest in putting exchange plans out for bid.

By statute, HHS will have to provide a definition of the essential benefits for exchange plans. Any such definition should only be a set of covered service categories (such as inpatient hospitalization) that plans need to cover and not a list of required treatments for specific conditions.

It has been Utah's approach to set parameters for plans and allow carriers to innovate and differentiate their products as long as they are adequately informing the consumers about their products at the time of purchase. Any attempt to standardize benefit designs tends to discourage competition and entry into the market and limits choice.

The Utah Health Exchange incorporates shopping tools that help consumers identify the type of plan that will work best for them and then assists them in finding plans that meet those criteria.

In the past, Utah has required insurers to offer state-defined plans in addition to their other products. In our experience, the state-defined plans were not successful. The plans are seldom chosen by consumers and quickly become an administrative burden for insurers.

With regard to benefit designs for plans that will be offered inside the exchange, state rules should promote creativity and flexibility. When it comes to defining a minimum standard for benefits designs, the following considerations should be taken into account:

- Most state laws already define what plans are acceptable for sale;
- More choice for consumers is better as long as they have full and accurate information;
- We should allow for variance in plan designs and provide the consumer with a clear summary of benefits; and
- An exchange market should be open to all solvent carriers and we should welcome entry.

Quality Improvement

If quality improvement is going to be a required activity in the exchange, states need to have the flexibility to develop processes that address local issues and needs. Our needs are unique to our markets. For example, in Utah there is currently a desirable level of choice available from reputable carriers. If we can design a process based on disclosure, competition will work to spur improvement.

It is our belief that it is more effective for states to focus on consumer education. When consumers understand better how insurance is priced and how the different elements of benefits design affect price, competition will be increased. What we most need to focus on in this regard is consumer engagement and development of tools that show consumers the information or answers to questions that they care about most.

In looking at the Medicare Advantage rating and quality improvement model, we find that it is not a helpful model to use for improving private insurance plans. The model does not allow for customization by the consumer based on their needs.

If we can design a process based on disclosure, competition will work to spur improvement. If federal regulations on quality are developed, the following areas could be considered for measures and targets:

- Claim denial rates and appeal resolution
- Timely payment of claims
- Internal and external review processes
- Adequacy of network
- Minimum loss ratio data and historical performance
- Rate increase

Rate Reviews

The state insurance department should regulate rates and conduct rate reviews, rather than a federal agency. When reviewing rate increases, Utah reviews the use of appropriate benefit factors, demographic factors, projections, claims paid and premium earned. It is important as the rates are reviewed to take into consideration the insurer's solvency and that pricing is adequate and within actuarial standards. Utah and other states can use rate review grants to develop the capacity within current staff to be able to make rate review determinations.

Marketing Rules

The regulation of marketing should be the purview of state law because the state regulators are familiar with local market issues and can react swiftly. Utah has statutory language to address marketing practices. For example, insurers are not allowed to price a plan based on the persons who are expected to enroll in that plan and commission schedules cannot be designed to discourage unhealthy people from enrolling.

Enrollment and Eligibility Systems

States will obviously need to have systems in place to determine eligibility for public programs and private insurance plans through the exchange. Similarly, once eligibility has been determined, states will need to create processes to facilitate enrollment into appropriate plans. However, there are requirements on these systems that are being contemplated that could be detrimental to states' efforts:

Determining the correct Medicaid match rate

In order for states to receive the higher match rate for individuals that are eligible due to the "new" rules, states will have to verify that any applicant to a public program would not have been eligible under the "old" rules. In effect, every applicant will have to be processed under both the legacy eligibility system and the new eligibility system. Given the fact that the eligible population is being expanded in most states, there will also be an increased number of cases to be evaluated. The increase in workload due to this combination of factors could be catastrophic.

This problem could be mitigated through alternate definitions of maintenance of effort, the ability of states to provide premium assistance, and allowing states the flexibility to develop and use a formula for claiming FMAP when purchasing family coverage.

Screening all individuals and employees for public program eligibility

There is some suggestion that exchanges will be required to screen everyone coming through the exchange for public program eligibility. This represents a significant paradigm shift in that traditionally, individuals or families are screened for eligibility upon application, which is done at their discretion. There are two aspects of any requirement to screen everyone

coming in through the exchange that are problematic.

First of all, there will be a tremendous increase in workload associated with processing information for an increased number of cases. In addition, this will likely result in a significant crowd-out as more people move from private insurance to public programs. Both of these factors work to dramatically increase the cost to the states.

Much of state concern here can be mitigated through clarification of the role of the exchange in determining eligibility and HHS allowance of administrative claiming for appropriate activities within the exchange. Allowing the state to use existing systems to determine Medicaid eligibility in coordination with the exchange is consistent with the plain language of the statute.

Should the state choose to contract any part of eligibility determination with a private vendor, that determination should be final. This clarity would avoid duplicative administrative costs. Allowing Medicaid funds to be used within the exchange has precedent. HHS allowed states to charge a significant share of administering the state Children's Health Insurance Program to Medicaid.

Options for low income families

It is not clear what options families below 138% of FPL will have with regard to the exchange. The principle of consumerism suggests that all families, regardless of current income should have the option to choose a private plan that best meets their family's needs. Those who are eligible for public programs may also have the option of choosing to enroll some or all of their eligible family members in public programs. The option for families to choose a private plan should be enhanced, not limited, in the exchange.

One possible solution would be to make any needed changes under Section 1906 to encourage states to use premium assistance. HHS should allow states to purchase a private plan available through the exchange for families and establish a type of savings account that can be used to cover out-of-pocket expenses associated with their choice of plan.

The time has come to give up the paternalism of Medicaid and allow individuals and families the opportunity to make choices for themselves. This increase in consumer engagement will result in more efficient decisions and a better overall consumer experience. The end goal for most low-income populations could be a Medicaid system where the only program is the amount of subsidy that a family qualifies for.

Section 1411 requirements

The eligibility requirements in Sections 1411, 1412, 1413 and 2201 are particularly onerous on states and have the potential to be a huge unfunded liability for states. For example, "Section 1411 of the Affordable Care Act requires the Secretary to establish a program for determining whether an individual meets certain eligibility requirements for exchange participation, premium tax credits and cost sharing reductions, and individual responsibility exemptions." This passage suggests that

states will have to become involved in determining individual eligibility for advanceable and refundable federal tax credits and payments to insurers by the federal government on behalf of families.

The first problem with this requirement is the sheer size and expense of taking on this responsibility. It is estimated that in the State of Utah as many as 70% or more of working families would be eligible for at least one federal program. It should also be noted that these determinations will be based on criteria that are different from any current program, so a new system for eligibility determination will be needed.

This represents an unprecedented expense for states to take on the responsibility of administering a federal program. As previously stated, HHS should provide clear guidance immediately that federal Medicaid funds can be claimed for appropriate activities within the exchange.

In addition to the difficulties and lack of funding to actually making those determinations, this creates a serious liability question for states. If the state system makes an error that results in an overpayment to an individual or insurance carrier, there is the potential for the state to be liable for that overpayment.

At a minimum, the federal agencies responsible for these programs should secure a funding source to compensate states for the administration costs and provide liability protection to the states.

Another complication is that there is no standard definition of income across federal welfare programs. Even within Medicaid, there will be different versions used for some categories of eligibility. It is imperative that the federal agencies agree on a synchronized definition of income that can be used for all federal programs.

Coordination of Eligibility and Enrollment between Medicaid, CHIP, and the Exchange

A state's ability to coordinate eligibility and enrollment effectively will depend on several factors. The first consideration, however, is that the state work to maximize consumer choice.

There will be families where only some members of the household qualify for public medical programs, while others do not. For example, families between 133% and 200% FPL may have children that are eligible for CHIP.

We need to clarify what options these families have. Can they choose to cover the non-eligible family members through an employer-sponsored plan and put the rest on a public program or would they be required to put all family members on the employer-sponsored plan? We would like to give families the option to use a premium assistance program in these cases.

States should be allowed to use Medicaid and CHIP dollars in the exchange to help lower premiums for everyone as plans compete for the 50-70 million low-income people who are generally very healthy. In reality, many (if not most) of the newly eligible population will be young, healthy adults who belong appropriately in the

same risk pool as their moderate-income neighbors.

As the Deputy Center Director for the Center for Medicaid, CHIP, and Survey and Certification recently pointed out, millions of Americans will be moving back and forth between Medicaid and the exchange. If this churning is not simplified and reduced, it will drive up both premiums and administrative costs.

The best solution to churning is to create state flexibility to keep insured families on their same plan by giving them premium subsidies without having to separately administer a wrap-around benefit. In addition, if needed, Medicaid or CHIP funds could be used to "buy-down" deductibles or be placed in a type of savings account to help lower the out-of-pocket cost to qualifying families without requiring them to change plans. Not only will this help lower the costs to Medicaid, it will provide better outcomes for families due to continuity.

In addition, it is a particularly complicated problem trying to interface month-to-month public programs with annual private programs. Special consideration has to be given to the challenges in verifying eligibility and making smooth transitions that this discrepancy creates.

An additional problem arises when we consider that the exchange is not only handling individual policies, but also employer-sponsored health plans. More thought needs to be incorporated into how to transition people from public programs to an employer-sponsored plan.

There is an incredible amount of information that would be required to assist a consumer in making a good decision from their globally available options, especially considered the problems already mentioned regarding determination eligibility under legacy systems and the varying definitions of income for federal programs. At a minimum, the exchange would have to collect the following information to do a reasonable job at pre-screening for eligibility:

- Citizenship status
- Household composition
- Demographic information
- Current case status and case history
- Employment status and the availability of private group coverage
- Household/family assets
- Insurance enrollment history

In addition, not everyone will have access to the computer resources to be able to use the system. Some ideas that may help improve consumer access and the consumer experience include:

- Make sure that the system uses plain language for everything so that the consumers really know what their options are and what they are getting
- Take advantage of technological resources to provide consumer education or information

- Maintain a dedicated call center or phone line to assist consumers that are struggling
- Set up a system where the consumer can authorize the state to access existing information so that the consumer doesn't have to submit everything again
- The system should be seamless; a truly one-stop shop for all consumers
- All agencies involved should have access to the information they need to avoid repeated requests to the consumer to re-submit information already in the system

Besides helping the consumer, there are some features that could reduce the administrative burden on the states. If the system could request permission from the consumers to pull their information from existing sources (such as IRS or state employment records) on an on-going basis, eligibility reviews could be conducted much more efficiently.

A way to do this while protecting the consumer's right to privacy would be to establish a Fast Lane option for eligibility. Consumers choosing this option would grant permission for the eligibility to be determined both initially and at designated review periods from existing databases. Consumers that do not wish to use this Fast Lane system would have the option of submitting manual documents for initial determination and at renewals.

Another administrative burden on the system is the need to coordinate Third Party Liability (TPL) for medical claims when a patient has more than one source of payment.

Premium aggregation and premium assistance could essentially eliminate TPL. The premium aggregator function of the exchange would allow any given individual or family to pool resources to purchase a single policy that meets their needs. If public program funds were allowed greater flexibility to be used in this way, TPL and the administrative burden it causes for providers, public programs, and insurance carriers could be eliminated.

Another desirable feature would be to move beyond scanned documents to a system when key information is taken from documents and entered in analyzable digital form. This would allow decisions to be automated. Similarly, the system should have the ability to communicate through electronic means (such as e-mail or electronic mailboxes) with consumers.

Finally, perhaps the most effective way to reduce administrative burden would be to reduce and simplify the number and type of public programs available.

Coordinating eligibility between Medicaid, CHIP, and the exchange is an enormous task that if fully implemented would place a large burden on states. However, if states were given enough flexibility, it is conceivable that states could come up with a way to coordinate both eligibility and enrollment using technology.

Adverse Selection

HHS regulations also have the potential to create havoc in the traditional small group markets if they are not done properly. In Utah, it is important that there be a level playing field for both employers and insurance carriers inside and outside the exchange. By over-regulating the exchange side of the equation, HHS would create adverse selection issues for carriers as higher risk people gravitate to the exchange.

At the same time, HHS should not take this as an invitation to regulate plans outside the exchange. This is the role of the state insurance departments. In this regard, HHS should work toward establishing a minimum set of criteria for states to be compliant with the statute then turn back to the states to regulate plans in a way that maintains the level playing field. In some circumstances, states may wish to consolidate all of their small group business into an exchange model, however, it is essential that this be a state decision, not a federal regulation.

Another potential for adverse selection that deserves mention has to do with the producers. States and HHS must be aware that financial incentives can be created for producers that will result in adverse selection and higher costs. It is important that whatever commissions or producer compensation that is developed be structured in a way to maintain the level playing field inside and outside the exchange as well as among carriers within the exchange.

Potential Cost Centers

It is also important to remember that the provision discussed here can also represent significant costs to states that may not be fully reimbursed by HHS. In addition to the obvious costs associated with developing the core functionality of the exchange and expanding Medicaid eligibility, there are other cost centers that may be overlooked. Here are some examples of cost centers to be conscious of.

Access Points

States may be required to provide access to the exchange system at multiple points and on multiple platforms (such as by phone, by mail, in person, or online). This duplicity in the system will necessarily raise costs and could potentially be very expensive to implement.

Insurance Carrier Interface

The process of having plans certified while still allowing for variety and choice could impose a significant additional administrative cost on carriers.

Employers

Additional federal requirements on employers to comply with certain provisions in order to qualify for subsidies, avoid penalties and engage in the new system can represent a significant unfunded cost of federal health care reform.

Public Outreach

States may find it difficult to comply with requirements regarding outreach, especially to under-served populations. While the reform contemplates a navigator system to actually accomplish that objective, it appears to also grow the role of state

government in overseeing, organizing, training, and implementing these programs.

Workload on Current Systems

Elsewhere in this document, we point out the significant increase in workload on current systems. Not only will this require an increase in staff, there is also the potential for the much higher volume to overload the system and require significant intervention to resolve the issues.

Indirect Cost to Medicaid

Estimates of the cost of increased enrollment on Medicaid often overlook the potential crowd-out effect as people drop private coverage to join public programs. This represents a net loss to the health care system as private funds that were previously coming into the system are no longer available.

Medicaid Operational Systems

We have examined problems related to eligibility elsewhere, but it should be noted that all Medicaid operational systems will see a corresponding increase in volume and may be forced above capacity, requiring intervention, or they may need to develop additional functionality to interface with the exchange in ways that have not been contemplated through eligibility.

Utah's Goals for Health System Reform

The core principle behind the Utah approach is the empowerment of individual consumers to make better decisions about their health and health care and reap the benefits from those decisions.

The Utah Model recognizes that the most effective way to make real progress in reforming the health care system is to rely on the invisible hand of the marketplace rather than the heavy hand of government.

Engaging the consumer represents the best hope for addressing the issue of costs. As consumers have an increased stake in their health and health care, competition at the consumer level will drive efficiency as well as better decisions on the part of individuals and families.

For the past forty years, policies have resulted in consumers believing more and more that it is "someone else's" responsibility to arrange for, pay for and provide their health care. The end result has been a system with poor incentives and poor health outcomes, despite our rapid advances in technology. Whatever system we end up with, consumers have to have some skin in the game if we are going to have different expectations and outcomes.

Each reform in Utah has required minimal intrusion from the state government. Each reform empowers businesses and employees to obtain insurance through the private market and does not expand current public insurance programs beyond existing law.

In 2005, policy analysts conducted research to help leadership understand the nature of the uninsured population in Utah. Three facts stood out: 1. The majority of uninsured Utahns were in families where one or more of the working adults were employed by a small business, 2. The percent of small businesses in Utah offering health insurance as a benefit declined rapidly from 2000 to 2005, resulting in Utah being significantly below the national average in terms of offer rates to employees of small businesses, and 3. Surveys of small business owners gave the lack of predictability of cost as the most common reason for small businesses not to offer a health benefit.

Based on these results, it was determined early on that developing reforms that could help small businesses and their employees would be a key to making a difference. While the reform effort has also incorporated other aspects, there is a particular sensitivity toward small business. The development of the Utah Health Exchange (the Exchange) is the most visible expression of that effort.

Defined Contribution Arrangements for Health Insurance

Before we explore the mechanics of the Exchange in detail, there are three pillars of health reform that deserve introduction.

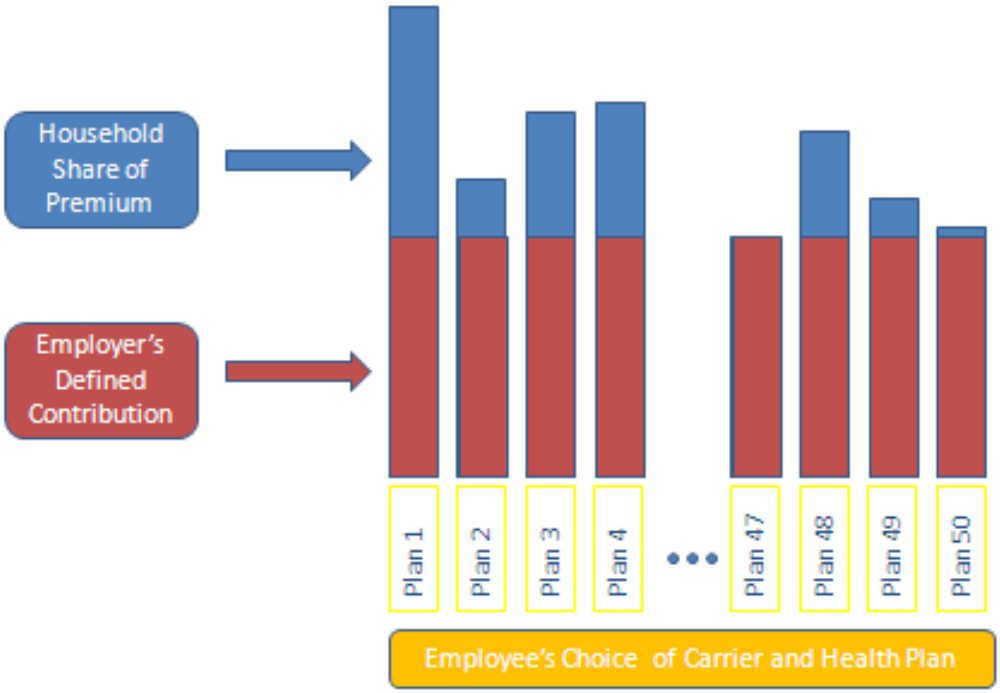

Figure 1. Defined Contribution Arrangements

The first foundational pillar of the Utah Model is the 2009 creation of a Defined Contribution market in the insurance industry. Defined Contribution arrangements provide a unique opportunity for reform to aid businesses in a way that promotes consumerism. The traditional model of health benefits where employers are responsible for making purchasing decisions on behalf of their employees is not consistent with the underlying philosophies of health system reform.

Similar to a movement from pensions to Defined Contributions in the employee retirement benefit, in the Defined Contribution market for health plans, employees have full control over decisions relating to their choice of insurance company, provider network, and benefit structure. Employers simply decide how much to contribute toward each employee's policy. The end results are greater efficiency in the labor market as compensation is more transparent as well as more competition in the health insurance market as plans have to compete directly for empowered consumers.

As shown in Figure 1, in a Defined Contribution setting, employees have access to an expanded set of options beyond a traditional health benefit. Funds from the employer's choice of Defined Contribution are applied to the premium associated with the employee's choice of health plan, and the employee is responsible to pay the difference, if any.

The true goal of health reform is to change the game when it comes to health outcomes. At the end of the process, we

need to have a system that results in a healthier population. Any other outcome cannot be represented as a success. If insurance reform or development is going to contribute to this success, insurance carriers need to be invested in the future health of their enrollees.

In a traditional employer-sponsored health plan, there is little chance for an insurance carrier to develop a long-term relationship with families. Employers often change their carriers and families are changing employers at an increasing rate. This lack of a long-term relationship diminishes the carrier's opportunity to work with families to promote a lifetime of health and wellness.

The Defined Contribution approach to employer-sponsored plans reverses this trend. As long as working families have an employer that participates, they can keep their carrier and plan if it is meeting their needs. This creates powerful opportunities for carriers to innovate based on the prospect of a long-term relationship.

Since Defined Contribution arrangements are a relatively new feature of the health insurance market, it appears that the statute did not adequately anticipate their relationship to subsidies and premium tax credits. HHS will need to think carefully about how to support and square eligibility requirements when employers are using Defined Contribution arrangements.

Prospective Risk Adjustment

Of course, flexibility and choice introduce the possibility for a new type of adverse selection into the employee health benefit market. It is possible that higher risk employees may gravitate to a particular insurance carrier, while lower risk employees may gravitate elsewhere. In order to protect carriers from this particular type of selection, Utah has introduced a Prospective Risk Adjuster. Actuaries and carrier representatives participating in the Defined Contribution market were brought together to design this unique mechanism.

Initially, each employee is evaluated for their prospective health risk. While this does not directly impact their premium, it does allow the carriers to compare the actual premium paid on behalf of each employee (based on their choice of coverage) with the risk-adjusted amount of premium for that same plan as shown in the left panel of Figure 2. In any market where the risks are not fully underwritten, some employees will pay less in premium than would be actuarially justified while others will pay more.

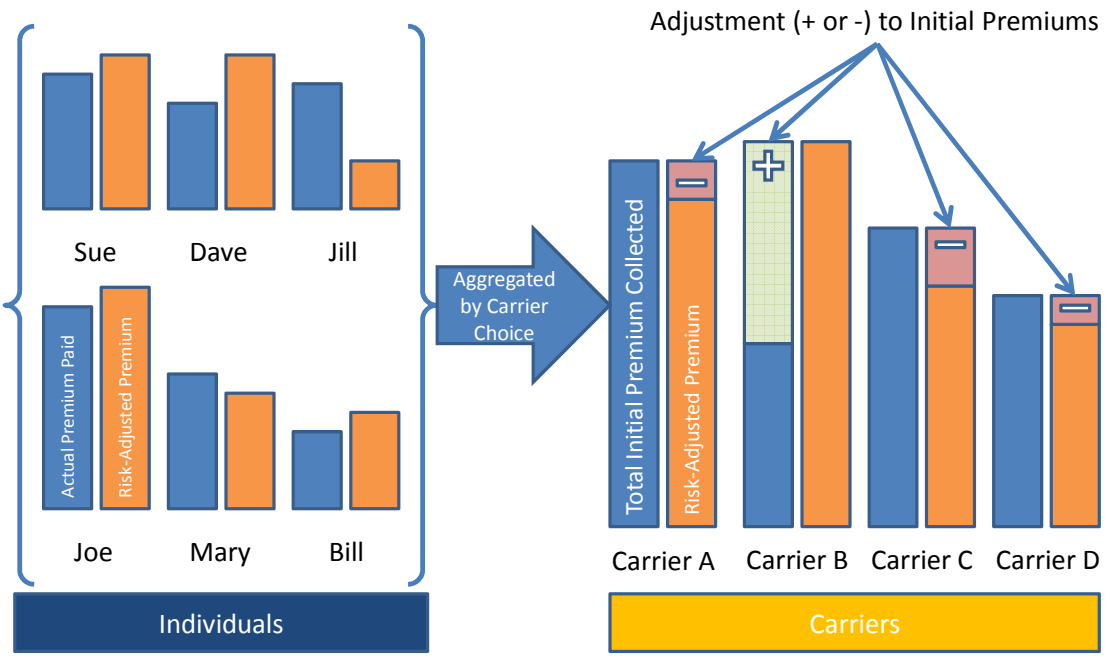

Figure 2. Prospective Risk Adjuster

Once the employees have chosen their plans, we can compare the total initial premium attributable to each carrier to the total risk-adjusted premium associated with the employees choosing their plans. In the right panel of Figure 2, the example shows that Carrier B was selected against, receiving a relatively high-risk set of employees, such that their total initial premium collected would be less than the total risk-adjusted premium.

At this point, the prospective risk adjuster transfers initial premium from carriers with relatively low-risk enrollees to those with relatively high-risk enrollees so that each carrier is receiving the correct risk adjusted premium.

There are a few features of this system to point out. First, the system was designed and agreed to by carriers to protect themselves against adverse selection. Second, this approach to prospective risk adjustment preserves incentives for carriers to work with their enrollees to keep them healthy and keep costs down. Third, it is a simple system to administer that can be used in other settings where this type of selection is likely to arise.

Premium Aggregation

The next key foundation of the Utah Model is the concept of Premium Aggregation. Traditionally, working families could not pool resources from multiple sources to purchase health insurance. In the Utah Model, this has been changed.

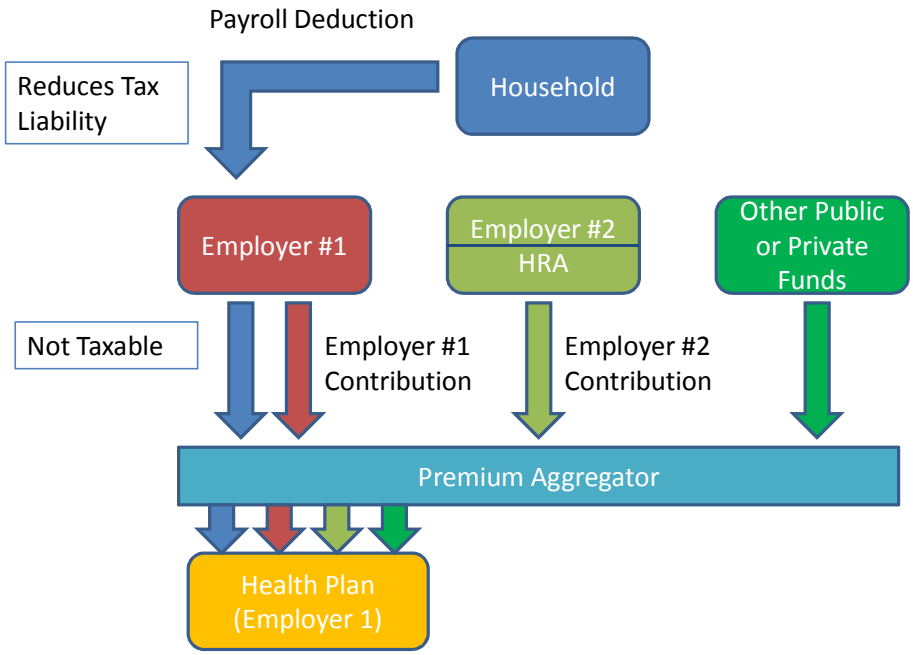

Figure 3. Premium Aggregator Flow of Funds

Having a Defined Contribution health benefit creates the opportunity for working families to combine contributions from multiple employers, public programs, and other sources toward the purchase of a single policy that best meets the family's needs. This is another example of how the Utah Model for health reform can facilitate consumerism in health care.

As shown in Figure 3, households that have more than one job with participating employers can now elect to have the Defined Contributions from all employers, as well as any public or private subsidy money pooled together for the purchase of a single health plan.

By conducting this arrangement within the confines of the Premium Aggregator, it is also possible for all contributions to be made with pre-tax or non-taxable dollars. The end result is that consumers will be able to take advantage of all of their resources to purchase a single plan that works best for them. In addition to a result that is more consumer-oriented, this reduces the distortions, bad incentives, and administrative costs that are associated with dual coverage and coordination of benefits.

Additionally, premium aggregation has the potential under the ACA to reduce the need for federal premium subsidies for lower income families who could pool together private resources to purchase a single policy for the family.

The Utah Health Exchange

Based on these pillars, it became obvious that operating a new method for providing insurance to the employees of small businesses could be significantly more complicated for the consumer. To address that issue, the Exchange was created to be the technology backbone that allows for the efficient operation of markets that feature expanded individual choice.

The very essence of the Exchange is to provide a single shopping point that connects consumers with the information they need to make informed choices and execute those choices electronically. The Exchange is a critical component in moving toward a consumer-based system.

Reliance on the Private Sector

Utah's approach is also distinguishable from other approaches in its pronounced emphasis on private markets. The Exchange brings together private partners with existing capabilities and resources and allows them to provide valuable services to working families in Utah. The Exchange's initial startup budget was approximately $500,000.

Instead of creating more government, the Exchange reached out to the private sector to identify existing technologies that could provide the functions needed for a successful consumer experience. Most of the technology needed to implement a successful Exchange already exists in the private sector. Private stakeholders are aware of the issues related to operating an Exchange and have the tools needed to address them.

For the small group market, two vendors were chosen through a competitive bidding process. One vendor, bswift, provides the electronic tools necessary for employer and employee enrollment as well as the critical tools necessary for employees to identify and compare plans to make an informed decision. bswift's package provides advanced decision-making tools to help employees find the right types of plans for their needs, based on their family structure, income, health history, and other features.

The other vendor, HealthEquity, performs the financial functions of the Exchange for the small group market. HealthEquity communicates with bswift to identify the correct premium contributions from each employer based on the employees' choices, collects those funds, applies the prospective risk adjuster, then disburses funds to the carriers and others that need to be paid.

Instead of hiring dozens of new government employees to develop and operate this system, the Exchange now has just three full-time employees and an annual operating budget of approximately $600,000.

The Risk Adjuster Board

Policies relating to the treatment of risk and premium in the Exchange are set by the Utah Defined Contribution Risk Adjuster Board (RAB). The RAB is composed primarily of representatives of the insurance carriers with actuarial experience. There are also representatives from government and the private business community.

Because its membership is heavily weighted toward the insurance carriers, it provides a unique opportunity for the carriers to

cooperate in designing a system that makes sense from a risk management perspective yet allows carriers a forum to compete aggressively at the consumer level for individual business.

As a practical matter, most of the technical solutions required to implement the Exchange have come as a result of cooperation among the participating carriers. As a protection to consumers, decisions of the RAB are subject to review and modification by the Insurance Commissioner.

Solutions for the Individual and Family Market

While the main focus of the Exchange recently has been to facilitate the Defined Contribution market for small businesses, there is also a component of the Exchange that facilitates choice and selection in the Individual and Family Product (IFP) market. In Utah, current statute allows products in the IFP market to be fully underwritten and carriers can deny coverage to applicants whose risk exceeds 325% of the standard expected risk for their case characteristics.

High-risk individuals that are denied coverage in the IFP market can purchase insurance through Utah's contracted federal pre-existing condition insurance plan (Federal HIPUtah) or the state's Comprehensive Health Insurance Pool (HIPUtah).

Early analysis showed there is already a significant amount of consumer choice in the IFP market and because it is not guaranteed issue, the premiums tend to be among the lowest in the state. While the market seems to function generally quite well, the Exchange has a valuable role to connect consumers with private companies that can help them identify and purchase the product that is best for them.

Since September 2009, the Exchange has been providing three options for these consumers to shop for and buy a policy: 1. they can use one of four available online shopping services, 2. they can buy direct from one of five carriers that sell direct to consumers, or 3. they can search for an agent that can provide in-person assistance.

Cost and Quality Data for Consumers

An Exchange should be a lot more than just a place to buy insurance. A third major role of the Exchange is to promote wellness and provide transparency on cost and quality for consumers.

Utah has one of the premier All-Payer Databases (APD) in the country. Because the Utah APD has a unique patient identifier, it is possible for the APD to be used to construct true costs for episodes of care, even if a patient switches providers or carriers during the episode.

This powerful tool is still being refined, but is already showing the capability of informing policymakers and consumers about critical areas of health care costs and quality. The eventual goal of the Exchange will be to link consumers to the cost and quality data they need to make informed decisions about their health care, increasing the efficiency of the provider system.

Interface with Public Subsidies

Utah statute also requires the Exchange to inform enrollees in the small group market

about potential public programs and subsidies for which they might qualify. The Exchange uses a simple pre-screening module based on self-reported income and household size to identify applicants that may be eligible for Medicaid, CHIP, or the premium subsidies through the Utah Premium Partnership (UPP) and provide them with an opportunity to apply for those programs.

Status Update

Here are some additional details about the operation of the Exchange, especially as it relates to the Affordable Care Act.

During September 2009, the Exchange conducted a limited launch of the small employer technology to identify and resolve technological issues. The launch was successfully completed with a total of 11 employers having a Defined Contribution arrangement for their employees with a January 1, 2010 effective date. All 11 are still with the Exchange and are currently going through the renewal process for 2011.

On September 1, 2010, the Exchange opened on a continuing basis for all small employers. Employees in the Exchange will have their choice of plans from four different insurance carriers who have submitted a total of more than 100 different plans.

Within the first two weeks over 200 small employers applied through the Exchange to offer a Defined Contribution arrangement for their employees with a January 1, 2011 effective date.

The exact number of employees in these arrangements will not be known until eligibility determinations are final, but based on our 2009 limited launch we estimate that small businesses will average around 15 employees, and employees will average around 2.5 covered lives per household. While it is not highly likely, if 200 employers are approved and enroll their employees through the Exchange, there is a potential for over 7,500 people to be covered through the small group component of the Exchange by January 1, 2011.

It is critical to keep in mind that many of the people purchasing coverage through the Exchange are self-employed owners of small businesses and their employees. To keep the cost and premiums down and enhance value, it is important to give them access to many options to purchase insurance products that best meet their needs.

Of course, as with any new program roll-out, we do not expect everyone to come on the first day. More realistically, we expect enrollment to grow steadily over time as the word gets out. At present the Exchange is open for employer application to have Defined Contribution effective dates of February 1, 2011.

At the same time as the small group market is opening in the Exchange, we are conducting a pilot program for large employers (with 51+ employees) to develop an adaptation of the technology to that case.

At present, there are around a dozen employers that are cooperating in the

development of this system. By the end of the year, those participants that wish to do so can choose to offer Defined Contribution arrangements to their employees with effective dates as early as January 1, 2011. The Exchange plans to be capable of offering Defined Contribution arrangements for all large groups in the state by the fall of 2011.

Critical Milestones between now and 2014

Between now and the HHS evaluation of the Exchange in January, 2013, the Governor's Office and state legislature will continue to work together to determine what adjustments should be made to ensure the success of the Utah Health Exchange in meeting Utah's vision of health reform and the needs of the Utah consumers.

Our legislature meets each year for a 45-day session beginning on the third Monday of January. We have two regular legislative sessions to make needed adjustments before 2013, putting the state well ahead of most other states in developing an insurance Exchange, but still needing to react quickly.

Here are the main milestones already anticipated in the Utah Model:

2010 Completion of the Small Group roll-out

Completion of the Large Group Pilot and resolution of any issues identified

2011 Final implementation and automation of the Premium Aggregator

Completion of the Large Group roll-out

Introduction of the Cost and Quality data interface

2012 Refinement of screening tools to identify those who may be eligible for subsidies

Development of a data interface with the public program eligibility system

2013 Developing a plan to deal with federally mandated guaranteed issue in the individual market in a way that is best for Utah's consumers

Governance, Legislative Authority, and Oversight

The Utah Health Exchange is housed within the Governor's Office of Economic Development in the Office of Consumer Health Services (OCHS). The legislature's role is to enact statutory changes it deems necessary to make corrections, to ensure the Exchange accomplishes the goal of simplifying the acquisition of health insurance and providing residents with transparent information to make them better consumers of health care.

The legislative Health System Reform Task Force is primarily responsible for developing such legislation. This task force is a legislative committee with members from both the Utah House and Senate. The task force is purely legislative and does not include stakeholders, such as hospital groups, insurance carriers or physicians.

However, much of the work of the task force is conducted in sub-committees

where all stakeholders are invited and encouraged to participate. This task force model has shown to be particularly effective in part because of this inclusive structure, but also because of the sense of urgency and priority communicated by legislative leadership.

The Exchange is not a regulatory body. It does not mandate that employers participate in the Exchange nor specify the nature or price of plans insurers can include. While all plans in the Exchange are structured so as to preserve the pre-tax benefit requirements, all regulation of health insurance, regardless of whether health insurance is offered in or out of the Exchange, is regulated by the Utah Insurance Department.

Utah's example of an Exchange contrasts with the "Connector" in Massachusetts. The Bay State's version of an exchange is a larger regulatory body with a significantly larger budget and scope of authority. The Utah approach shows how an exchange can be built with minimal investment. The goal, however, is the same; to decrease the ranks of the uninsured.

Regional or interstate jurisdiction

Utah is currently considering whether a regional or interstate Exchange would increase the effectiveness of the Exchange model. However, discussions and analysis are still in the very early stages and it would be premature to draw conclusions at this time.

That said, we believe it is critical that states have the flexibility to study and consider options that make the most sense for their local circumstances as they negotiate the terms of such regional Exchanges or inter-state cooperation.

State agency v. non-profit

Perhaps the biggest difference between the Exchanges in Massachusetts and Utah is the scope of authority. Massachusetts operates an exchange through the Connector, a governmental agency that is independent, existing as a separate legal authority. The tasks of collecting premium payments and ensuring proper payroll deductions are accomplished by this agency.

Utah's approach is to create the Exchange with limited authority. While the Exchange is not necessarily a non-profit organization wholly separate from the state government, it does contract with private companies experienced in benefits management for most of the Exchange's functions, including premium collection.

Each state faces a decision of how its Exchange will be governed, especially in terms of the level of authority given to the agency running the Exchange. In this sense, Massachusetts and Utah may well serve as bookends for other states; wide-sweeping authority for the Massachusetts Connector, or limited authority for the Utah Health Exchange.

Business Plan & Budget

The Exchange's business plan relies on a very small amount of state general funds to aid in the development and implementation of the Exchange. So far, the Exchange has been able to manage on a budget of around $600,000 per year, which mostly pays for staff time and development. The business plan of the Exchange going forward is that virtually all of the cost of operating the

Exchange's technology features can be funded by the users of the Exchange at a very low level.

In fact, when the Exchange is fully developed and operational, there is no specific reason that it should need to stay as a state-sponsored agency. It could very easily be converted into some form of quasi-governmental or private non-profit entity that is self-sustaining.

We can also foresee the great potential for the creation of competing private exchanges, especially as employers seek new options and innovators respond to that demand. Under no circumstances should HHS discourage the development of private exchanges nor attempt to regulate activities that do not rely on federal funding.

Expectations for Development and Operational Costs

At present, the Exchange has been very successful in leveraging private resources for the development and operation of the Exchange. HHS should not move forward with an expectation that states will be required to fund the development and implementation of federal reforms with public funds.

How planning grants can be helpful

It is good policy for states to carefully consider how to proceed and whether to apply for or accept any federal funds relating to the establishment of an exchange. Planning grants provide a unique opportunity for states to make those determinations thoroughly without committing state funds.

Planning grants can be most helpful to states if HHS is willing to give states greater flexibility in how they are used. Our experience has shown that it is difficult to anticipate even a few months in advance what issues will arise and require resources to address. The recent planning grant proposal was less effective than it could have been because of the requirement that states be fairly specific about the projects and plans for the coming year.

By its nature a planning grant should anticipate that states do not know what challenges they will be facing and should allow states the opportunity and flexibility to explore and address those issues.

Depending on the level of imposition by federal regulations, Utah will have various needs as it continues to build out the Utah Health Exchange. We may need HHS grant funding to:

- Figure out how to develop and pay for a private sector solution for the call center to assist consumers, employers and insurance producers in navigating the Exchange and the Defined Contribution insurance market. In particular, we will need to explore how to coordinate the efforts of that call center with the various existing call centers in both the public and private sectors.
- Understand the full impact of federal requirements to replace our currently functional individual market, with an untested model of guaranteed issue individual policies.

- It appears that we may also need funding to develop technologies for the state to collect information on the private transactions between individuals and insurers in order to meet federal requirements regarding eligibility screening and enrollment. Currently, we do not monitor or collect information the purchase of private individual policies through the Exchange.

- We may also need planning and implementation funding to meet other requirements that fall outside our current desired scope of reform, such as establishing rate reviews, administering small employer tax subsidies, and other functions associated with business operations in the Exchange.

- Of course, we also need to continue development of the existing long-term objectives of the Exchange.

These are just a few examples of ways Utah may need to use planning grant funds. Fortunately, Utah is ahead of most states in forming an exchange, and as such would use planning grant funds differently than most states. **However, Utah's advanced position makes these grants no less vital.**

Future Concerns

We have put a lot of effort into ensuring that the rules governing health plans in the Exchange are the same as plans outside the Exchange, resulting in robust risk pools in both markets. The Utah Health Exchange's success in the following years depends on health insurance premiums that are competitively priced with plans outside the Exchange.

Through the efforts of the state government and the Risk Adjustor Board, private insurers have worked together cooperatively to ensure a competitive marketplace for consumers. The greatest desire in terms of the ACA is that this process moves forward with Utah in the driver's seat. We believe that Utah's goals are fundamentally compatible with the aims of the ACA, but Utah must retain flexibility, especially in terms of the Exchange, in order to produce a result that works best for its residents.

Utah's experience in bringing the consumer back into the equation can inform the operation of exchanges in other states. Each state is unique, with its own insurance market structure, consumer involvement and regulatory environment. No one model can work for every state and each state will need a significant amount of flexibility to develop a solution that will work for its state. However, all states can learn a great deal from the Utah experience.

Based on the Utah experience, we anticipated that we can identify aspects where some industry standardization across the states would be desirable. Certainly the financial sector has benefitted from national standards.

For example, there are technological components that could enhance efficiency across states. Since most insurance carriers will be operating in more than one state, it makes sense to use a common standard for them to interface with the various exchanges. Private firms can develop

modern, flexible, and simple technologies and standards for exchanges.

Similarly, as states may be required in the future to communicate with federal agencies, it also makes sense for a common technology standard to be implemented. If states are to be required to screen enrollees for eligibility in public programs, it also makes sense to have a standard technology that can serve as a preprocessor or module for each state's exchange to implement.

While the federal government can provide leadership by working on public and private sector technologies, any standards should be considered as "national" instead of "federal." With private partners, state should maintain flexibility in the adoption of national standards and the means of adopting them.

At the same time, there are many aspects where flexibility across states is desirable. It is important to recognize that each state has its own political reality and governance structure that will impact the way that state government will interact with the exchange.

Similarly, each state has its own set of local markets and health care systems, which will also greatly affect how an exchange will operate. These variations range from the insurance market structure, labor market structure, business environment, and health care system.

Utah has a high percentage of small business related employment, strong and competitive hospital networks, and a fairly robust insurance market for a state of our size. Considering these factors, it seems obvious that a Defined Contribution market is right for our state. Insurance carriers in Utah need a lot of flexibility in plan benefit designs to be able to compete successfully and remain viable.

From the Utah experience, we have also learned that there are several major systems that are necessary for the Exchange to function successfully. The following systems represent some of the key areas of attention needed to have a successful Exchange:

Insurance carrier involvement

Insurance carriers need to be able to communicate critical information with the Exchange about plan structures, enrollment, and pricing. In addition, the carriers need to be able to retrieve the information they need to be able to correctly price plans within state guidelines.

Employer involvement

While part of the goal of an exchange is to greatly reduce the burden on the employer, there are still some legal requirements that an employer will need to deal with.

In order to make that as easy as possible, an exchange needs to allow employers to manage their employee involvement in the plan. Employers will need to add or drop employees as their employment or benefit eligibility status changes. There must also be a mechanism for the Exchange to communicate critical information to employers or their representatives.

In addition, due to archaic tax laws, the employer is heavily involved in the funding of employment-based Exchange plans. Both the employer and the employee's payroll

deduction contribution are sent by the employer to the Exchange.

The Exchange must be able to easily verify the total amount due from an employer and compare that with the employer's contribution, then deal with any overage or underage. The Exchange must also have the capability to forward those funds to the correct recipient, whether that is a carrier, producer, or other vendor in the system

Employee and individual involvement

This is the heart of the Exchange functionality. The most critical function of the Exchange is to facilitate informed consumer choice. Employees and individuals must be able to view the plans that are available to them, with accurate information about prices, benefit design, and provider networks.

In our experience, most employees will need tools to help them filter the available options down to the choices that are most consistent with their needs. This functionality is similar to how travel web-sites allow a person to enter information about the desired destination, dates and times of travel, type of fare, and other restrictions and receive back a short of list of the matching flights and prices.

It is critical that the Exchange offer similar functionality to purchasers of health benefit plans. It is also important for the choice to be executed electronically and in real time.

Utah-based Responses to Specific Questions

Comments on Insurance Market Issues

Rating Areas

Currently, the boundaries of rating areas in Utah are established by the carriers, not by the state. Most carriers have established rating areas based on their experience in the underlying markets.

It is typical for carriers to distinguish between rural areas and the more densely populated Wasatch Front (Weber, Davis, Salt Lake, and Utah counties). Some carriers also establish a separate area for the St. George region. Factors in making these decisions include the availability and location of providers.

Interstate rating areas in Utah are not common because Utah has a young and healthy population with high quality health care compared to neighboring areas.

Our view – Rating areas should be voluntary for carriers, but should definitely be allowed.

Risk Adjustment, Risk Corridors, and Reinsurance

Outside the Utah Health Exchange there are no state-sponsored programs or formal arrangements between carriers for dealing with risk. However, most (if not all) carriers in the state are using reinsurance at reasonable levels.

Inside the Utah Health Exchange, we use a prospective risk adjuster to help protect insurers from possible selection issues in the Defined Contribution arrangements. In order to carry this out, the carriers have to know the relative risk of a given client in order to calculate the adjusted premiums and the funding has to be available for adjustment and disbursement to the carriers according to the risk-adjusted formulas. The participating carriers in the Utah Health Exchange are also developing possible tools for retrospective risk adjustment and sharing, although nothing formal is in operation at this time.

Our view – Prospective risk adjustment is the most appropriate tool for dealing with potential selection issues that might arise from additional consumer choice because it preserves the proper incentives for carriers to monitor high-dollar cases and implement cost-saving and efficiency-enhancing tools.

CO-OP plans

CO-OP type plans are allowed in Utah, but the results are mixed at best. Our experience with these types of plans indicates that they tend to have a high rate of noncompliance or fraud. If CO-OP type plans are going to be encouraged, states need to have regulations in place that put in strong rules that address both solvency and marketing practices to protect those who are insured.

Our view – Our experience with CO-OP type plans is not encouraging. Strong oversight from states would be warranted to avoid consumer issues.

Comments on Eligibility and Enrollment Issues

Dealing with Adverse Selection through Limited Enrollment Periods

The main impetus for limiting open enrollment periods for individuals and families is to deal with the selection issues that can arise, especially in the context of guaranteed issue. While it is important to address those selection issues, closing enrollment for individual policies in the Exchange may not be the most effective way to approach this issue. In the past Utah has had periods of open and closed enrollment for our CHIP program, and we have learned from that experience.

Limiting enrollment periods for private insurance is likely to drive people that would otherwise have chosen private insurance onto public programs. During a full open enrollment period, we have the opportunity to conduct a coordinated process to get individuals and families on the "right" program.

Other options that ought to be considered in place of limited open enrollment include increasing the penalties for people that sit out or delay enrollment unnecessarily or implementing a delayed effective date. In any case, if there were to be a requirement for limited open enrollment periods, careful thought needs to be given to the appropriate timing and frequency of those periods, and the option of creating special open enrollments for qualifying life events as is common in the private market.

Our view – Given the possible combination of guaranteed issue and no pre-existing conditions limitations in the individual market, something needs to be done to protect insurers from adverse selection. However, limiting enrollment periods may be counterproductive and drive more people onto public programs. Therefore, if limited enrollment becomes standard in the individual markets, states should be given the flexibility as under the CHIP program to schedule open enrollment periods for Medicaid to reduce "crowd out."

Major considerations in setting up an online enrollment system

The most important consideration in developing an online enrollment system is that its primary value is in its ability to screen people and direct them to the options that create the most value for them.

In that light, it is important to know what constraints will be placed on the hierarchical structure of options. For example, if all individuals that are eligible for Medicaid must be enrolled in Medicaid (whether it is their first choice or not), then essentially every individual coming into the system will need to be screened for public program eligibility.

This suggests that the screening tool not be required to be a comprehensive screening tool at the outset. As individuals come into contact with the system, a preliminary screen based on limited information needs to guide the structure of the system. A full screen for Medicaid eligibility is not only costly to the State, it can also be discouraging to the consumer.

It should be noted that the required type of screening and eligibility determination tool could be very expensive to create; cost is a serious consideration.

States should be able to claim Medicaid administrative dollars in the Exchange, just as they are allowed to do with CHIP. As an alternative, if states were allowed to use an exchange to determine eligibility without any further review, states should be able to collectively save billions of dollars in avoided administrative costs.

We support the concept of full choice and freedom for the consumer. We reject the idea that if a person is determined to be eligible for Medicaid on CHIP they must enroll in that program. We believe that it is the State's role to provide information and options, but the individual must be allowed to choose the option that works best for them.

One of the most challenging complications introduced by the federal funding formulas is the need to determine whether a person is eligible under the new expansion rules or whether they would have been eligible under the pre-ACA rules. This is particularly onerous for Utah because we have had an asset test for some eligibility categories.

Effectively, in order for us to get the higher match, we are required to verify that the person would not have been eligible under the old rules; we have to gather information, including assets, to make that determination. If we are no longer going to be allowed to have an asset test for our public programs, we need to be able to qualify for the higher federal match rate without collecting information on client assets.

We also need the federal government to sync all income eligible programs to have just one standard. There needs to be an official determination based on a single formula. It appears that in the future, MAGI will be used for some eligibility determinations, but not for others (such as aged, blind, and disabled). Is there a way to make this simpler?

Our view – While the main need regarding the establishment of an online eligibility and enrollment system is the need for state flexibility, there are significant federal issues that need to be resolved to greatly reduce the administrative burden on the states that wish to set up such a system.

Data Linkages with Federal and State Data Sources and Data Sharing Issues

Currently Utah agencies are using several data linkages to administer existing programs. For example, state agencies are already able to link to the Social Security Administration to verify citizenship and HHS for Medicare issues.

Several state agencies are using eFIND, which accesses 17 data sources (state and federal) with a single login. This tool is being used to verify "wages, unemployment insurance, child support enforcement, SSI, vehicle assets, household composition," and other data for determining eligibility for entitlement programs.

However, our experience in these data linkages is that existing capacity is outdated and limited. A fully automated exchange

will require auto-pulls from various sources. Similarly, we conduct some eligibility business through inbound phone lines. This system will also have very limited connectivity to a fully functional exchange.

As the complexity of implementing this coordination increases, the prospect of making a full range of services available to diverse populations becomes increasingly daunting. In particular, populations with limited access to computers or internet service may be significantly impacted.

Our view – While some data linkages do exist, the experience has been less than convincing about the prospects for interfacing at the level that the Exchange will require. Federal agencies must provide to states a single data access point where all of the needed information can be transferred to or from state systems.

Comments on User Engagement

Outreach and the Navigator Program

In Utah the best sources of consumer outreach and assistance are the licensed producers and community-based organizations. Licensed producers would be the best source of assistance because they are already trained and experienced in how to explain complex issues and guide consumers through the process.

While many producers have the ability to reach out to and assist diverse populations, it is likely that additional assistance for some populations will be needed in order to maximize success. Community-based organizations that are equipped to help diverse populations will be particularly valuable going forward.

At the same time, there are other natural points of contact in the communities that could be put to work. Most importantly, the public education system interfaces with the majority of families with children. Similarly, community health centers are another natural point of contact to reach out to families that need extra support in joining the system.

There are several elements that would be required to achieve a successful private sector system to aid in outreach and navigation, including:

- Educating the consumer
- Providing accurate and useful information
- Providing referrals to appropriate places to get assistance
- Adequate oversight and funding
- A significant amount of on-going training
- Some additional investment in technology
- Possible need for compensation for successful enrollment

Our view – The best navigators will be those who have the training and expertise to provide advice and assistance to consumers. In addition, there are many points of contact where consumers connect to the health care system that can be leveraged to provide valuable support to the consumers.

Focusing on the Consumer Experience

The most important aspect of the Exchange when it comes to the consumer experience is the ability of the consumer to make a good decision easily and efficiently. This may require a variety of approaches depending on the variety of consumer needs.

The Exchange must communicate value to the consumer. Consumers must understand the costs and benefits to them of any given choice. Standard insurance arrangements typically do not communicate costs very well, in large part due to the fact that the true costs of a policy are not realized until the consumer needs health care. Nevertheless, the Exchange needs to be able to summarize effectively the costs a consumer might expect to see under each alternative.

It may also be important to communicate value to the consumer through a tool that evaluates each option on a consistent basis. Such an evaluation might take into account the premiums, rate increases, provider networks, out-of-pocket limits, and other cost features. Consumers should also understand the relationship between premium and total expected cost to the insurer.

The are many venues where consumers can be reached, including the work place, health care providers, social services offices, schools, libraries, and other local government offices or services.

The Exchange could be an incredible tool for outreach and navigation if it contains elements that make it a workable facilitator to get a consumer to the right solution for their family.

In some cases, especially for populations that do not have ready access to traditional internet services, a type of case management might be appropriate. In any case, the outreach and navigation system should take full advantage of existing data systems and linkages to help coordinate outreach efforts.

We also note that the best way to ensure that consumers are protected against misrepresentation or fraud by the insurance industry is to have a knowledgeable and well-staffed insurance department.

Our view – The most critical element for the consumer is to be able to easily make an informed choice. In order to spur competition, the Exchange must expand consumer choice, however, the Exchange must also provide clear and understandable information about those choices for the consumer to gain full advantage.

Facilitating Employer Participation

When it comes to the employer side of the equation, it is helpful to remember that most employers are not in the human resources business. Several elements will help keep the Exchange accessible to all employers. Most importantly, the process should be as absolutely simple as possible from the employer's perspective.

We also have to maintain a level playing field between the Exchange and any external markets. We do not want the structure to artificially drive employers into or out of the Exchange. All participants have to accept that risk adjustment, properly

done, will be adequate to achieve price parity in a Defined Contribution market.

Over time, it will be critical to communicate to employers and employees the concept of total compensation. Using the value of total compensation to evaluate job opportunities will become a tool of competition that will promote efficiency in the labor markets. Both employers and employees will need to get used to thinking of their compensation in dollar terms instead of intangibles and commodities.

We also recognize that employers have made significant gains in the area of employee wellness. While this is a welcome development, it is probably not the long-term role of the employer to work on this. The time has come to pass off the wellness baton to the consumers and the insurers as they continue to promote healthy behaviors among workers.

The Defined Contribution system has tremendous power and advantages to an employer, especially a small one. However, in order to provide that advantage to the employers, the system needs to stay simple and easy to access. Employers also need to have flexibility in determining the best time for them to transition over to an exchange system.

Our view – Any reform system designed to help small employers must have clear advantages to the employer, including simplifying the process of providing a health benefit, providing a level playing field for competition inside and outside the Exchange, and the flexibility to meet the employers financial and business goals.

Summary of the Main Issues and Concerns Related to Federal Regulation of Exchanges

- The single most important message in this response is that HHS needs to grant states broad flexibility moving forward.
- HHS should work with the sovereign states to create laboratories of innovation that can inform efforts moving forward.
- HHS should not require proof of success before state "experiments" can be certified. 50 states should be allowed to try things so we can learn what works and what doesn't.
- It is the responsibility of each state to define its goals and objectives. It is then the role of HHS to help states get there.
- Insurance carriers in each state need flexibility to innovate and develop plan designs that are competitive, consumer-focused, and have the ability to contain costs.
- While states should set parameters for exchanges, state Insurance Departments should not be in the business of deciding what can or should be sold on the exchanges.
- Any national definition of an essential benefits package should only be a set of service categories (like inpatient hospital) and not a list of required specific treatments for specific conditions. States should then have the ability to determine how best to adopt those standards.
- Mandatory coverage of treatments for specific conditions is the purview of state legislatures.
- We have to give up the paternalism in Medicaid. The end goal for most populations could be a Medicaid system where the only program is the amount of subsidy you qualify for.
- Exchanges need to be empowered to maintain or increase continuity as families move onto or off public programs.
- We need serious consideration and support to implement simple and effective premium assistance programs.
- There needs to be a bridge to resolve the disconnect between monthly eligibility for public programs and the traditional annual basis for private insurance contracts.
- We are concerned that the ACA creates an imbalanced treatment of the traditional and exchange markets. This uneven playing field can create problems with markets and selection issues.

- Requirements on plans inside/outside the exchange need to be the same to avoid selection. Since it is not the role of HHS to regulate all plans, the only way to approach this is for HHS to give very broad guidelines and allow states to implement and regulate.
- States and HHS need to be aware of the many potential cost centers associated with compliance with the statute and potential regulations.
- States should be allowed and encouraged to explore the possibility of implementing a Defined Contribution market as part of their exchange implementation plan.
- The true goal is to change the game in terms of health outcomes. We want to have a healthier population at the end of the day.
- All consumers have to have some of their own money on the table if we are to have different expectations and outcomes.
- Exchanges should encourage innovations that increase the longevity of the consumer-plan relationship.
- There is no need for states or HHS to re-invent the wheel. States and private partners already have in place most of the technology and regulation that is needed for success.
- An exchange can be successful (and perhaps even more so) with less state regulation. The private stakeholders are aware of the issues and generally have the tools needed to address them.
- The premium aggregator has the potential under the ACA to reduce the need for federal premium subsidies for lower income families who would be able to pool private resources to purchase a single policy for the family.
- We need consideration and support to square eligibility requirements for premium credits and subsidies with Defined Contribution arrangements.
- An exchange should be a lot more than just a place to buy insurance. The Exchange has a critical role in promoting wellness and providing transparency on cost and quality information.
- It is critical that states have the flexibility to study and consider options that make the most sense for their local circumstances as they negotiate the terms of such regional exchanges or inter-state cooperation.
- State exchanges may have standards for plans, but should not have a regulatory function. Regulation of carriers should be limited to one state agency - the Insurance Department.

- States should be circumspect and consider carefully how to proceed and whether to accept/apply for federal funds. Planning grants may be critical tools for states as they weigh those decisions.

- Each state is unique with its own insurance market structure, consumer involvement and regulatory environment. No model can work for every state; however, states can learn a great deal from the Utah experience as they begin to move forward.

- The federal government should provide a common technology standard to help states communicate with federal agencies and provide the support and funding to help state systems interface with federal agencies.

- Many elements of exchanges lend themselves to the opportunity for states to share services with other exchanges, especially technology solutions. HHS should facilitate state cooperation and sharing. The concept of HHS paying 90% for states to independently develop systems that are nearly identical is suboptimal.

- Exchange technologies should be modern, flexible, and simple.